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## On Health, Law, and Religion

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# On Health, Law, and Religion

Stacey A. Tovino, J.D., Ph.D.\*

## *Abstract*

*The Supreme Court recently decided a number of cases involving health, law, and religion, including Whole Woman's Health v. Hellerstedt, Zubik v. Burwell, and Burwell v. Hobby Lobby Stores, Inc. These cases were important for understanding constitutional undue burden limitations and the boundaries of religious exercise during the Obama Administration. Unfortunately, the Supreme Court's recent opinions addressing health, law, and religion have little value for many health law professors and most practicing health care attorneys. These individuals, tasked with teaching and applying the thousands of federal and state statutes, regulations, and government guidance documents that address a wide variety of health care access, quality, liability, organization, and finance issues, do not deal with constitutional undue burden limitations and the boundaries of religious exercise on a regular basis. Instead, these individuals focus on practical legal questions raised by the day-to-day delivery of health care.*

*This Article seeks to remedy the lack of judicial and academic attention to practical issues that lie at the intersection of health, law, and religion. Drawing guidance from fields as wide ranging as constitutional law, transportation law, utilities law, criminal law, contract law, tax law, and trusts and estates law, this Article proposes new federal regulations and agency guidance in four*

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*illustrative contexts that implicate health, law, and religion. These contexts include religious nonmedical health care, home health care, hospice care, and health information confidentiality. If adopted by the federal Department of Health and Human Services, the proposals set forth in this Article will improve the counsel provided by regulatory health care attorneys as well as the public's understanding of issues that lie at the intersection of health, law, and religion.*

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### *I. Introduction*

The Supreme Court recently decided a number of cases involving health, law, and religion. In *Whole Woman's Health v. Hellerstedt*,<sup>1</sup> a group of abortion providers challenged a Texas law requiring physicians who perform abortions to maintain admitting privileges at a local hospital as well as a second provision requiring abortion facilities to meet requirements applicable to surgery centers.<sup>2</sup> On June 27, 2016, the Court ruled that each provision constituted an undue burden on abortion access in violation of the Fourteenth Amendment to the U.S. Constitution.<sup>3</sup>

In *Zubik v. Burwell*,<sup>4</sup> by further example, a group of nonprofit organizations that provide health insurance to their employees challenged federal regulations requiring, as an exception to a

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1. 136 S. Ct. 2292 (2016).

2. *Id.* at 2296.

3. *Id.* at 2300.

4. 136 S. Ct. 1557 (2016).

contraception coverage mandate, submission of a religious objection form to the government.<sup>5</sup> The petitioners alleged that the requirement to submit the form substantially burdened their exercise of religion<sup>6</sup> in violation of the Religious Freedom Restoration Act (RFRA).<sup>7</sup> On May 16, 2016, the Court remanded the case, asking the parties to craft an approach that accommodated petitioners' religious exercise and that ensured contraception coverage for women employees.<sup>8</sup>

In *Burwell v. Hobby Lobby Stores, Inc.*,<sup>9</sup> by final example, three closely held corporations challenged federal regulations requiring them to provide health insurance coverage of their employees' contraception.<sup>10</sup> Because the owners of the corporations sincerely believed that life begins at conception, they objected to birth control that could destroy such life.<sup>11</sup> On June 30, 2014, the Court ruled that the contraceptive coverage mandate substantially burdened the corporation owners' exercise of religion in violation of RFRA.<sup>12</sup>

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5. *See id.* at 1559 ("Petitioners allege that submitting this notice substantially burdens the exercise of their religion, in violation of the Religious Freedom Restoration Act of 1993 . . ."); 45 C.F.R. § 147.131(c)(1) (2016) (stating that a health plan complies with the Affordable Care Act's contraception coverage requirement when it provides a copy of a self-certification to each health insurance issuer or a notice to the federal Department of Health and Human Services objecting to coverage of contraceptive services on religious grounds); 26 C.F.R. § 54.9815-2713(b)–(c) (2015) (same); 29 C.F.R. § 2590.715-2713(b)–(c) (2016) (same). *See generally* Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,874 (July 2, 2013) ("After meeting a self-certification standard . . . nonprofit religious organizations that qualify for these accommodations are not required to contract, arrange, pay, or refer for contraceptive coverage.").

6. *Zubik*, 136 S. Ct. at 1559.

7. *See* 42 U.S.C. § 2000bb-1(a) (2012) (prohibiting the government from substantially burdening a person's exercise of religion even if the burden results from a rule of general applicability).

8. *Zubik*, 136 S. Ct. at 1560.

9. 134 S. Ct. 2751 (2014).

10. *See id.* at 2754 ("Nonexempt employers are generally required to provide coverage for the 20 contraceptive methods approved by the Food and Drug Administration . . .").

11. *See id.* at 2759 ("In these cases, the owners of three closely held for-profit corporations have sincere Christian beliefs that life begins at conception and that it would violate their religion to facilitate access to contraceptive drugs or devices that operate after that point.").

12. *See id.* at 2759 ("We hold that the regulations that impose this obligation

The petitioners in *Whole Woman's Health*, *Zubik*, and *Hobby Lobby* were successful in part because they were politically motivated<sup>13</sup> and in part because they were threatened by large-scale clinical and financial losses.<sup>14</sup> Without the ruling in *Whole Woman's Health*, tens of thousands of Texas women would have lost access to safe abortions<sup>15</sup> and abortion clinics would have spent millions of dollars on surgery center compliance.<sup>16</sup> Likewise, the employers in *Zubik* and *Hobby Lobby* would have had to

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violate RFRA, which prohibits the Federal Government from taking any action that substantially burdens the exercise of religion unless that action constitutes the least restrictive means of serving a compelling government interest.”).

13. See, e.g., *Advocacy*, WHOLE WOMAN'S HEALTH, <https://wholewomanshealth.com/about-us/advocacy/> (last visited Sept. 20, 2017) (“Whole Woman's Health remains a strong advocate and community pillar wherever we have clinics, becoming the voice of women's reproductive justice . . .”) (on file with the Washington and Lee Law Review); Eli Clifton, *Hobby Lobby's Secret Agenda: How It's Quietly Funding a Vast Right-Wing Movement*, SALON (Mar. 27, 2014, 11:45 AM), [http://www.salon.com/2014/03/27/hobby\\_lobbys\\_secret\\_agenda\\_how\\_its\\_secretly\\_funding\\_a\\_vast\\_right\\_wing\\_movement/](http://www.salon.com/2014/03/27/hobby_lobbys_secret_agenda_how_its_secretly_funding_a_vast_right_wing_movement/) (last visited Sept. 20, 2017)

[Hobby Lobby provides] funding for a group that backs a political network of activist groups deeply engaged in pushing a Christian agenda into American law . . . . [E]ntities related to [Hobby Lobby are] two of the largest donors to the organization funding a right-wing Christian agenda, investing tens, if not hundreds, of millions of dollars into a vast network of organizations . . . . That network of activist groups has succeeded in passing legislation in Arizona requiring women to undergo an ultrasound before an abortion, banning taxpayer-funded insurance paying for government employees' abortions, defining marriage as a union between a man and woman, and funding abstinence education.

(on file with the Washington and Lee Law Review).

14. See *infra* notes 15–18 and accompanying text (referencing these large-scale clinical and financial losses).

15. See, e.g., Dahlia Lithwick, *Texas' Big Lie*, SLATE (Mar. 1, 2016, 7:23 PM), [http://www.slate.com/articles/news\\_and\\_politics/jurisprudence/2016/03/whole\\_woman\\_s\\_health\\_v\\_hellerstedt\\_is\\_a\\_test\\_for\\_the\\_supreme\\_court\\_can\\_the.html](http://www.slate.com/articles/news_and_politics/jurisprudence/2016/03/whole_woman_s_health_v_hellerstedt_is_a_test_for_the_supreme_court_can_the.html) (last visited Sept. 20, 2017) (“[T]here is virtually no doubt that closing clinics en masse will lead to terrible health outcomes for Texas women . . . . Tens of thousands of women across the state will thus lose access to clinics. They will not have safer, cleaner clinics. They will simply have none.”) (on file with the Washington and Lee Law Review).

16. See, e.g., *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2318 (2016) (“[T]he costs that a currently licensed abortion facility would have to incur to meet the surgical-center requirements were considerable, ranging from \$1 million per facility (for facilities with adequate space) to \$3 million per facility (where additional land must be purchased).”).

provide contraception coverage to thousands of employees in violation of their religious beliefs or pay millions of dollars per year in taxes and penalties without Supreme Court rulings in their favor.<sup>17</sup>

The opinions in *Whole Woman's Health*, *Zubik*, and *Hobby Lobby* were important for understanding constitutional undue burden limitations and the boundaries of religious exercise when President Obama was in office.<sup>18</sup> How constitutional undue burden limitations, including those articulated in *Whole Woman's Health*, will fare during the Trump Administration remains to be seen. Given the appointment of Neil Gorsuch to the Supreme Court,<sup>19</sup> further restrictions on women's reproductive rights are expected.<sup>20</sup>

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17. See, e.g., *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2764–65 (2014) (noting that petitioner Conestoga Wood Specialties has 950 employees, petitioner Hobby Lobby has 13,000 employees, and petitioner Mardel has 400 employees; describing the companies' Christian values and religious beliefs); *id.* at 2775–76 (calculating the millions of dollars of taxes and penalties that Conestoga Wood Specialties, Hobby Lobby, and Mardel would owe if they failed to provide insurance coverage of contraception or if they stopped providing health insurance coverage altogether).

18. See, e.g., Adam Liptak, *Supreme Court Strikes Down Abortion Restrictions*, N.Y. TIMES (June 27, 2016), [https://www.nytimes.com/2016/06/28/us/supreme-court-texas-abortion.html?\\_r=0](https://www.nytimes.com/2016/06/28/us/supreme-court-texas-abortion.html?_r=0) (last visited Sept. 20, 2017) (discussing the importance of the Supreme Court's decision in *Whole Woman's Health*) (on file with the Washington and Lee Law Review); see also Binyamin Appelbaum, *What the Hobby Lobby Ruling Means for America*, N.Y. TIMES (July 22, 2014), <https://www.nytimes.com/2014/07/27/magazine/what-the-hobby-lobby-ruling-means-for-america.html> (last visited Sept. 20, 2017) (discussing the significance of the Supreme Court's decision in *Hobby Lobby*) (on file with the Washington and Lee Law Review).

19. See Lisa Mascaro & David G. Savage, *Senate Confirms Neil Gorsuch, Trump's Supreme Court Nominee*, L.A. TIMES (Apr. 7, 2017, 2:10 PM), <http://www.latimes.com/politics/la-na-pol-gorsuch-confirmed-20170407-story.html> (last visited Sept. 20, 2017) (reporting the Senate's confirmation of Gorsuch) (on file with the Washington and Lee Law Review).

20. See, e.g., *id.* (“[Gorsuch] will restore a narrow conservative majority on issues such as campaign funding, religious liberty and support for gun ownership rights. The new justice is expected to join his conservative colleagues in upholding further restrictions on abortion.”); see also Adam Liptak, *What the Trump Presidency Means for the Supreme Court*, N.Y. TIMES (Nov. 9, 2016), <https://www.nytimes.com/2016/11/10/us/politics/trump-supreme-court.html> (last visited Sept. 20, 2017) (“The election of Donald J. Trump means that Justice Antonin Scalia's seat, vacant since he died in February, will almost certainly be filled by a conservative nominee. Back to full strength, the court will again tilt right, as it has for decades.”) (on file with the Washington and Lee Law Review).

Regardless of Gorsuch's ideology and the Supreme Court's restored conservative tilt, the Supreme Court's recent opinions addressing health, law, and religion have little value for many pure health law professors and many practicing health care attorneys. These individuals, tasked with teaching and applying the thousands of federal and state statutes, regulations, and government guidance documents that address a wide variety of health care access,<sup>21</sup> quality,<sup>22</sup> liability,<sup>23</sup> organization,<sup>24</sup> and finance<sup>25</sup> issues, do not deal with constitutional undue burden limitations and the boundaries of religious exercise on a regular basis.

As an illustration, I have been practicing, teaching, and writing in a number of heavily regulated areas of health law, including Medicare-participating hospital operations,<sup>26</sup> general Medicare and Medicaid reimbursement,<sup>27</sup> Medicare and Medicaid reimbursement of inpatient and outpatient mental health services,<sup>28</sup> Medicare and Medicaid financing of graduate medical

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21. See, e.g., 42 U.S.C. § 1395dd (2012) (codifying the federal Emergency Medical Treatment and Active Labor Act, which governs access to Medicare participating hospitals' emergency departments, including medical screening examinations, necessary stabilizing treatments, and appropriate transfers).

22. See, e.g., 42 U.S.C. §§ 11111–52 (codifying the federal Health Care Quality Improvement Act, which promotes professional review activities designed to improve the quality of health care).

23. See, e.g., TEX. CIV. PRAC. & REM. CODE §§ 74.001–74.507 (2016) (codifying the Texas Medical Liability Act, which governs health care liability claims in the State of Texas).

24. See, e.g., TEX. OCC. CODE §§ 162.001–162.003 (2016) (governing the organization of nonprofit health corporations in the State of Texas).

25. See, e.g., NEV. REV. STAT. §§ 422.270–422.27495 (2017) (governing the Nevada Medicaid and the Nevada Children's Health Insurance Program, two public health care programs that finance health care for Nevada adults and children with low income and low resources).

26. See Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 566–71 (2007) (proposing changes to Medicare regulations governing the use of restraint and seclusion in the hospital setting).

27. See Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471, 514–15 (2012) (proposing to improve the essential health benefits required by the Affordable Care Act).

28. See Stacey A. Tovino, *All Illnesses Are (Not) Created Equal: Reforming Federal Mental Health Insurance Law*, 49 HARV. J. LEGIS. 1, 45–50 (2012) (proposing to improve health insurance coverage of mental illness).

education,<sup>29</sup> and Medicare and Medicaid health care fraud and abuse,<sup>30</sup> for the past two decades. During my law practice and now in my law teaching, I have witnessed firsthand the multiple ways in which religion intersects the daily practice and teaching of health law, yet I rarely find case law that addresses these intersections. The issues in which I am interested tend not to be litigated because they do not threaten patients or providers with large scale clinical or financial losses and do not otherwise draw significant political attention.

The day-to-day issues that lie at the intersection of health, law, and religion also receive scant attention from legal scholars. Many law professors who write about the role of religion in health care specialize in constitutional law or law and religion. These scholars focus almost exclusively on Supreme Court decisions such as *Whole Woman's Health*, *Zubik*, and *Hobby Lobby*, as well as related hot topics, including religious liberty,<sup>31</sup> religious accommodation,<sup>32</sup> conscientious objection,<sup>33</sup> sexual orientation

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29. See Stacey A. Tovino, *I Need a Doctor: A Critique of Government Financing of Graduate Medical Education*, 71 WASH. & LEE L. REV. 2431, 2491–09 (2014) (proposing to improve Medicare financing of graduate medical education).

30. See Stacey A. Tovino, *Incorporating Literature into a Health Law Curriculum*, 9 J. MED. & L. 213, 245–47 (2005) (discussing methods of teaching the law governing public health care program fraud and abuse using literature).

31. See Douglas Laycock, *Religious Liberty, Health Care, and the Culture Wars*, in LAW, RELIGION AND HEALTH IN THE UNITED STATES (Holly Fernandez Lynch, I. Glenn Cohen & Elizabeth Sepper eds., 2017) [hereinafter LAW, RELIGION & HEALTH] (reviewing the *Burwell v. Hobby Lobby* and *Zubik v. Burwell* cases, assessing alleged conflicts between religious liberty and health care, and considering appropriate limits on religious exemptions in the health care context).

32. See Agenda, Harvard Law Petrie-Flom Center, 2015 Annual Conference: Law, Religion, and Health in America (May 8–9, 2015), <https://bsl.app.box.com/s/w1drs6pglz8ez6xx3b19ix6fspnzxh14.pdf> [hereinafter Harvard Law, Religion, and Health Conference] (discussing the topic of religious accommodations).

33. See *id.* at 3 (addressing conscience objections).



counseling,<sup>34</sup> reproductive decision-making,<sup>35</sup> and brain death.<sup>36</sup> Perhaps because not all of these scholars are familiar with the American health care delivery system and the federal and state laws that govern it,<sup>37</sup> the intersection of religion with this system receives little academic attention, leaving many pure health law professors and most practicing health care attorneys with much confusion and little guidance when religion intersects their daily work.

This Article seeks to remedy this problem. That is, this Article identifies four illustrative ways in which religion intersects the daily practice of health law, including issues that courts have not carefully addressed and legal academics have not thoroughly examined in traditional law review scholarship.<sup>38</sup> Drawing guidance from fields as wide ranging as constitutional law,

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34. See Craig Konnoth, *Reclaiming Biopolitics: Religion and Psychiatry in the Sexual Orientation Change Therapy Cases and the Establishment Clause Defense*, in LAW, RELIGION & HEALTH, *supra* note 31 (exploring the pedigree of therapies that undergird sexual orientation change efforts (SOCE) and showing that SOCE is best understood as a form of religious ministry); see also Susan Stable, *Religious Convictions About Homosexuality and the Training of Counseling Professionals: How Should We Treat Religious-Based Opposition to Counseling About Same-Sex Relationship?* in LAW, RELIGION & HEALTH, *supra* note 31 (arguing that the religious convictions of those who wish to enter the counseling professions can be respected while still safeguarding the interest of individuals seeking same-sex counseling).

35. See B. Jessie Hill, *Regulating Reasons: Government Regulation of Private Deliberation in Reproductive Decision-Making*, in LAW, RELIGION & HEALTH, *supra* note 31 (considering the legal and constitutional significance of religious motivations in private decision-making in the context of reproductive health care); see also I. Glenn Cohen, *Religion and Reproductive Technology*, in LAW, RELIGION & HEALTH, *supra* note 31 (examining four particular intersections of religion and reproductive technology); see also Dov Fox, *Religion and the Unborn Under the First Amendment*, in LAW, RELIGION & HEALTH, *supra* note 31 (arguing that certain challenges to the Establishment Clause trade on a misunderstanding of religion and its relationship to ideas about the unborn).

36. See Thaddeus Pope, *Brain Death Rejected: Expanding Legal Duties to Accommodate Religious Objections*, in LAW, RELIGION & HEALTH, *supra* note 31 (arguing that all states should require hospitals to accommodate families with religious objections to determination of death by neurological criteria).

37. Both federal and state laws govern the health care industry and the health care delivery system. See, e.g., 42 C.F.R. Parts 2-1008 (2016) (federal regulations governing Medicare-participating health care providers and suppliers); see also NEV. REV. STAT. Ch. 449 (2016) (state statutes governing medical facilities in Nevada).

38. *Infra* Parts II–V.

transportation law, utilities law, criminal law, contract law, tax law, and trusts and wills law, this Article proposes three sets of federal regulations and three guidance documents designed to advise and inform practicing health care attorneys, pure health law professors, and the general public.<sup>39</sup> This Article also calls on constitutional law and law and religion scholars to bring their significant expertise to bear on the practical yet important questions raised herein.<sup>40</sup> This Article concludes by making three administrative recommendations that, if implemented by the federal Department of Health and Human Services (HHS), would improve the counsel provided by regulatory health care attorneys as well as the public's understanding of issues that lie at the intersection of health, law, and religion.<sup>41</sup>

This Article proceeds as follows: Part II examines the law governing religious nonmedical health care institutions (RNHCIs), which are nonprofit, tax-exempt religious organizations that furnish only nonmedical health care items and services to patients who elect to rely solely upon religious methods of healing.<sup>42</sup> Part II illustrates the mixing of religious and non-religious care provided by RNHCIs and reviews the Supreme Court case law and federal regulations that govern direct federal financing of health and social services.<sup>43</sup> Part II applies this legal authority to Medicare coverage of RNHCIs and proposes amendments to 42 C.F.R. §§ 403.720 and 403.766 as well as guidance that would clarify outstanding issues for practicing health care attorneys and the general public.<sup>44</sup>

Part III explores the intersection of religion and home health care law.<sup>45</sup> Home health care includes a wide range of health care

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39. *Infra* Parts II–V.

40. *Infra* Parts II–V.

41. *Infra* Part VI.

42. See 42 C.F.R. § 403.702 (defining religious nonmedical care); see also *Religious Nonmedical Health Care Institutions*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/RNHCIs.html> (last updated Apr. 10, 2013) (last visited Sept. 20, 2017) [hereinafter CMS Summary of RNHCIs] (describing religious nonmedical health care institutions) (on file with the Washington and Lee Law Review).

43. *Infra* Part II.

44. *Infra* Part II.

45. *Infra* Part III.

services that providers can safely deliver to patients who are confined to their homes.<sup>46</sup> As one might expect, Medicare prohibits home health agencies from seeking reimbursement for home health services provided to beneficiaries who are not actually confined to their homes.<sup>47</sup> Although HHS's Centers for Medicare and Medicaid Services (CMS) has stated that beneficiaries who leave the home for short periods of time for religious services still may be considered confined to their homes,<sup>48</sup> practicing attorneys frequently confront cases in which beneficiaries may be using attendance at religious services as a cover, as well as cases in which beneficiaries participate in choir practice, prayer groups outside of church, church-sponsored meals, church bus trips, and church bazaars but still wish to be considered confined to the home. Part III explores the proper division of religious services and other activities for purposes of Medicare coverage of home health care and proposes content for two new regulatory definitions that would be codified at 42 C.F.R. § 484.2 as well as complementary CMS guidance defining religious services.<sup>49</sup>

Part IV examines the intersection of spirituality and hospice law.<sup>50</sup> Hospice is a program of palliative care and support, but not treatment or cure, for individuals with terminal illness.<sup>51</sup> Medicare-participating hospice programs are required by federal law to assess and meet the spiritual needs of hospice patients and their family members.<sup>52</sup> Practicing health care attorneys who have little or no training in religious or spiritual studies frequently work on cases in which the hospice patient, his or her family, or CMS following a complaint from the family alleges that the hospice did

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46. See U.S. DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., CMS PROD. NO. 10969, MEDICARE AND HOME HEALTH CARE 4–5 (rev'd May 2010) (describing home health care and defining the homebound requirement).

47. See *id.* at 5 (“If you have Medicare, you can use your home health benefits if: . . . [y]ou’re homebound, and a doctor certifies that you’re homebound.”).

48. See *id.* (“[A person] may leave home for medical treatment or short, infrequent absences for non-medical reasons, like attending religious services.”).

49. *Infra* Part III.

50. *Infra* Part IV.

51. See U.S. DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., CMS PROD. NO. 02154, MEDICARE HOSPICE BENEFITS 4 (rev'd Feb. 2016) (defining hospice).

52. See 42 C.F.R. § 418.54 (2016) (requiring an assessment of spiritual needs).

not identify—and therefore did not meet—the patient’s or family’s spiritual needs, frequently because they were not recognized by hospice workers as such.<sup>53</sup> Part IV explores a variety of legal and industry understandings of spirituality and proposes that HHS issue a guidance document offering a framework for spirituality and explaining if, when, and in which contexts certain needs would qualify as spiritual needs.<sup>54</sup>

Part V examines the intersection of religion and the law governing health information confidentiality.<sup>55</sup> The federal HIPAA Privacy Rule, for example, carefully distinguishes health care providers from religious and spiritual care providers,<sup>56</sup> even though many hospitals and other health care institutions consider chaplains an important part of the health care team.<sup>57</sup> Attorneys with expertise in health information confidentiality are frequently asked to mediate this conflict, with mixed results.<sup>58</sup> Part V proposes important amendments to 45 C.F.R. § 164.501, including a new definition of “health care chaplain” and amendments to the definition of “health care operations” that would include the religious, spiritual, and other services provided by hospital chaplains.<sup>59</sup>

After identifying additional, illustrative issues that lie at the intersection of health, law, and religion, this Article concludes by making three procedural recommendations. If implemented, these recommendations would improve the counsel provided by regulatory health care attorneys as well as the public’s

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53. *Infra* Part IV.

54. *Infra* Part IV.

55. *Infra* Part V.

56. *See* Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,568 (Dec. 28, 2000) (“[H]ealth care’ as defined under the rule does not include methods of healing that are solely spiritual. Therefore, clergy or other religious practitioners that provide solely religious healing services are not health care providers within the meaning of this rule.”).

57. *See, e.g., Your Health Care Team*, CHRISTIANA CARE HEALTH SYS., <http://www.christianacare.org/yourhealthcareteam> (last visited Sept. 20, 2017) (discussing the inclusion of staff chaplains within the health care team) (on file with the Washington and Lee Law Review).

58. *Infra* Part V.

59. *Infra* Part V.

understanding of issues that lie at the intersection of health, law, and religion.<sup>60</sup>

## *II. Religious Nonmedical Health Care*

A good portion of health law is designed to identify which individuals and institutions constitute health care providers and suppliers that are eligible to receive Medicare, Medicaid, or other federal health care program reimbursement in exchange for providing health-related services and supplies to government beneficiaries.<sup>61</sup> Physicians and hospitals obviously can qualify, but a range of other health care institutions, including religious organizations, also may be eligible depending on the circumstances.

For example, certain RNHCI are considered health care providers under federal law and are eligible to receive Medicare reimbursement for certain health-related services provided to Medicare beneficiaries.<sup>62</sup> RNHCI are nonprofit, tax-exempt

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60. *Infra* Part VI.

61. See 42 C.F.R. § 488.1 (2016) (defining “provider of services” to include hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical therapy and speech pathology services); *id.* § 489.2 (defining “provider” to include the following entities if they have an agreement to participate in Medicare: hospitals, transplant centers, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospices, religious nonmedical health care institutions); *id.* § 488.1 (defining “supplier” to include providers of independent laboratory services, portable x-ray services, physical therapists in independent practice, end-stage renal disease facilities, rural health clinics, federally qualified health centers, chiropractors, and ambulatory surgical centers); *id.* § 489.2 (providing “supplier” entities participating in Medicare including: independent laboratories, durable medical equipment suppliers, ambulance service providers, independent diagnostic testing facilities, physicians, physician assistants, physical therapists in independent practice, suppliers of portable x-ray services, rural health clinics, federally qualified health centers, ambulatory surgical centers and certain end-stage renal disease facilities); *id.* § 488.30 (defining “provider of services, provider, or supplier” to include ambulatory surgical centers, transplant centers, and religious non-medical health care institutions).

62. See *id.* § 498.2 (defining “provider” to include RNHCI); see also *id.* § 403.752 (addressing Medicare payment for RNHCI services). RNHCI also may be eligible to receive Medicaid payments under a State Plan option. See Medicare and Medicaid Programs; Religious Nonmedical Health Care

religious organizations that furnish only nonmedical health care items and services to patients who elect to rely solely upon religious methods of healing<sup>63</sup> and for whom the acceptance of medical health services would be inconsistent with their religious beliefs.<sup>64</sup> RNHCIs include, but are not limited to, Christian Science sanatoria.<sup>65</sup>

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Institutions and Advance Directives, 68 Fed. Reg. 66,710, 66,710 (Nov. 28, 2003) (discussing amendments to federal law governing RNHCIs under Medicare and as a State Plan option under Medicaid). For ease of analysis, this Article will limit its discussion to Medicare coverage of RNHCIs.

63. Federal regulations define “religious nonmedical care” and “religious method of healing” as “health care furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets to fulfill a beneficiary’s total health care needs.” 42 C.F.R. § 403.702.

64. See 42 U.S.C. § 1395i-5 (2012) (establishing the statutory basis for Medicare payments to RNHCIs); 42 C.F.R. § 440.170(b)(1)–(10) (describing the characteristics of RNHCIs); *id.* §§ 403.700–403.770 (establishing the Medicare conditions of participation for RNHCIs); *id.* § 403.702 (defining “election” as a written statement signed by the beneficiary indicating the beneficiary’s choice to receive nonmedical care or treatment for religious reasons). Medicare recognizes RNHCIs as providers but uses different terminology with respect to RNHCIs compared to other health care providers. For example, Medicare-participating hospitals are required to maintain “medical records,” whereas Medicare-participating RNHCIs are required to maintain “patient records.” See 42 C.F.R. § 489.102(a)(2) (requiring most Medicare-participating health care providers to document whether or not an individual has an advance directive in the patient’s medical record while requiring RNHCIs to document such information in the patient care record).

65. See Medicare and Medicaid Programs; Religious Nonmedical Health Care Institutions and Advance Directives, 64 Fed. Reg. 67,028, 67,028 (Nov. 30, 1999) (“While the previous [rules] were specific to Christian Science sanatoria, the new amendments make it possible for institutions other than Christian Science facilities to qualify as RNHCIs and to participate in Medicare and Medicaid.”); see also *Kong v. Min de Parle*, No. C 00–4285 CRB, 2001 WL 1464549, at \*4 (N.D. Cal. Nov. 13, 2001) (“Congress intended the statute to be sect-neutral. Congress explicitly stated that the exemption is intended to provide ‘a sect-neutral accommodation to any person . . . for whom the acceptance of medical health services would be inconsistent with his or her religious beliefs.’” (citations omitted)).

Although Medicare does not pay for the religious aspects of beneficiaries' RNHCI care,<sup>66</sup> Medicare Part A<sup>67</sup> will cover

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66. See Centers for Medicare & Medicaid Services, STATE OPERATIONS MANUAL, APPDX. U, SURVEY PROCEDURES AND INTERPRETIVE GUIDELINES FOR RESPONSIBILITIES OF MEDICARE PARTICIPATING RELIGIOUS NONMEDICAL HEALTHCARE INSTITUTIONS 3 (May 21, 2004), [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_u\\_rnhci.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_u_rnhci.pdf) [hereinafter State Operations Manual Provisions] ("Note: Religious components of the healing are not covered."); *id.* at 11 ("The religious aspects of care are the financial responsibility of the patient."); see also *Religious Non-Medical Health Care Institution (RNHCI) Items & Services*, MEDICARE.GOV, <https://www.medicare.gov/coverage/rnhci-items-and-services.html> (last visited Sept. 20, 2017) ("Medicare doesn't cover the religious portion of RNHCI care.") (on file with the Washington and Lee Law Review); U.S. DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., CMS MANUAL SYSTEM, PUB. 100-02 MEDICARE BENEFIT POLICY, REVISIONS TO INSTRUCTIONS FOR CONTRACTORS OTHER THAN THE RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTION (RNHCI) SPECIALTY CONTRACTOR REGARDING CLAIMS FOR BENEFICIARIES WITH RNHCI ELECTIONS, at 8 (2006) [hereinafter Transmittal 45] ("As in the original RNHCI benefit, Medicare will only pay for nonmedical services in the home, but not for those religious items or services provided by the RNHCI.").

67. Medicare is a public healthcare program that, in 1966, began providing health insurance to individuals age 65 or older who were insured under the federal Old-Age and Survivors Insurance Program. See Social Security Amendments of 1965, Pub. L. No. 89-97, §101, 79 Stat. 286 (stating the purpose behind the Hospital Insurance Act of 1965). The Social Security Amendments of 1972 expanded Medicare eligibility to include certain individuals under the age of 65 who had disabilities and certain individuals with end-stage renal disease. See Social Security Amendments of 1972, Pub. L. No. 92-603, § 299I 86 Stat. 1329 (expanding Medicare eligibility). At the time of the Social Security Amendments of 1965 and 1972, Medicare coverage consisted only of hospital insurance (i.e., Medicare Part A) as well as supplemental medical insurance (i.e., Medicare Part B). See 42 U.S.C. §§ 1395c–i-5 (2006 & Supp. IV 2010) (codifying "[Medicare] Part A—Hospital Insurance Benefits for Aged and Disabled"); *id.* §§ 1395j–1395w-5 (codifying "[Medicare] Part B—Supplementary Medical Insurance Benefits for Aged and Disabled"). In the Balanced Budget Act of 1997, Congress added a third part to the Medicare Program (Medicare Part C). Originally named Medicare Choice, this part provided Medicare beneficiaries with managed care options. See 42 U.S.C. §§ 1395w-21–w-28. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Congress changed the compensation and business practices for insurers offering Medicare Choice plans, renaming the part Medicare Advantage (MA). Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, §§ 201–238, 117 Stat. 2066. The MMA also added a fourth part to the Medicare Program (Medicare Part D), which provided a prescription drug benefit that subsidized the costs of prescription drugs and prescription drug insurance premiums for Medicare beneficiaries. See 42 U.S.C. §§ 1395w-101–w-154 ("A reduction in the annual deductible, a

nonreligious, nonmedical health care provided to RNHCI beneficiaries, including inpatient care in an RNHCI, as well as intermittent nursing care<sup>68</sup> and durable medical equipment (DME)<sup>69</sup> provided to beneficiaries in their homes, when certain conditions are satisfied.<sup>70</sup> The federal legislation authorizing Medicare payments to RNHCI has survived constitutional challenges by taxpayers and other stakeholders who have argued that the legislation should be subject to strict scrutiny and that the legislation impermissibly establishes religion in violation of the First Amendment.<sup>71</sup> Constitutional law scholars who have written about RNHCI have focused on the general questions raised by these constitutional challenges; that is, whether the RNHCI legislation should be subject to strict scrutiny and whether Medicare funding of RNHCI impermissibly establishes religion.<sup>72</sup>

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reduction in the coinsurance percentage, or an increase in the initial coverage limit with respect to covered part D drugs . . .”).

68. Intermittent nursing care eligible for Medicare coverage includes assistance with the activities of daily living, assistance in moving, turning, positioning, ambulation, nutritional assistance, and the provision of comfort and support measures. *See* 64 Fed. Reg. 67,028, 67,030 (Nov. 30, 1999) (“Furnishes nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of these patients.”).

69. DME eligible for Medicare coverage include canes, crutches, walkers, commodes, a standard wheelchair, hospital beds, bedpans, and urinals. *See* Transmittal 45, *supra* note 66, at 9 (listing examples of reimbursable durable medical equipment).

70. For example, the RNHCI must be a certified Medicare-participating provider and the RNHCI utilization review committee must agree that the patient would require hospital or skilled nursing facility care but for the patient’s religious beliefs. *See* CMS Summary of RNHCI, *supra* note 42 (“Furnishes nonmedical items and services to inpatients on a 24-hour basis.”); *see also* 42 C.F.R. §§ 403.764–403.766 (2017) (governing Medicare payment for home health services provided by RNHCI).

71. *See, e.g., Kong v. Scully*, 341 F.3d 1132, 1141 (9th Cir. 2003) (“[T]axing for health care and providing it to its citizens, an incidental expenditure, less than 1/10 of 1% of the amount annually expended, in order to accommodate . . . the religious beliefs of a minority is not . . . an establishment of religion.”); *see also* *Children’s Healthcare v. Min de Parle*, 212 F.3d 1084, 1088 (8th Cir. 2000) (holding that strict scrutiny review does not apply to RNHCI legislation and that federal law authorizing Medicare payments to RNHCI is a permissible accommodation of religion).

72. Some scholars agree with the case law upholding the federal statutes and regulations that govern RNHCI. *See, e.g.,* Thomas C. Berg, *Religious Organizational Freedom and Conditions on Government Benefits*, 7 GEO. J. L. & PUB. POL’Y 165, 190 (2009) (“The Eighth Circuit was correct in upholding the



Scholars, practicing attorneys, and current and former members of the Christian Science Church have opposing viewpoints on these issues.<sup>73</sup>

Neither the enabling legislation,<sup>74</sup> nor the implementing regulations,<sup>75</sup> nor the State Operations Manual,<sup>76</sup> nor legal scholarship distinguishes religious and non-religious care. Only the implementing regulations even touch on the subject, stating

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accommodations in the funding program. Whether or not the government is required to preserve religious organizations' choice in the funding context, it should at least be permitted to do so." (citation omitted)). Others disagree. *See, e.g.,* Breanna R. Harris, Note, *Veiled in Textual Neutrality: Is That Enough? A Candid Reexamination of the Constitutionality of Section 4454 of the Balanced Budget Act of 1997*, 61 ALA. L. REV. 393, 394 (2010) (addressing "the magnitude of this issue (for example, hundreds of millions of Medicare and Medicaid dollars are spent annually and program funds are quickly evaporating, putting millions of American citizens at risk of depleting health care resources)" and calling for "government action to remedy this violation").

73. *See, e.g.,* Berg, *supra* note 72, at 167 (making the case that "religious organizations ought to be able to challenge . . . conditions that exclude them from benefits because of their religious character or a practice important to the organization's religious identity"); *see also* Harris, *supra* note 72, at 394 (disagreeing with court decisions upholding the constitutionality of Section 4454 of the Balanced Budget Act of 1997); CBS, *60 MINUTES By Faith Alone*, YOUTUBE (July 26, 2013), <https://www.youtube.com/watch?v=TQ2hfRbXUq8> (last visited Sept. 20, 2017) (highlighting the difference of opinion held by many in and around the Christian Science Church regarding Medicare payments to RNHCIs, including Sen. Orrin Hatch, attorney Bob Bruno, outside counsel to the Christian Science Church Michael McConnell, and former Church member Leslie Saunders) (on file with the Washington and Lee Law Review); Jarred Booth, *Christian Science Health Care Scam Part 3: Medicare and Medicaid Have Been Paying Out Millions Each Year to Christian Science Non-Medical Facilities*, NEWS HUB (May 15, 2016, 9:58 AM), <https://bsl.app.box.com/s/xp1zutqjfkoi4h6idiflx1zma3i8afbf> (last updated July 31, 2016) (last visited Sept. 20, 2017) ("Whether the Christian Science leaders are sincere in their beliefs or not is completely irrelevant . . . . The fact that they [won't remove spiritual healing from the Church], while continuing to rake in the millions from the government, convinces me that, yes, Christian Science healing is a scam.") (on file with the Washington and Lee Law Review).

74. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, 105th Cong. § 4454 (titled "Coverage of services in religious nonmedical health care institutions under the Medicare and Medicaid programs").

75. *See* 42 C.F.R. §§ 403.700–403.770 (2017) ("Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment.").

76. *See* State Operations Manual Provisions, *supra* note 66, at 3, 11 (stating that Medicare does not cover the religious aspects and the religious components of care without discussing what constitutes a religious aspect or component of care).

that care provided by religious practitioners is not eligible for Medicare reimbursement.<sup>77</sup> These primary and secondary authorities also do not address a question that practicing health-care attorneys frequently receive from disgruntled taxpayers, hospital associations, general medical associations, medical specialty associations, organizations that oppose medical neglect of children, and other stakeholders: whether RNHCIs may provide religious and non-religious care to Medicare beneficiaries at the same time and in the same location without violating the Establishment Clause.

The question is common given the well-known body of legal authority prohibiting the mixing of religious services with programs receiving direct federal financial assistance.<sup>78</sup> President Obama's Executive Order 13279 (Order), for example, requires faith-based organizations to perform their religious activities "outside of programs that are supported with direct [f]ederal financial assistance" and to conduct them "separately in time or location from any such programs or services supported with direct [f]ederal financial assistance."<sup>79</sup> The Order also requires "explicitly religious activities" to be voluntary for beneficiaries of programs that receive direct federal financial assistance.<sup>80</sup>

The separation and voluntariness requirements are codified in federal regulations as well. For example, HHS regulations prohibit organizations that receive direct financial assistance from HHS from engaging in "inherently religious activities, such as worship, religious instruction, or proselytization, as part of the programs or services funded with direct financial assistance from [HHS]."<sup>81</sup> These regulations further require organizations to conduct any inherently religious activities "separately, in time or location, from the programs or services funded with direct financial assistance

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77. See 64 Fed. Reg. 67,028, 67,029 (Nov. 30, 1999) ("[The regulations] do not mention the use of a religious practitioner since we consider the cost of using a religious practitioner the financial responsibility of the patient.").

78. See *infra* notes 79–91 and accompanying text (providing examples of both Congress and the Executive branch attempting to enforce a separation between religion and federal funds).

79. See Exec. Order No. 13279, 67 Fed. Reg. 77,141, 77,142 (Dec. 16, 2002) (outlining fundamental principles and policymaking criteria for partnerships with faith-based and other neighborhood organizations).

80. *Id.*

81. *Id.*

from [HHS],” and to make participation in such activities voluntary for the beneficiaries of the federally funded services.<sup>82</sup> Regulations promulgated by other federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA),<sup>83</sup> the Veterans Administration (VA),<sup>84</sup> the Department of Housing and Urban Development (HUD),<sup>85</sup> and the Department of Agriculture (USDA),<sup>86</sup> contain the same rules and prohibitions.

Historically, there has been disagreement regarding the degree of separation required between programming receiving direct federal financial assistance and religious activities.<sup>87</sup> In a 2010 report by President Obama’s Advisory Council on Faith-Based and Neighborhood Partnerships (Council), for example, Council members disagreed regarding whether the government should allow subsidized social services to be provided in rooms that contain religious art, scripture, messages, or symbols.<sup>88</sup> A majority of Council members believed that the government should neither require nor encourage the removal of religious art, scripture, messages, or symbols in rooms where

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82. *Id.*

83. *See* 42 C.F.R. § 54a.4 (2017) (“No funds provided directly from SAMHSA . . . may be expended for inherently religious activities . . . . If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA . . . .”).

84. *See* 38 C.F.R. § 62.62(c) (“Organizations that engage in inherently religious activities, such as worship, religious instruction, or proselytization, must offer those services separately in time or location from any programs or services funded with direct financial assistance from VA under this part . . . .”).

85. *See* 24 C.F.R. § 5.109(c) (mirroring the language of the SAMHSA and VA regulations set forth at *supra* notes 83 and 84).

86. *See* Policy Memorandum No. FD-138 from Laura Castro, Dir., USDA Food Distribution Div., on Written Notice and Referral Requirements for Beneficiaries Receiving TEFAP & CSFP Benefits from Religious Organizations (June 10, 2016) (“Because TEFAP is supported in whole or in part by financial assistance from the Federal Government, we are required to let you know that . . . we must separate in time or location any privately funded explicitly religious activities from activities supported with USDA direct assistance . . . .”).

87. *See infra* notes 88–91 and accompanying text (explicating the disagreement).

88. *See* PRESIDENT’S ADVISORY COUNCIL ON FAITH-BASED AND NEIGHBORHOOD PARTNERSHIPS, A NEW ERA OF PARTNERSHIPS: REPORT OF RECOMMENDATIONS TO THE PRESIDENT 132 (2010) [hereinafter COUNCIL REPORT] (detailing the views of the various factions among the Council).

funded services are provided.<sup>89</sup> A minority of Council members believed that federally funded programming should only take place in rooms with religious items if removing such items would be infeasible and no space without such items existed.<sup>90</sup> Two Council members believed that the government should amend federal law to permit nongovernmental organizations to offer federally funded programming only in areas devoid of religious items.<sup>91</sup>

Given this body of law and the historical disagreement regarding its interpretation, practicing health care attorneys are frequently asked by stakeholders to further challenge the constitutionality of Medicare coverage of RNHCI care. The requested challenge is that RNHCI care involves the simultaneous provision—many times in the same room and sometimes at the same time of day—of Medicare-reimbursed health care and religious care, including spiritual healing prayers, Bible readings, and hymn singing,<sup>92</sup> by Christian Science nurses<sup>93</sup> and Christian Science practitioners.<sup>94</sup>

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89. See *id.* (noting that sixteen Council members held this view).

90. See *id.* at 132–33 (noting that seven Council members held this view).

91. See *id.* at 133 (stating that these two Council members specifically “believe the Administration should amend existing regulations, guidance, and an executive order to permit nongovernmental organizations to offer federally funded programming only in areas devoid of such items”).

92. See *Christian Science Sanatoriums (LL-6000.1500)*, INFO. AND REFERRAL FEDERATION L.A. COUNTY, <https://211taxonomy.org/search/record?code=LL-6000.1500> (last updated Nov. 4, 2009) (last visited Sept. 20, 2017) (defining Christian Science Sanatoriums [sic]: “Christian Science nursing facilities that treat people who are ill with prayer instead of traditional medicine. In place of the drugs, surgery and therapy . . . sick church members receive care that includes praying, Bible reading and hymn singing”) (on file with the Washington and Lee Law Review).

93. See *Christian Science Nursing*, CHRISTIAN SCI., <http://www.christianscience.com/member-resources/christian-science-nursing> (last visited Sept. 20, 2017) (noting that Christian Science nursing care includes “[r]eading to or with an individual from the Bible, Science and Health with Key to the Scriptures and other writings by Mary Baker Eddy, and additional literature published by The Christian Science Publishing Society . . .”) (on file with the Washington and Lee Law Review).

94. See *Christian Science Practitioners*, CHRISTIAN SCI., <http://www.christianscience.com/member-resources/christian-science-practitioners> (last visited Sept. 20, 2017) (noting that Christian Science practitioners’ scope of services include providing requested prayer and visiting the person who is requesting prayer) (on file with the Washington and Lee Law Review); see also RITA SWAN, *THE LAST STRAWBERRY* 7–40 (2010) (describing Rita and Doug Swan’s use of Christian

Specific examples of this simultaneous, or mixed, RNHCI care may be helpful before proceeding. In Christian Science nursing homes, which are a type of RNHCI facility, broadcasts of Sunday services and Wednesday testimony meetings from the First Church of Christ, Science, are played through the RNHCI's public address (PA) system while beneficiaries may be receiving Medicare-covered services such as wound cleansing and bandaging, assistance with positioning and ambulation, assistance with nutrition, and provision of comfort and support measures.<sup>95</sup> Christian Science nursing homes also require all guests, including Medicare beneficiaries, to "[a]ctively study and practice Christian Science."<sup>96</sup> Christian Science nursing homes further allow all guests, including Medicare beneficiaries, to request prayer,<sup>97</sup> spiritual encouragement, and reading aloud from a Christian Science practitioner.<sup>98</sup> The required study and requested prayer

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Science practitioners for the care of their fifteen-month-old son, Matthew, who died on July 7, 1977 of untreated meningitis).

95. See 64 Fed. Reg. 67,028–030 (Nov. 30, 1999) (listing RNHCI services covered by Medicare); see also *Inpatient/Outpatient Care*, CHESTNUT HILL BENEVOLENT ASS'N, <http://www.chbenevolent.org/christian-science-nursing/inpatient-care-outpatient-care> (last visited Sept. 20, 2017) ("Each room receives the Christian Science textbook, hymns and a variety of Christian Science broadcasts on our PA system . . . Informal church services are held Sunday afternoons and Thursday evenings in our activity room.") (on file with the Washington and Lee Law Review); *Christian Science Nursing Care*, ARDEN WOOD, <http://ardenwood.org/christian-science-nursing-care/services-accommodations/> (last visited Sept. 20, 2017) ("Patients are cared for in private rooms . . . Audio broadcasts of Christian Science hymns, the weekly Bible Lesson and *Science and Health with Key to the Scriptures* as well as live Sunday and Wednesday church services are available in each room.") (on file with the Washington and Lee Law Review); *Activities*, FERN LODGE, <http://fernlodge.org/admissions/activities/> (last visited Sept. 20, 2017) (referencing the Church Services as well as a television station that makes such services available to guests who do not leave their rooms) (on file with the Washington and Lee Law Review).

96. See, e.g., MORNING LIGHT VISITING CHRISTIAN SCIENCE NURSING SERVICE, AGREEMENT FOR CHRISTIAN SCIENCE NURSING CARE, INCLUDING YOUR RIGHTS AS A PATIENT 1, [http://morninglightcs.org/docs/MLF\\_Visiting\\_Nurse\\_Agreement.pdf](http://morninglightcs.org/docs/MLF_Visiting_Nurse_Agreement.pdf) [hereinafter MORNING LIGHT] (stating the pledge that patients of this facility must make).

97. See Booth, *supra* note 73 ("Prayer by a Christian Science practitioner is very different from what Christians normally think of as prayer. It is not intercessory prayer, petitioning God for healing. Rather, it is mental argument against the false belief that is affecting the patient.").

98. See MORNING LIGHT, *supra* note 96 (offering "spiritual encouragement" and "reading aloud").

can and does take place in the same facility and many times in the same room where Medicare-covered care is provided.<sup>99</sup>

In theory, it might seem that an RNHCI facility could deliver its religious and nonreligious services separately.<sup>100</sup> When teaching Medicare coverage of RNHCI, I am frequently asked whether RNHCI beneficiaries can receive their nonreligious services in their private rooms and their religious services in separate prayer or reading rooms, perhaps because the Council and the courts have suggested that such separation can occur.<sup>101</sup> Although some beneficiaries' physical and metaphysical care could be separated, other beneficiaries' acute, near-death conditions cause them to be confined to their beds. These latter patients do, as a practical and clinical matter, receive both types of care while they lie in their beds.<sup>102</sup>

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99. See *Christian Science Nursing*, CHRISTIAN SCI., <http://www.ChristianScience.com/member-resources/christian-science-nursing> (last visited Sept. 20, 2017) ("Christian Science nursing facilities or houses provide a sanctuary where an individual's desire to rely solely on prayer for healing is upheld by the spiritual reassurance and practical care given by Christian Science nurses. These organizations offer 24-hour skilled Christian Science nursing care.") (on file with the Washington and Lee Law Review).

100. See *Children's Healthcare is a Legal Duty, Inc. v. Min de Parle*, 212 F.3d 1084, 1098 (8th Cir. 2000) ("[N]othing in [the Balanced Budget Act] suggests that these physical care services cannot be separated from the prayer and other religious activities that may occur within RNHCI's."); see also *id.* at 1100 ("[T]he physical services provided by Christian Science sanatoria are distinct and separable from any religious activity that may take place within such facilities.").

101. See, e.g., COUNCIL REPORT, *supra* note 88, at 149–51 (demonstrating how religion-based abstinence education programs can be completely separated in time and location from federally funded programming, including by "eliminat[ing] all religious materials from the presentation of the federally funded abstinence education program," which includes rings with religious messages and bibles); see also *Children's Healthcare Is a Legal Duty, Inc.*, 212 F.3d at 1098–1100 (suggesting that religious services can be separated from Medicare-funded services in RNHCI's).

102. See *supra* note 73 (referencing a "60 Minutes" episode that discussed a woman dying of breast cancer in an RNHCI; noting that the RNHCI's PA system, which plays Christian Science broadcasts, was turned up while the woman was screaming in pain); see also *Christian Science Nursing Care*, ARDEN WOOD, <http://ardenwood.org/christian-science-nursing-care/services-accommodations/> (last visited Sept. 20, 2017) (stating that "[f]or every patient, our nurses perform the following tasks: . . . Cleanse and bandage wounds . . . Read aloud the Bible Lesson and other authorized Christian Science literature") (on file with the Washington and Lee Law Review); *Christian Science Nursing Service at Sunrise Haven*, SUNRISE HAVEN, <http://www.sunrisehaven.org/web/cs-nursing-care/nursing-services> (last visited Sept. 20, 2017) (summarizing the 24-hour Christian

The mixing of religious and non-religious care occurs in the outpatient RNHCI context too. Homebound RNHCI beneficiaries may be living in a small home or apartment and may receive their Medicare-covered intermittent nursing services, use their Medicare-covered DME items such as wheelchairs and hospital beds, and receive their religious care all in the same room.<sup>103</sup> RNHCI nurses, trained to provide both physical and metaphysical care, do not leave the beneficiaries' homes between the provision of nursing and religious care so as to separate in time the Medicare-covered services and the non-covered religious services.<sup>104</sup>

Given the unique way in which RNHCI care is delivered, many stakeholders, including practicing health care attorneys who are asked to represent such stakeholders, are perplexed regarding how it is that RNHCI legislation authorizing Medicare payment of RNHCI care remains constitutional. The catch, which usually only scholars and practitioners of constitutional law understand, is that the regulatory prohibitions against mixing religious services with non-religious programming only apply to organizations that receive direct federal financial assistance. Although Medicare-participating RNCIs certainly receive federal financial assistance,<sup>105</sup> that assistance likely would be considered indirect—

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Science nursing care available to guests) (on file with the Washington and Lee Law Review); *Sunrise Haven Skilled Nursing Home Kent Washington*, INNOMOM, <http://www.senior-care-resources.com/directory/listing/sunrise-haven-skilled-nursing-home-kent-washington/> (last visited Sept. 20, 2017) (“Our services include . . . [P]ersonal care, bandaging, and bed care, as needed . . . . Your day might include working with the Christian Science study books, periodicals, and audiotapes; being read to by a staff member or volunteer; and other activities, such as musical events, a movie, or a scenic ride . . . .”) (on file with the Washington and Lee Law Review).

103. See Transmittal 45, *supra* note 66, at 11 (explaining that Medicare covers the costs of nursing care provided to RNHCI beneficiaries in the home, that such care is provided by nursing personnel who are “skilled in ministering to a beneficiary’s religious needs” as well as supporting the beneficiary’s activities of daily living).

104. See, e.g., COUNCIL REPORT, *supra* note 88, at 149 (suggesting that separation of a religious and a federally funded program may be accomplished by having “sufficient time between the two programs to vacate the room . . . [and] completely dismiss the participants of the first program” before the second set of participants enter the room).

105. See *Frazier v. Bd. of Trs. Of Nw. Miss. Reg’l Med. Ctr.*, 765 F.2d 1278, 1288–89 (5th Cir. 1985) (holding that a county hospital that received Medicare

i.e., the result of private choice—if analyzed under current Supreme Court authority.

The Establishment Clause commands that there shall be “no law respecting an establishment of religion.”<sup>106</sup> The evils against which the Establishment Clause was intended to afford protection include “sponsorship, financial support, and active involvement of the sovereign in religious activity.”<sup>107</sup> In *Lemon v. Kurtzman*,<sup>108</sup> the Supreme Court stated a three-part test for assessing sect-neutral legislation<sup>109</sup> challenged under the Establishment Clause; that is, whether the legislation: (1) has a secular legislative purpose; (2) has a principal or primary effect that neither advances nor inhibits religion; and (3) does not foster an excessive government entanglement with religion.<sup>110</sup> The Supreme Court has struggled to apply this test<sup>111</sup> and has acknowledged that it can only “dimly perceive the boundaries of permissible government activity in this sensitive area.”<sup>112</sup>

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and Medicaid payments was a recipient of federal financial assistance); *What Qualifies as Federal Financial Assistance*, U.S. DEP’T HEALTH & HUMAN SERVS., CIVIL RIGHTS, <http://www.hhs.gov/civil-rights/for-individuals/faqs/what-qualifies-as-federal-financial-assistance/301/index.html> (last visited Sept. 20, 2017) (stating that hospitals and nursing homes that receive Medicare Part A payments receive federal financial assistance) (on file with the Washington and Lee Law Review).

106. U.S. CONST. amend. I.

107. *Lemon v. Kurtzman*, 403 U.S. 602, 612 (1971).

108. 403 U.S. 602 (1971).

109. *Id.* at 612; *see also* Kong v. Min de Parle, No. C 00-4285 CRB, 2001 WL 1464549, \*4 (N.D. Cal. Nov. 13, 2001) (“Congress intended the statute [authorizing RNHCIs] to be sect-neutral. Congress explicitly stated that the exemption is intended to provide ‘a sect-neutral accommodation to any person . . . for whom the acceptance of medical health services would be inconsistent with his or her religious beliefs.’” (citations omitted)), *aff’d sub nom.* Kong v. Scully, 341 F.3d 1132 (9th Cir. 2003), *reh’g denied*, 357 F.3d 895 (9th Cir. 2004) (amending opinion).

110. *See Lemon*, 403 U.S. at 612–13 (articulating a three-part test for determining Establishment Clause violations).

111. *See Mitchell v. Helms*, 530 U.S. 793, 807 (2000) (“[W]e have consistently struggled to apply these simple words in the context of governmental aid to religious schools.”).

112. *See Tilton v. Richardson*, 403 U.S. 672, 678 (1971) (“And, as we have noted in *Lemon v. Kurtzman* and *Earley v. DiCenso*, candor compels the acknowledgment that we can only dimly perceive the boundaries of permissible government activity in this sensitive area of constitutional adjudication.”) (citations omitted).



The question whether governmental aid results in governmental indoctrination turns on the question whether any religious indoctrination that occurs could reasonably be attributed to governmental action.<sup>113</sup> Here, the Supreme Court's opinion in *Mitchell v. Helms*<sup>114</sup> is instructive.<sup>115</sup> In *Mitchell*, the Court examined Chapter 2 of Title I of the (since-reauthorized) Elementary and Secondary Education Act of 1965 (ESEA), pursuant to which the federal government distributes funds to state and local governmental agencies, which in turn lend educational materials and equipment to public and private schools based on how many students are enrolled in those schools.<sup>116</sup> At the time of this litigation, in Jefferson Parish, Louisiana, approximately thirty percent of ESEA funds went to private schools, mostly Catholic and other religious schools, because approximately thirty percent of Jefferson Parish students enrolled in private schools.<sup>117</sup> The question before the Court was whether ESEA violated the Establishment Clause as applied in Jefferson Parish.<sup>118</sup>

In distinguishing between indoctrination that is attributable to the government and indoctrination that is not, the Court in *Mitchell* explained that neutrality is key: "If the religious, irreligious, and areligious are all alike eligible for governmental aid, no one would conclude that any indoctrination that any particular recipient conducts has been done at the behest of the government."<sup>119</sup> To assess neutrality in cases in which federal funds assist religious institutions, the Court asks whether such

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113. See, e.g., *Agostini v. Felton*, 521 U.S. 203, 226 (1997) (asking whether the presence of a sign-language interpreter at a Catholic school could be attributed to state decision making).

114. 530 U.S. 793 (2000).

115. See *id.* at 801–03 (discussing whether funding secular educational materials in religious schools violates the Establishment Clause).

116. *Id.* at 801.

117. See *id.* at 803 ("It appears that, in an average year, about 30% of Chapter 2 funds spent in Jefferson Parish are allocated for private schools.").

118. See *id.* at 801 ("The question is whether Chapter 2, as applied in Jefferson Parish, Louisiana, is a law respecting an establishment of religion, because many of the private schools receiving Chapter 2 aid in that parish are religiously affiliated.").

119. *Id.* at 809.

funding is a result of the “genuinely independent and private choices of individuals.”<sup>120</sup>

In *Mitchell*, Justice Clarence Thomas (with three Justices concurring and two Justices concurring in the judgment) held that because federal ESEA funds were neutrally available to all schools, public and private, and before reaching the religious schools “passe[d] through the hands, literally or figuratively, of numerous private citizens who [we]re free to direct the aid elsewhere” by enrolling in public or private schools of their choice, ESEA did not support religion in violation of the Establishment Clause.<sup>121</sup>

This analysis is useful in considering Medicare payments to RNHCIs. As with the students in *Mitchell*, Medicare beneficiaries make their own private choice to seek medical care at a nonreligious medical facility such as a traditional hospital or, if they elect to rely solely upon religious methods of healing due to their religion, nonmedical care at an RNHCI. Medicare reimbursement follows the beneficiary’s private choice regarding the type of facility from which he or she seeks care, not the other way around. In summary, Medicare coverage of nonreligious, nonmedical care at an RNHCI, even when mixed with religious care, should survive constitutional and regulatory challenge under current law.<sup>122</sup>

The catch is that most practicing health care attorneys do not have the background in constitutional law to conduct this level of analysis quickly and efficiently. Indeed, President Obama’s Advisory Council on Faith-Based and Neighborhood Partnerships found that, “The distinction between direct and indirect financial assistance ‘has great practical significance, but it is not generally well understood except among religious freedom specialists.’”<sup>123</sup>

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120. *Id.* at 810 (citing *Agostini*, 521 U.S. at 226).

121. *Id.* at 795, 815.

122. *See, e.g.*, 45 C.F.R. § 87.1(c)(1) (2017)

Federal financial assistance provided to an organization is considered indirect when: (i) The Government program through which the beneficiary receives the voucher, certificate, or other similar means of Government-funded payment is neutral toward religion; (ii) The organization receives the assistance as a result of a decision of the beneficiary, not a decision of the government; and (iii) The beneficiary has at least one adequate secular option for the use of the voucher, certificate, or other similar means of Government-funded payment.

123. COUNCIL REPORT, *supra* note 88, at 133.

Although the Executive Order and the federal regulations that reference the prohibition against mixing religious services with funded, nonreligious programming<sup>124</sup> are easily findable on the Internet by taxpayers, hospital associations, medical associations, medical specialty groups, and other stakeholders who search for ways to challenge Medicare coverage of RNHCIs, the proper interpretation of these prohibitions is not readily available or accessible for individuals without expertise in religious freedom.<sup>125</sup>

I have three recommendations for correcting this problem. First, HHS should issue a notice of proposed rulemaking (NPRM) that would propose to add a new sub-paragraph (f) to 42 C.F.R. § 403.720, as illustrated by the language set forth below. This new sub-paragraph would provide regulatory guidance for attorneys who are asked to represent inpatient RNHCI facilities and attorneys who are asked to represent disgruntled taxpayers and other stakeholders who wish to challenge Medicare payment to inpatient RNHCI facilities.

42 C.F.R. § 403.720—Conditions of Coverage

Medicare covers services furnished in an RNHCI if the following conditions are met:

...

(f) To the extent otherwise permitted by Federal law, the restrictions on inherently religious activities set forth at 45 C.F.R. Part 87 do not apply where Medicare Part A funds are provided to RNHCIs as a result of a genuine and independent private choice of a beneficiary, provided the RNHCI otherwise satisfies the conditions of payment set forth in this Part. An

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124. *Supra* notes 79–86 and accompanying text.

125. See COUNCIL REPORT, *supra* note 88, at 134 (“Members of the Council nonetheless agree that it would be beneficial if the Administration—not the Council—stated clearly its operative understanding of the existing law [regarding the distinction between direct and indirect federal financial assistance], especially in ways accessible to non-legal and otherwise broader audiences.”); *id.* (“The Council also believes that it would have practical value to make this distinction and its consequences better known and understood by Federal employees, service providers and beneficiaries. That additional measure of clarity would promote better communication and collaboration, and correspondingly reduce confusion and potential litigation.”); *id.* (“For example, if service providers are told clearly which existing programs involve direct and which involve indirect aid, providers that are unwilling to separate religious and secular components of their programming are likelier to self-select out of direct aid programs.”).

RNHCI receives Medicare Part A funds as the result of a beneficiary's genuine and independent choice if the beneficiary is voluntarily and conscientiously opposed to the acceptance of nonexcepted medical treatment, the beneficiary voluntarily and independently acknowledges that the acceptance of nonexcepted medical treatment is inconsistent with his or her sincere religious beliefs, the beneficiary has a genuine and independent choice among religious and nonreligious health care providers, and the beneficiary voluntarily and independently elects to receive care in an RNHCI facility.

In the preamble to the NPRM, HHS should solicit commentary on this language not only from regulatory health care attorneys but also from scholars of constitutional law and law and religion. HHS should use the commentary it receives to adjust the final regulatory language.

Second, in the same NPRM, HHS should propose to add a new sub-paragraph (f) to 42 C.F.R. § 403.766, as illustrated by the language set forth below. This new sub-paragraph would provide regulatory guidance to attorneys and stakeholders in litigation involving providers and suppliers of home health services and DME items when such services are provided to RNHCI beneficiaries in their homes.

42 C.F.R. 403.766—Requirements for Coverage and Payment of  
RNHCI Home Services

...

(f) To the extent otherwise permitted by Federal law, the restrictions on inherently religious activities set forth at 45 C.F.R. Part 87 do not apply where Medicare Part A funds cover home services and DME items provided to RNHCI beneficiaries in their homes as a result of a genuine and independent private choice of a beneficiary, provided the other conditions of payment set forth in this Part are satisfied. A beneficiary exercises a genuine and independent private choice if the beneficiary is voluntarily and conscientiously opposed to the acceptance of nonexcepted medical treatment, the beneficiary voluntarily and independently acknowledges that the acceptance of nonexcepted medical treatment is inconsistent with his or her sincere religious beliefs, the beneficiary has a genuine and independent choice among medical and religious home health and DME service providers, and the beneficiary voluntarily and independently selects RNHCI home health and DME services.

Again, HHS should solicit commentary not only from regulatory health care attorneys but also from scholars of constitutional law and law and religion. HHS should use the commentary it receives to adjust the final regulatory language.

Third, I propose that HHS issue a guidance document titled “Religious Nonmedical Health Care Institutions and the Establishment Clause,” clarifying that under Supreme Court case law and federal regulations, Medicare coverage of RNHCI care is considered indirect financial support due to Medicare beneficiaries’ private choice in selecting among medical and religious facilities. The guidance document should further clarify that in cases involving indirect financial support, the prohibitions against separating religious services from funded, nonreligious programming do not apply. Finally, the guidance document should clarify that RNHCI care, by definition, involves the provision of religious and nonreligious care at the same location—either the RNHCI facility or the home depending on whether the beneficiary is using his or her inpatient or home health benefits—and sometimes at the same time of day. However, Medicare is only paying for nonreligious services, not religious services, and the cost of using a religious practitioner is a personal financial responsibility of the beneficiary.

In terms of format and accessibility, this guidance should be modeled on existing HHS guidance documents that are readily available on the Internet and that provide clear answers on other complex health law topics such as the regulation of human subjects research,<sup>126</sup> HIPAA Privacy,<sup>127</sup> and health care fraud and abuse.<sup>128</sup>

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126. See *Office for Human Research Protections, Guidance*, U.S. DEP’T HEALTH & HUM. SERVS., <http://www.hhs.gov/ohrp/regulations-and-policy/guidance/> (last visited Sept. 20, 2017) (“OHRP has published a variety of guidance documents to assist the research community in conducting ethical research that is in compliance with the HHS regulations. On this page, OHRP guidance documents are organized in categories that should be intuitive for members of the research community.”) (on file with the Washington and Lee Law Review).

127. See *Health Information Privacy, Guidance on Significant Aspects of the Privacy Rule*, U.S. DEP’T HEALTH & HUMAN SERVS., <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/significant-aspects/index.html> (last visited Sept. 20, 2017) (providing sixteen guidance documents on a range of HIPAA Privacy topics) (on file with the Washington and Lee Law Review).

128. See *Office of Inspector General, Compliance Guidance*, U.S. DEP’T HEALTH & HUM. SERVS., <https://oig.hhs.gov/compliance/compliance-guidance/index.asp> (last visited Sept. 20, 2017) (developing a series of voluntary compliance program

*III. Home Health Care*

Part II addressed the intersection of religion and the law governing Medicare payment of RNHCI care.<sup>129</sup> Religion intersects Medicare payment law in other ways as well. For example, Medicare will cover medically necessary home health services, called home health care, provided to Medicare beneficiaries who are confined to their homes.<sup>130</sup> CMS considers a beneficiary to be confined to the home if leaving the home is medically contraindicated or if the beneficiary needs the aid of a supportive device such as a wheelchair, walker, or special transportation in order to leave the home.<sup>131</sup> A Medicare beneficiary who frequently leaves the home, or who leaves the home for long periods of time, even if only infrequent, is not considered confined to the home and is not eligible for home health services.<sup>132</sup> Indeed, home health agencies that bill for such services may be engaging in federal health care fraud and abuse and may be subject to stringent civil and criminal penalties.<sup>133</sup>

During my practice, I frequently represented home health agencies that billed Medicare for home health services provided to beneficiaries who left the home on a weekly basis to attend religious services and also had a lunch or dinner or other social activity (or series of activities) outside the home preceding or following such services. In these cases, the legal question was

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guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers) (on file with the Washington and Lee Law Review).

129. *See supra* Part II (discussing whether the RNHCI legislation should be subject to strict scrutiny).

130. *See* 42 U.S.C. § 1395k(a)(2)(A) (2012) (providing home health services coverage).

131. U.S. DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., CMS MANUAL SYSTEM, PUB. 100-02 MEDICARE BENEFIT POLICY, TRANSMITTAL 192, at 5 (2014) [hereinafter CMS HOME HEALTH GUIDANCE]. Additional criteria must be met in order for a Medicare beneficiary to be considered confined to the home. *See id.* (providing detail regarding the requirements for a Medicare recipient to be considered confined to the home).

132. *See id.* (providing exemptions only for absences that are “infrequent or of relatively short duration”).

133. *See* 31 U.S.C. § 3729(a)(1)(A), (B) (identifying the submission of false claims or false records to the government as grounds for civil liability under the federal False Claims Act).

whether the beneficiary was actually confined to the home. CMS has stated that beneficiaries who leave the home for short periods of time for religious services still may be considered confined to the home,<sup>134</sup> although healthy beneficiaries who use attendance at religious services as a cover or who otherwise abuse this provision certainly may be treated differently.

The dividing line between religious services and other pre- and post-religious service activities is not always clear. For example, many places of worship offer religious- and non-religious music, food, and other activities immediately before or after formal services at a church, temple, mosque, or other place of worship. As an illustration, a Lutheran church may hold choir practice immediately before a religious service; a Catholic church may offer a seven-fish dinner following Christmas Eve mass; a Catholic church may hold a baptism, first penance, first communion, confirmation, wedding, or funeral before or after a regular religious service or at a separate time during the week; or any place of worship may hold a day- or week-long religious retreat. Taking it further, many places of worship sponsor annual, semi-annual, or monthly bazaars, bake sales, and bus trips for their parishioners. Whether a Medicare home health beneficiary who wishes to participate in one or more of these activities should still be considered confined to his or her home is a question that has not been carefully addressed by the courts or by legal academics.<sup>135</sup>

This issue came up several times in my law practice when a home health beneficiary or family member would tell a home health aide or the beneficiary's attending physician that the

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134. See CMS HOME HEALTH GUIDANCE, *supra* note 131, at 60.4.1 (stating, “[a]ny absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration”); see also CMS MANUAL SYSTEM, PUB 100-02, MEDICARE BENEFIT POLICY, TRANSMITTAL 172, CHANGE REQUEST 8444, Oct. 18, 2013, at 7 (“[A]ny absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.”). See generally U.S. DEP’T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., MEDICARE BASICS 27 (2011) (discussing Medicare coverage of home health services).

135. See, e.g., *Russell v. Sebelius*, 686 F. Supp. 2d 386, 391 (D. Vt. 2010) (discussing whether an individual who left the home once or twice a month to go grocery shopping and to Big Lots, but not to religious services, was confined to the home for purposes of qualifying as a Medicare home health beneficiary).

beneficiary would be attending, or already had attended, some type of activity, or series of activities, before or after attending a formal religious service at a place of worship. The aide or physician would typically respond by reminding the beneficiary that Medicare requires the beneficiary to be confined to the home in order to receive reimbursed home health care services. In turn, the family member would tell the aide or physician that the beneficiary has a legal right to practice his or her religion and that a complaint to the media, a lawyer, or CMS would follow if the beneficiary could not participate in the requested “religious” activity.

This threat would place my client in a difficult position. Most home health agencies, home health aides, and referring physicians do not want to open the door to a complaint or a lawsuit, especially not a religion-based complaint or lawsuit, so they may immediately drop the issue even though they suspect or know that the beneficiary is not really confined to his or her home. However, most providers also know that they can risk stringent civil and criminal penalties for submitting false claims to Medicare and otherwise committing health care fraud, including the certification of a beneficiary as homebound when there is evidence to the contrary.<sup>136</sup> I was frequently asked to navigate my home health

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136. See 31 U.S.C. § 3729(a)(1)(A), (B), (b)(1) (2012) (imposing federal False Claims Act liability on any person who knowingly presents a false or fraudulent claim for payment to the government or who knowingly makes, uses, or causes to be made a false or fraudulent claim for payment or approval); *id.* (defining knowingly to include situations in which a person has actual knowledge of the information as well as situations in which a person acts in deliberate ignorance or in reckless disregard of the truth or falsity of the information); see also U.S. DEPT’ HEALTH & HUMAN SERVS., OFF. INSPECTOR GEN., OEI-04-11-00240, INAPPROPRIATE AND QUESTIONABLE BILLING BY MEDICARE HOME HEALTH AGENCIES 2–3, 7, 33 (Aug. 2012) (defining homebound, stating that a physician or other approved provider must visit a beneficiary at his or her home and make a determination that the beneficiary is homebound and that home health services are medically necessary before ordering home health services for the beneficiary); *id.* (noting additionally that federal False Claims Act liability can be imposed on non-compliant home health agencies); *North Richland Hills Physician Admits Role in Health Care Fraud Conspiracy*, U.S. DEPT’ JUSTICE (June 16, 2016), <https://www.justice.gov/usao-ndtx/pr/north-richland-hills-physician-admits-role-health-care-fraud-conspiracy> (reporting that a physician signed orders for home health care on behalf of Medicare beneficiaries who were not homebound or qualified for Medicare-covered home health care services; the physician faces a maximum statutory penalty of five years in federal prison, a \$250,000 fine, and may be ordered to pay restitution) (on file with the Washington and Lee Law Review). See generally *National Medicare Fraud Takedown Results in Charges*



agency clients through this rock and hard place. However, there is no relevant CMS or academic guidance addressing which activities are considered religious services and which are not.<sup>137</sup>

A few cases illustrate industry understandings of the phrase “religious services,” although the courts in many of these cases have reserved passing on these definitions. In *State ex rel. North Carolina Utilities Commission v. McKinnon*,<sup>138</sup> for example, the Supreme Court of North Carolina examined whether defendant Safety Transit Company (Safety) violated the state’s Bus Act of 1949 (Bus Act).<sup>139</sup> Safety believed it had the authority to transport religious groups to “religious services” without obtaining prior approval from the North Carolina Utilities Commission (Commission) under a Bus Act exemption.<sup>140</sup>

In an earlier order to Safety, the Commission had defined the phrase “religious services” somewhat circularly as “religious services or ‘divine services’ . . . [but not] church picnics, church recreational meetings or other outings to lakes and beaches sponsored by churches or Sunday schools . . . [and not] collateral or auxiliary meetings sponsored by churches or Sunday schools but which do not fall within the meaning or definition of religious services or ‘divine services.’”<sup>141</sup>

In subsequent litigation, Safety argued that the Commission’s previous definition of the phrase was too narrow.<sup>142</sup> However, the Supreme Court of North Carolina did not address Safety’s argument because of the lack of an allegation that Safety

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*Against 243 Individuals for Approximately \$712 Million in False Billing*, U.S. DEPT JUSTICE (June 28, 2015), <https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900> (noting that home health fraud was prominent among the types of health care fraud discovered in a recent federal government investigation) (on file with the Washington and Lee Law Review).

137. Cf. Kevin Lemley, *A Proposal to Expand the Religious Services Exemption under the Copyright Act*, 34 U. ARK. LITTLE ROCK L. REV. 481, 481 (2012) (“No court has yet interpreted this exemption, and scholars have given it a similar level of review. As such, an analysis of this exemption’s constitutionality . . . is an issue that has largely gone unaddressed by both the judiciary and academic communities.”).

138. 118 S.E.2d 134 (N.C. 1961).

139. *Id.* at 139.

140. *Id.* at 137.

141. *Id.* at 138–39.

142. *Id.* at 143.

violated the provision allowing transportation of groups to religious services.<sup>143</sup>

In criminal cases, courts have interpreted the phrase “religious service” as synonymous with “divine worship” and “assembly for religious purposes.” In *McDaniel v. State*,<sup>144</sup> for example, the defendant allegedly disturbed a Methodist Episcopal Church service and was charged with violating a Georgia Penal Code provision prohibiting the disturbance of a congregation of persons lawfully assembled for “divine service.”<sup>145</sup> In its jury charge, the trial court used the word “religious” instead of the word “divine.”<sup>146</sup> On appeal, the Georgia Court of Appeals overruled an exception to the word swap reasoning that, “In a broader and philosophic sense of the word there may be a shade of difference in meaning between the two expressions, but in popular usage they are synonymous.”<sup>147</sup> The court of appeals further stated that, “there was nothing harmful or confusing in using the expressions, ‘assembled for religious purposes,’ ‘assembled for divine service,’ and ‘assembled for religious services,’ synonymously and interchangeably.”<sup>148</sup>

Breach of contract cases further suggest that the phrase “religious services” include the praying, teaching, preaching, and counseling provided by clergypersons, as well as the performance of formal services in accordance with the canons of a religious organization. In *Nikulnikoff v. Archbishop and Consistory of Russian Orthodox Greek Catholic Church, et al.*,<sup>149</sup> for example, the plaintiff clergyman alleged that the defendant Russian Orthodox Greek Catholic Church breached its contract to pay the plaintiff for his performance of religious services.<sup>150</sup> In determining the religious services allegedly required of the plaintiff, the court

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143. *Id.*

144. 63 S.E. 919 (Ga. Ct. App. 1909).

145. *Id.* at 920.

146. *Id.*

147. *Id.*

148. *Id.*

149. 142 Misc. 894 (N.Y. Sup. Ct. 1932).

150. *Id.* at 897 (“The claim of the plaintiff is that [of] an agreement in writing with [defendant] wherein it was mutually agreed that plaintiff should perform religious services for said association and said mission and they would jointly pay to plaintiff therefor a sum of ninety dollars per month . . .”).

explained, “[r]eligious services of a clergyman may be said to require him under superior authority to offer prayers and sacrifices, to teach, preach, and give counsel, and to perform services and acts in accordance with the beliefs, principles, doctrines, canons, rules, and regulations of his religious organization.”<sup>151</sup>

Statutory income tax exemptions also have used, but not defined, the phrase “religious service.” Under the Houses of Worship Free Speech Restoration Act (Act), for example, the tax-exempt status of a church cannot be terminated due to political advocacy so long as any political speech stays within the “content, preparation, or presentation of any homily, sermon, teaching, dialectic, or other presentation made during religious services or gatherings.”<sup>152</sup> Relying on fourteen factors used by the Internal Revenue Service to evaluate the legitimacy of an organization claiming to be a church, one tax law scholar defined “religious service” for purposes of the Act’s income tax exemption as a “gathering by a regular congregation at an established place of worship for the purpose of a regular service.”<sup>153</sup>

Counties, school districts, and other governmental entities also have used the phrase “religious services” in published policies limiting the use of governmental space for religious services. In litigation against it, Centennial School District in Warminster, Pennsylvania, revealed that it had defined religious services to include the “invocation of, worship to, prayer to, or adoration of a deity.”<sup>154</sup>

The above discussion focused on definitions and interpretations of “religious services” found in case law. Federal and state statutes and regulations also may be helpful in providing meaning to terms used but not defined in the law governing home health care. Although research revealed no federal regulation

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151. *Id.* at 902.

152. H.R. 235, 108th Cong. (1st Sess. 2003).

153. Richard J. Wood, *Pious Politics: Political Speech Funded through I.R.C. § 501(c)(3) Organizations Examined under Tax Fairness Principles*, 39 ARIZ. ST. L.J. 209, 224 (2007).

154. See, e.g., *Gregoire et al. v. Centennial Sch. Dist.*, 701 F. Supp. 103, 104 (E.D. Pa. 1988) (stating that in a policy prohibiting the use of its buildings and facilities for religious services, defendant Centennial School District defined the term as “the invocation of, worship to, prayer to, or adoration of a d[e]ity”).

defining “religious services,” many state regulations do define the phrase. California juvenile justice regulations, for example, define “religious services” as the “regularly scheduled weekly gatherings of a religious faith group such as Catholicism, Protestantism, Islamism, Judaism, and Native American.”<sup>155</sup> Rhode Island corrections regulations define the phrase as a “meeting which is religious in nature and provides an opportunity for worship, fellowship, or congregational participation.”<sup>156</sup> Illinois transportation regulations define the phrase as the “coming together of a group of persons with the same or similar religious beliefs for the purpose of exercising those beliefs.”<sup>157</sup> Massachusetts corrections regulations define the phrase as a “[m]eeting which is religious in nature and provides an opportunity for worship, fellowship, or congregational participation.”<sup>158</sup>

The above cases and regulations set forth a number of different definitions of “religious services.”<sup>159</sup> At their heart are the concepts of meeting or gathering, worship, and regularity of schedule. Although imperfect, a common understanding, or definition, of “religious services” might be that of “a regularly scheduled meeting or gathering that is religious in nature and that provides an opportunity for worship.”

Let us now return to home health law, which allows Medicare beneficiaries to leave the home for short periods of time for religious services and still be considered confined to their homes.<sup>160</sup> A beneficiary’s attendance at a regularly scheduled weekly

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155. CAL. CODE REGS. tit. 15, § 4750(a) (2016).

156. R.I. ADMIN. CODE § 17-1-15:III(A)(11) (2016).

157. ILL. ADMIN. CODE tit. 92, § 1001.610 (2016).

158. 103 MASS. CODE REGS. § 471.05 (2016).

159. See *supra* notes 154–158 and accompanying text (explaining that no federal regulation defines the phrase “religious services,” but state regulations do).

160. See CMS HOME HEALTH GUIDANCE, *supra* note 131, at 60.4.1 (“[A]ny absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.”); see also CMS Manual System, Pub 100-02, Medicare Benefit Policy, Transmittal 172, Change Request 8444, Oct. 18, 2013 (“[A]ny absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.”). See generally U.S. DEPT’ HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., MEDICARE BASICS 27 (2011) (discussing Medicare coverage of home health services).

meeting that is religious in nature and provides an opportunity for worship would meet this exception.

A slightly more difficult question is whether a Medicare beneficiary who attends a special service such as a baptism, brit milah, penance, communion, confirmation, bat mitzvah, wedding, or funeral would still be considered confined to the home. Although the common law and regulatory definitions offered above do not expressly include these special services,<sup>161</sup> other regulations suggest that the answer to this question is “yes.” Arkansas embalming and funeral regulations, for example, define “funeral service or funeral” as a “period following death in which there are religious services or other rites or ceremonies with the body of the deceased present.”<sup>162</sup> California juvenile justice regulations, by further example, define “special religious activities” as “activities other than regularly scheduled religious services and programs such as epiphanies, baptisms, and religious retreats.”<sup>163</sup> Virginia tax regulations, by final illustrative example, define “religious worship service” as “regularly scheduled church services and includes, but is not limited to, weddings, bar mitzvahs, bat mitzvahs, baptisms, christenings, funerals, and special services conducted during religious holidays, when conducted at the public church building.”<sup>164</sup> Although baptisms, communions, weddings, and the like may be thought of as special, or occasional, religious services, state law suggests that they should fall within the general definition of “religious services.”

A final question is whether a Medicare beneficiary who attends a church- or other place-of-worship-sponsored bake sale,

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161. The Centers for Medicare and Medicaid Services have stated in an answer to a frequently-asked question that a Medicare beneficiary’s infrequent attendance at a funeral of short duration would not cause the beneficiary to lose homebound status. See Ctrs. Medicare & Medicaid Servs., Frequently Asked Question 2389, *Could You Clarify CMS’ Policy about the Homebound Status of Home Health Patients Who Can Drive?*, <https://questions.cms.gov/faq.php?id=5005&faqId=2389> (last visited Sept. 20, 2017) (“[I]nfrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are . . . infrequent . . . or are . . . relatively short . . . and . . . the patient . . . [does not have] the capacity to obtain the health care provided outside . . . the home.”) (on file with the Washington and Lee Law Review).

162. ARK. ADMIN. CODE § 043.00.1-I(28) (2016).

163. CAL. CODE REGS. tit. 15, § 4750(a) (2016).

164. 23 VA. ADMIN. CODE § 10-210-310(A) (2016).

bazaar, picnic, bus trip, or similar activity, would still be considered confined to the home. Given that the common thread among the definitions of religious services was that of a regularly scheduled meeting that is religious in nature and that provides an opportunity for worship, these activities may fail due to lack of frequency or regularity as well as the lack of worship purpose. Bake sales, bazaars, picnics, and bus trips may not be scheduled with the same regularity as regular worship services. Even if they are, their primary purpose may be to raise money or to promote recreation, leisure, or community, not worship. Indeed, some agencies, such as the North Carolina Utilities Commission in the *McKinnon* case,<sup>165</sup> would expressly exclude “church picnics, church recreational meetings or other outings to lakes and beaches sponsored by churches or Sunday schools” as well as “collateral or auxiliary meetings sponsored by churches or Sunday schools”<sup>166</sup> from the definition of “religious services.”

Although the federal statute authorizing Medicare payment of home health services to beneficiaries who are confined to the home is easily findable on the Internet,<sup>167</sup> neither the statute nor the implementing regulations nor any case law nor any HHS guidance provides a definition of the religious services a beneficiary may attend without losing homebound status. As with the law governing RNHCIs, the proper interpretation of this exception is not readily available or accessible for practicing health care attorneys and the general public.

One way to correct this problem is for HHS to issue a NPRM proposing to establish new definitions of the phrases “confined to the home” and “religious services” applicable to the regulations governing Medicare payment to home health agencies, as illustrated by the italicized language set forth below.

42 C.F.R. § 484.2—Definitions.

As used in this part, unless the context indicates otherwise—

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165. State ex rel. N.C. Util. Comm’n v. *McKinnon*, 118 S.E.2d 134, 139 (N.C. 1961).

166. *Id.* at 138–39.

167. See 42 U.S.C. § 1395f(a)(2)(C) (2012) (“[P]ayment for services furnished an individual may be made only . . . in the case of home health services, such services are or were required because the individual is or was confined to his home . . .”).

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Confined to the home means, with respect to a beneficiary, that leaving the home is medically contraindicated or that the beneficiary needs the aid of a supportive device such as a wheelchair, walker, or special transportation in order to leave the home. Beneficiaries who leave the home for short periods of time for religious services may still be considered confined to the home.

Religious services means a regularly scheduled meeting or gathering that is religious in nature and that provides an opportunity for worship. The term includes special religious services such as baptisms, weddings, and funerals, and other similar services. The term does not include collateral or auxiliary meetings or gatherings, such as church-sponsored bake sales, picnics, and other outings, that are not regularly scheduled and/or that have as their principal purpose fundraising, recreation, or leisure.

In the preamble to the NPRM, HHS should solicit commentary on these definitions not only from regulatory health care attorneys but also from scholars of constitutional law and law and religion who are familiar with the different types of regular religious services and special religious services as well as the boundaries between these services and auxiliary activities. HHS should use the commentary it receives to adjust the final regulatory language.

#### IV. Hospice Care

The focus of this Article thus far has been religion, not spirituality.<sup>168</sup> I would be remiss if I failed to mention the

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168. For wide-ranging discussions of the distinctions between religion and spirituality by authors with a variety of educational, professional, and experiential backgrounds, see Paul S. Mueller et al., *Religious Involvement, Spirituality, and Medicine: Implications for Clinical Practice*, 76 MAYO CLINIC PROC. 1225, 1225 (2001).

The word religion is from the Latin *religare*, which means 'to bind together.' A religion organizes the collective spiritual experiences of a group of people into a system of beliefs and practices. Religious involvement or religiosity refers to the degree of participation in or adherence to the beliefs and practices of an organized religion. Spirituality is from the Latin *spiritualitas*, which means 'breath.' It is a broader concept than religion and is primarily a dynamic, personal, and experiential process. Features of spirituality include quest for

frequency with federal law requires Medicare-participating providers to assess and respond to the spiritual needs of patients. The best illustration here is Medicare payment for hospice care. Hospice is a comprehensive set of services designed to address the physical, emotional, psychosocial, and spiritual needs of terminally ill beneficiaries and their family members.<sup>169</sup> Medicare-participating hospice programs are required by federal law to assess and meet the spiritual needs of each terminally ill

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meaning and purpose, transcendence . . . connectedness . . . values . . .

See also Laurel Arthur Burton & Marcia Sue DeWolf Bosek, *When Religion May Be an Ethical Issue*, 39 J. RELIGION & HEALTH 97, 98 (2000) (“Perhaps the easiest distinction is to think of spirituality as a person’s sense of meaning and purpose in life, or one’s relation to the Cosmos. Religion, on the other hand, can be understood as organized spirituality that includes doctrines, prescribed rituals, and governing structures.”); Peter C. Hill, et al., *Conceptualizing Religion and Spirituality: Points of Commonality, Points of Departure*, 30 J. THEORY OF SOC. BEHAV. 51, 52 (2000) (reviewing and analyzing how religion and spirituality have been conceptualized in the literature); Christopher J. Eberle, *Religion and Insularity: Brian Leiter on Accommodating Religion*, 51 SAN DIEGO L. REV. 977, 994 n.56 (2014)

One central difference between religion and spirituality, in my idiolect at least, is that the latter is individualistic in respects that the former is not. The radically subjective, individualistic ‘Sheilaism’ made famous decades ago by Robert Bellah and his collaborators is not really religion; it is a vague, socially disembodied, and amorphous spirituality.

Lucia Ann Silecchia, *Integrating Spiritual Perspectives with the Law School Experience: An Essay and an Invitation*, 37 SAN DIEGO L. REV. 167, 179–80 (2000)

If spirituality is not synonymous with either religion or professional ethics, how might it be most helpfully defined? Spirituality may be described in many varied ways. Viewed broadly, it entails a way of defining and pursuing truth beyond oneself that is more important than the individual, giving the individual’s actions meaning and purpose in a larger context.

Calvin G. C. Pang, *Eyeing the Circle: Finding a Place for Spirituality in Law School Clinic*, 35 WILLAMETTE L. REV. 241, 254–55 (1999) (“As stated in my introduction, spirituality is not religion or religiosity. Unlike spirituality, which inheres in each person, religion is a framework or system of values and beliefs, often organized and institutionalized, that serves as a vehicle for spiritual expression and development.”).

169. See 42 C.F.R. § 418.3 (2017) (defining hospice care as a “comprehensive set of services . . . identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.”).



patient and his or her family.<sup>170</sup> Hospices may meet the spiritual needs of their patients by providing spiritual counseling in accordance with the patient's and family's acceptance of this service, and in a manner consistent with the patient's and family's beliefs and desires.<sup>171</sup> Family bereavement assessments also are required, and these assessments must identify the spiritual factors that may impact family members' ability to cope with the patient's death.<sup>172</sup> Once the family members' bereavement needs are identified, Medicare requires participating hospices to provide family bereavement counseling for up to one year following the patient's death.<sup>173</sup> In addition to hospices, other Medicare-participating providers, including long-term care facilities, also are required to assess patients' spiritual needs.<sup>174</sup>

In practice, attorneys who represent hospices as well as attorneys who represent terminally ill patients are frequently asked to provide advice regarding whether a hospice failed to assess and/or meet the spiritual needs of the patient or a family member. These cases typically occur when hospice workers do not identify a patient's expressed need as spiritual and therefore do not meet that need. During my practice, examples of needs that hospice patients and/or their family members identified as spiritual included name brands of foods, name brands of drinks, name brands of coffee and espresso, live music, recorded music, radio music, television, movies, candles, cigars, incense, marijuana, herbs, oils, soaps, shampoos, conditioners, books, magazines, clothing, jewelry, hair styles, décor, objects, and other items.

No federal statute or regulation expressly defines the word "spiritual" or the phrase "spiritual needs." Federal and state laws

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170. See *id.* § 418.54 (requiring the hospice to conduct a comprehensive assessment of the spiritual and other needs of each hospice patient and his or her family); *id.* § 418.56(a) (requiring the hospice to designate an interdisciplinary group of individuals who will work together to meet the spiritual and other needs of each hospice patients and his or her family).

171. See *id.* § 418.64(d)(3) (identifying spiritual counseling as a core hospice service).

172. *Id.* § 418.54(c)(7).

173. *Id.* § 418.66(d)(1).

174. See *id.* § 488.110 (requiring Medicare surveyors to assess whether Medicare-participating long-term care providers are meeting their residents' spiritual needs).

do define “palliative care” to include care that addresses spiritual needs,<sup>175</sup> and federal law also require hospices to “facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient’s spiritual needs.”<sup>176</sup> Some state regulations offer definitions for the phrase “spiritual counselor;” that is, a “person who is ordained clergy (individual ordained for religious service), pastoral counselor or other person who can support the patient’s spiritual needs.”<sup>177</sup> And, some local tax codes include within their definition of “charitable organization” organizations that minister to the spiritual needs of persons, thereby lessening a government burden.<sup>178</sup> But none of these federal or state laws expressly defines the word “spiritual” or the phrase “spiritual need.”

Although falling short of offering such definitions, one line of cases sheds light on the relationship between spirituality and religion.<sup>179</sup> This line of cases rejects the inclusion of anything an individual just happens to find spiritually significant as within the definition of religion protected under the First Amendment.<sup>180</sup> In

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175. See *id.* § 418.3 (“Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care . . . involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.”); see also CONN. AGENCIES REGS. § 19a-495-6a(28) (2016) (defining palliative care under Connecticut law); see also 130 MASS. CODE REGS. § 437.402 (2016) (defining palliative care under Massachusetts law).

176. 42 C.F.R. § 418.64(d)(3)(iii) (2017).

177. CONN. AGENCIES REGS. § 19a-495-6a(42) (2016).

178. See *Catholic Health Initiatives v. City of Pueblo*, 207 P.3d 812, 816 (Colo. 2009) (citing the definition of charitable organization set forth in Pueblo, Colorado’s Municipal Code).

179. Although the Supreme Court has attempted to establish standards that distinguish religious beliefs and actions from nonreligious beliefs and actions, the Supreme Court has not articulated one definition of religion that should be used in all contexts for all questions. However, a series of Supreme Court cases, published since 1890, suggest context-specific understandings of the term. See, e.g., *Davis v. Beason*, 133 U.S. 333, 342 (1890) (expressing religion in traditional theistic terms: “[t]he term ‘religion’ has reference to one’s views of his relations to his Creator, and to the obligations they impose of reverence for his being and character, and of obedience to his will.”).

180. See, e.g., *Alvarado v. City of San Jose*, 94 F.3d 1223, 1230 (9th Cir. 1996) (“While the First Amendment must be held to protect unfamiliar and idiosyncratic as well as commonly recognized religions, it loses its sense and thus its ability to protect when carried to the extreme proposed by the plaintiffs.”).

*Alvarado v. City of San Jose*,<sup>181</sup> for example, the court held that a work of art was not imbued with religious content for purposes of the First Amendment just because the work affected the plaintiff on a spiritual or emotional level.<sup>182</sup>

A second line of cases suggests that spirituality concerns the meaning of life at a more general level than does religion. In *Freedom from Religion Foundation, Inc. v. Nicholson*,<sup>183</sup> for example, taxpayers argued that the Department of Veterans Affairs (VA) advanced religion in violation of the Establishment Clause through its integration of faith and spirituality concerns into health care services provided to veterans.<sup>184</sup> The VA offered its understanding of spirituality during the litigation: “[S]pirituality is not necessarily religious because it concerns the meaning of life on a more general level.”<sup>185</sup>

Also falling short of an express definition, a third line of cases suggests a relatively low standard for characterizing something as spiritual.<sup>186</sup> Mississippi law, for example, limits the individuals who may conduct a marriage to ministers, rabbis, judges, mayors, and any “other spiritual leader of any other religious body authorized under the rules of such religious body to solemnize rites of matrimony and being in good standing.”<sup>187</sup> In *In re Blackwell*,<sup>188</sup> a widow challenged her husband’s will devising real property to

181. 94 F.3d 1223 (9th Cir. 1996).

182. See *id.* at 1231 (holding that the statements of an individual attesting to her emotional and spiritual response to a work of art, including the fact that the work of art moved the individual to tears, “does not imbue the work with religious content”); see also *Johnson v. Pa. Bureau Corrs.*, 661 F. Supp. 425, 436 (W.D. Pa. 1987) (holding that the Spiritual Order of Universal Beings did not qualify as a religion protected under the First Amendment because the spiritual leader testified that the order’s belief system is “eclectic” and that each member may adopt the beliefs of any religion or philosophy).

183. 469 F. Supp. 2d 609 (W.D. Wis. 2007).

184. *Freedom from Religion Found., Inc. v. Nicholson*, 469 F. Supp. 2d 609, 617 (W.D. Wis. 2007), *vacated and remanded*, 536 F.3d 730 (7th Cir. 2008) (taxpayers lacked standing to challenge Veterans Administration programs).

185. *Id.* at 614.

186. See, e.g., *Henry v. Red Hill Evangelical Lutheran Church*, 201 Cal. App. 4th 1041, 1055 (Cal. Ct. App. 2012) (holding that a church preschool teacher is a spiritual leader for purposes of the ministerial exception to enforcement of civil employment law).

187. MISS. CODE ANN. § 93-1-17 (West 2016).

188. 531 So. 2d 1193 (Miss. 1988).

the husband's first wife.<sup>189</sup> In their counterclaim, the husband's siblings argued that the widow and the decedent were not legally married under Mississippi law because the individual who presided over the ceremony uniting the widow and decedent was not a spiritual leader under Mississippi Law.<sup>190</sup> That individual, a constable by trade, claimed that the blank credentials he secured from the Universal Life Church (ULC) of Modesto, California—credentials that he had to fill in with his own name upon receipt in the mail—empowered him to marry the widow and decedent.<sup>191</sup>

On review, the Supreme Court of Mississippi found that ULC was “hardly a conventional church by Bible Belt standards” because ULC had no formal doctrine, members could worship God in any way they saw fit, and its ministers were not required to learn anything about ULC or any particular religious beliefs before becoming ministers.<sup>192</sup> The court declined, however, to establish a “hard-edged line of demarcation prescribing minimum qualifications” for a spiritual leader under Mississippi law, holding that the individual was “enough of a ‘spiritual leader’” that the marriage between the widow and the decedent was legal.<sup>193</sup>

Although the Supreme Court of Mississippi in *In re Blackwell* established a relatively low standard for those wishing to qualify as spiritual leaders, a fourth line of cases confirms that spirituality does have some content. In *In re Fuhrer*,<sup>194</sup> for example, the Supreme Court of Richmond County, New York, was asked to decide whether grand jury questions put to a witness—a rabbi—implicated the state's clergyman-penitent privilege.<sup>195</sup> The questions at issue were designed to elicit whether the rabbi was depositing checks from nursing home vendors and then returning a percentage of them to employees in violation of Medicaid anti-kickback rules.<sup>196</sup> The court stated that although the

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189. *Id.* at 1194.

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. 100 Misc. 2d 315 (N.Y. Sup. Ct. 1979).

195. *See id.* at 320 (quoting the New York clergyman-penitent privilege: “a clergyman . . . shall not be allowed to disclose a confession or confidence made to him in his professional character as spiritual advisor”).

196. *Id.* at 316–17.

statutory privilege should be interpreted “broadly and liberally,” the communication to the Rabbi must be, at the very least, in the Rabbi’s “professional character as a spiritual advisor” in order to be privileged.<sup>197</sup> The court interpreted the phrase “professional character as a spiritual advisor” to mean “seeking religious counsel, advice, solace, absolution or ministration.”<sup>198</sup> Without defining the words religious or spiritual, the court concluded that the privilege had no application to the case because none of the questions put to the rabbi involved spiritual matters.<sup>199</sup>

Research revealed one century-old murder case expressly defining the word “spiritual.” In *Johnson v. State*,<sup>200</sup> the Supreme Court of Mississippi in 1914 reviewed the admissibility of a confession secured by a reporter from the defendant while the defendant was in jail.<sup>201</sup> Before obtaining the confession, the reporter made the following representation to the defendant: “I am a Spiritualist, and I can look down in your black heart and see this diabolical crime you committed at midnight the other night.”<sup>202</sup> The defense argued that the subsequent confession was inadmissible because it was neither free nor voluntary; that is, the confession resulted from actual, physical fear, threat, and undue influence.<sup>203</sup> The prosecution, on the other hand, argued that the reporter’s statements constituted permissible spiritual influence.<sup>204</sup>

The court agreed with the defense, holding that the reporter used more than spiritual influence to elicit the confession.<sup>205</sup> The court defined spiritual—with respect to the hopes and dreams of a defendant charged with murder from whom a confession is sought—as “that which pertains to the soul or higher endowments of the mind in its relation to the Spirit of God—the Holy Spirit—and that which pertains to our holy religion. The spiritual nature

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197. *Id.* at 320.

198. *Id.* at 320–21.

199. *Id.*

200. 65 So. 218 (Miss. 1914).

201. *Id.* at 218.

202. *Id.* at 219.

203. *Id.*

204. *Id.*

205. *Id.* at 220.

of a man would be his higher self, not the carnal.”<sup>206</sup> The court concluded that the reporter’s statements conveyed supernatural powers, not just lay notions of spirituality, and that the representation of such supernatural powers constituted undue influence vis-à-vis the defendant.<sup>207</sup>

The federal and state regulations and cases discussed above suggest that the test for spirituality is considerably less rigorous, and significantly more general, than the test for religion, and that spirituality does not rise to the level of the supernatural.<sup>208</sup> Although helpful, these authorities still do not provide practicing health care attorneys with the specificity they need to bring an action against a hospice or defend a case involving a hospice that allegedly fails to meet a patient’s or family member’s spiritual needs.

Industry guidance and scholarly writings<sup>209</sup> are somewhat more helpful. Several groups and institutions have developed spiritual assessment tools that assist health care providers in eliciting patients’ thoughts and beliefs relating to religion and spirituality.<sup>210</sup> These spiritual assessment tools, including the FICA Spiritual History Tool (FICA),<sup>211</sup> the HOPE Questions

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206. *Id.*

207. *Id.*

A man ill and nervous could be thrown into a serious physical fear and constraint, even though from superstition, which is a fear of that which is unknown or mysterious, by the intense statement of one who claimed he was a spiritualist—that is, one who holds communications with departed and disembodied spirits . . . .

208. *See supra* notes 175–207 and accompanying text (illustrating and supporting the proposition that the legislative and judicial framework for determining spirituality is less rigorous than the test for religion).

209. *See supra* note 168 (offering definitions and comparisons of religion and spirituality in scholarly writings).

210. *See* Aaron Sagul & Karen Phelps, *The Spiritual Assessment*, 86 AM. FAM. PHYSICIAN 546, 546 (2012) (explaining the purpose of spiritual assessment tools).

211. *See FICA Spiritual Assessment Tool*, GEORGE WASH. INST. FOR SPIRITUALITY AND HEALTH, <https://smhs.gwu.edu/gwish/clinical/fica> (last visited Sept. 20, 2017) (providing information about the FICA Spiritual Assessment Tool) (on file with the Washington and Lee Law Review).

(HOPE),<sup>212</sup> and the Open Invite Mnemonic (OIM),<sup>213</sup> suggest meaning for spirituality. For example, one FICA question asks, “Do you have spiritual beliefs that help you cope with stress?”<sup>214</sup> If the patient responds ‘no,’ FICA encourages the follow-up question: “What gives your life meaning?”<sup>215</sup> At some level, then, the FICA spiritual assessment tool associates an individual’s spirituality to the meaning of life.<sup>216</sup>

Although many of the HOPE questions use the word spirituality, one HOPE question asks, “What are your sources of hope, strength, comfort, and peace?”<sup>217</sup> A second HOPE question asks, “What do you hold on to during difficult times?”<sup>218</sup> The HOPE questions suggest that spirituality is associated with sources of meaning, hope, strength, comfort, peace, and security.

Similarly, the OIM includes questions such as, “[w]hat helps you through hard times?” and “[i]s there a way in which I or another member of the medical team can provide you with support?” and “[a]re there resources in your faith community that you would like for me to help mobilize on your behalf?”<sup>219</sup> Like FICA and HOPE, the OIM questions associate spirituality with support.

Recognizing the difficulty associated with precisely defining spirituality, the authors of the HOPE spiritual assessment tool explain that spirituality is complex and multidimensional; that it has cognitive, experiential, and behavioral aspects; that it includes the search for meaning, purpose, and truth; that it includes the beliefs and values by which an individual lives; that it involves feelings of hope, love, connection, inner peace, comfort, and support; and that it includes the types of relationships and connections that exist with self, the community, the environment,

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212. See Gowri Anandarajah & Ellen Hight, *Spirituality and Medical Practice: Using the HOPE Questions as a Practical Tool for Spiritual Assessment*, 63 AM. FAM. PHYSICIAN 81, 85–86 (2001) (discussing the HOPE Questions).

213. See Saguil & Phelps, *supra* note 210, at 549, tbl. 3 (illustrating the OIM).

214. See *id.* at 548 (listing several FICA questions).

215. *Id.*

216. See *id.* (illustrating FICA questions).

217. Anandarajah & Hight, *supra* note 212, at 87, tbl. 4.

218. *Id.*

219. See Saguil & Phelps, *supra* note 210, at 549 (illustrating the Open Invite Mnemonic).

nature, and the transcendent.<sup>220</sup> The authors of the HOPE questions further explain that many individuals find spirituality “through religion or through a personal relationship with the divine,” but that others may find it “through a connection to nature, through music and the arts, through a set of values and principles or through a quest for scientific truth.”<sup>221</sup>

Given the complex and multidimensional nature of spirituality, I do not recommend that HHS issue an NPRM attempting to craft a precise regulatory definition. However, I do recommend that HHS issue a draft guidance document outlining the dimensions of spirituality in a manner similar to the HOPE authors’ description of spirituality<sup>222</sup> and with reference to the definitions of spirituality found in scholarly writings.<sup>223</sup> Using the FICA, HOPE, and OIM questions, HHS should provide examples of expressed needs that, in certain contexts, would or would not meet the definition of a spiritual need for purposes of federal hospice law.<sup>224</sup> Given the frequency in my practice with which hospice patients and family members asserted that name brands of foods, name brands of drinks, name brands of coffee and espresso, live music, recorded music, radio music, television, movies, candles, cigars, incense, marijuana, herbs, oils, soaps, shampoos, conditioners, books, magazines, clothing, jewelry, hair styles, décor, objects, and other items constituted spiritual needs, the HHS guidance should address if, when, and in which contexts these items would constitute spiritual needs that Medicare-participating hospices must meet. In the preface to the draft guidance document, HHS should solicit comments from individuals with expertise in spirituality as well as religious studies and should adjust the final HHS guidance document accordingly. In terms of format and accessibility, this guidance should be modeled on prior HHS guidance documents that are

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220. Anandarajah & Hight, *supra* note 212, at 83.

221. *Id.*

222. *See id.* (providing HOPE’s description of the concept of spirituality as being complex and multidimensional).

223. *See supra* note 168 (providing definitions of spirituality found in illustrative scholarly writings).

224. *See supra* note 170 and accompanying text (noting that federal law requires Medicare-participating hospices to assess and meet the spiritual needs of patients and family members).



readily available on the Internet and that provide guidance and illustrations relating to other complex health law topics.<sup>225</sup>

### V. Health Information Confidentiality

Parts II through IV discussed the intersection of religion and federal law governing Medicare payment of RNHCI, home health, and hospice care.<sup>226</sup> Religion also intersects federal and state laws governing health information confidentiality, including laws applicable to health care providers who electronically transmit health information in connection with claims for payment to Medicare, Medicaid, and other third party payors. I will use the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (Privacy Rule)<sup>227</sup> as an example, although many states have analogous laws that have similar intersections with religion.

The HIPAA Privacy Rule is a set of regulations promulgated by HHS that governs health information confidentiality at the federal level.<sup>228</sup> The HIPAA Privacy Rule applies to all health plans and all health care clearinghouses, but only certain health care providers; that is, health care providers who transmit health information in electronic form in connection with certain standard transactions (collectively, covered entities).<sup>229</sup> The most common standard transaction is the health care claim transaction, which is implicated when a physician, hospital, or other individual or institutional health care provider electronically transmits health information to a public health care program such as Medicare or Medicaid or a private payor as part of a request for reimbursement for health care delivered to a patient who is a beneficiary or an

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225. See *supra* notes 126–128 (referencing other guidance documents released by HHS).

226. *Supra* Parts II–IV.

227. 45 C.F.R. §§ 164.500–164.534 (2017).

228. See *id.* (codifying the HIPAA Privacy Rule).

229. See *id.* § 160.102(a)(1)–(3) (identifying health plans, health care clearinghouses, and health care providers who transmit health information in electronic form in connection with a standard transaction as needing to comply with the HIPAA Administrative Simplification Provisions); *id.* § 164.500(a) (requiring covered entities to comply with the Privacy Rule).

enrollee.<sup>230</sup> Because Medicare generally requires health care providers to submit their health care claims electronically,<sup>231</sup> Medicare-participating providers must comply with the HIPAA Privacy Rule.<sup>232</sup> Health information confidentiality obligations are thus linked to health care finance, and academics and attorneys with expertise in health care finance frequently work with the health information confidentiality requirements set forth in the HIPAA Privacy Rule.

The HIPAA Privacy Rule requires covered entities to adhere to certain use and disclosure requirements<sup>233</sup> when internally using or externally disclosing individually identifiable health information that meets the definition of protected health information (PHI).<sup>234</sup> PHI includes patient identifiable medical records, billing records, and other designated record sets, including lists of current hospital inpatients and outpatients.<sup>235</sup> Religion intersects the Privacy Rule's information use and disclosure requirements in several different ways. One way relates to the use and disclosure of PHI by hospital chaplains. Some background information regarding hospital chaplaincy is necessary before proceeding.

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230. See *id.* § 160.103 (identifying the health care claim as one of the standard transactions).

231. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., FACT SHEET: MEDICARE BILLING: 837P AND FORM CMS-1500 4 (2013) ("Initial claims for payment under Medicare must be submitted electronically unless a health care professional or supplier qualifies for a waiver or exception from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.").

232. See, e.g., U.S. DEP'T HEALTH & HUMAN SERVS., NIH PUBL'N NO. 03-5388, PROTECTING PERSONAL HEALTH INFORMATION IN RESEARCH: UNDERSTANDING THE HIPAA PRIVACY RULE, [https://biotech.law.lsu.edu/cases/medrec/research\\_HIPAA\\_01v.pdf](https://biotech.law.lsu.edu/cases/medrec/research_HIPAA_01v.pdf) ("For example, hospitals, academic medical centers, physicians, and other health care providers who electronically transmit claims transaction information directly or through an intermediary to a health plan are covered entities.").

233. See 45 C.F.R. §§ 164.502–164.514 (2016) (codifying the HIPAA Privacy Rule's use and disclosure requirements).

234. See *id.* § 160.103 (defining PHI).

235. See *Individuals' Right under HIPAA to Access their Health Information* 45 C.F.R. § 164.524, U.S. DEP'T HEALTH & HUMAN SERVS., <http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access> (last visited Sept. 20, 2017) (noting that "designated record set," a subset of PHI, includes medical records and billing records) (on file with the Washington and Lee Law Review).

When a hospital employs or contracts with a minister, priest, pastor, rabbi, or other clergyperson to provide religious or spiritual services to patients in its facility, the provision of such services is known as hospital chaplaincy and the individuals who provide such services are known as hospital chaplains.<sup>236</sup> The services provided by hospital chaplains are extensive and include religious and spiritual services as well as other services.<sup>237</sup>

Hospital chaplain services that are partly or mostly religious or spiritual in nature include, but certainly are not limited to: offering patients, family, and staff members an emotionally and spiritually safe professional from whom they can seek counsel or guidance, performing spiritual assessments of patients, performing patient risk screenings, including identifying patients whose religious beliefs or spiritual conflicts may help, compromise, or hinder their recovery from illness, charting religious or spiritual activities in patient medical records, discussing with hospital workforce members particular patient beliefs regarding the healing power of religion or spirituality, providing grief and loss care; discussing with patients or family members religious and spiritual beliefs regarding organ and tissue donation and transplantation, designing and leading religious ceremonies of worship and ritual including prayer, meditation, reading of holy texts, observation of holy days, blessings, sacraments, memorial services, funerals, and birth and death rituals, making community and professional presentations regarding the relationship between religion or spirituality and health, training and supervising volunteers from religious communities who provide religious or spiritual care to hospital patients; conducting professional clinical education programs for seminarians, clergypersons, and religious leaders; developing congregational health ministries, educating health professional students, interns, residents, and fellows regarding the relationships between and among religion, spirituality, health, and medicine, engaging in research activities

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236. See, e.g., Stacey A. Tovino, *Hospital Chaplaincy Under the HIPAA Privacy Rule: Health Care or "Just Visiting the Sick,"* 2 IND. HEALTH L. REV. 51, 66 (2005) [hereinafter Tovino, *Hospital Chaplaincy*] (discussing the history of clinical pastoral education and American hospital chaplaincy) (internal citations and references omitted).

237. For a history of the relationship between religion and medicine in general and hospital chaplaincy and health care in particular, see *id.* at 59–73.

relating to the development of religious and spiritual assessment, and promoting research investigating the relationship between or among, as appropriate, religion, spirituality, medicine, and health.<sup>238</sup>

Hospital chaplains also provide additional non-religious and non-spiritual services in their roles as general employees or workforce members of covered hospitals. These services include, but are not limited to: communicating with caregivers, facilitating staff meetings and other communications, resolving conflicts among staff members, patients, and family members, referring patients to internal and external resources including other health care providers, patient advocates, and community and social resources; providing institutional support during change or crisis, participating in rounds and patient care conferences, participating in interdisciplinary education, assisting patients and families in executing or completing advance directives, participating in ethics committees and institutional review boards, clarifying the application of institutional policies and behaviors to patients, community clergy, and religious organizations; conducting or participating in general educational programs, interpreting and analyzing cultural traditions that may impact clinical services; representing community issues and concerns to the organization, and acting as “cultural brokers” between institutions, patients, and family members.<sup>239</sup>

In light of the many services they provide, many hospital chaplains view themselves, and many health care institutions view hospital chaplains, as part of the hospital’s health care team.<sup>240</sup> Dr. Harold Koenig, Professor of Psychiatry and Behavioral Sciences and Director of the Center for Spirituality, Theology, and Health at Duke University Medical Center, has recommended the full integration of hospital chaplains into the multidisciplinary health care team, including their participation in morning and afternoon

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238. See, e.g., *id.* at 69 (identifying the religious and spiritual functions and duties of today’s hospital chaplain (citations omitted)).

239. See, e.g., *id.* at 69–70 (identifying additional chaplain functions and duties) (citations omitted).

240. See, e.g., Rodney J. Hunter, *Pastoral Care and Healthcare Chaplaincy*, in 4 *ENCYCLOPEDIA OF BIOETHICS* 1975, at 1976–77 (Stephen G. Post ed., 3d ed. 2004) (“[T]hey view themselves as significant members of the healthcare team, and increasingly are being viewed in that way by the medical professions.”).

rounds with physicians, nurses, and other licensed health care professionals and their participation in patient discharge planning.<sup>241</sup> Dr. Robert Orr, Co-chair of the Healthcare Ethics Council and Senior Fellow with The Center for Bioethics & Human Dignity at Trinity International University, also has recommended that hospital chaplains serve as important consultants to the health care team.<sup>242</sup>

A review of current hospital policies and procedures indicates that many hospitals expressly recognize chaplains as members of the health care team.<sup>243</sup> For example, Brackenridge University Medical Center in Austin, Texas, considers its chaplains to be members of the interdisciplinary patient care team.<sup>244</sup> Orlando Regional Medical Center in Orlando, Florida, also considers its chaplains to be integral members of the health care team.<sup>245</sup> At Yale-New Haven Hospital, chaplains participate fully in patient care meetings.<sup>246</sup>

In institutions in which they are viewed as part of the health care team, chaplains frequently “chart” in accordance with 2009 Association of Professional Chaplains (APC) standards; that is, they document the religious or spiritual care they provide to

241. See generally HAROLD G. KOENIG ET AL., HANDBOOK OF RELIGION AND HEALTH 451 (2d ed. 2001).

242. See generally Robert D. Orr & Leigh B. Genesen, *Requests for ‘Inappropriate’ Treatment Based on Religious Beliefs*, 23 J. Med. Ethics 142, 146 (1997) (“This individual should serve as a consultant to the care-team . . .”).

243. See, e.g., *infra* notes 244–246 (illustrating hospitals in Texas, Florida and Connecticut).

244. See *Chaplain Servs. and Spiritual Care*, SETON HEALTHCARE FAMILY, <https://www.seton.net/medical-services-and-programs/chaplain-services-and-spiritual-care/> (last visited Sept. 20, 2017) (“In addition to providing spiritual and emotional care, Staff Chaplains are members of the interdisciplinary patient care team. Our Chaplains serve on numerous committees, including hospital Ethics Committees.”) (on file with the Washington and Lee Law Review).

245. See *Interfaith Spiritual Care*, ORLANDO REG’L MED. CTR., <http://www.ufhealthcancerorlando.com/our-services/interfaith-spiritual-care> (last visited Sept. 20, 2017) (“Patients, families, and staff alike find the hospital chaplain to be an integral member of the healthcare team in the provision of clinical spiritual care.”) (on file with the Washington and Lee Law Review).

246. See *Spiritual Care*, YALE NEW HAVEN HOSP., <http://www.ynhh.org/patient-information/religious-ministries.aspx> (last visited Sept. 20, 2017) (noting chaplain “[p]articipation in patient care meetings, family meetings and interdisciplinary team meeting”) (on file with the Washington and Lee Law Review).

patients in medical records in the same way that physicians, nurses, or other licensed health care professionals document the medical, nursing, and other care they provide to patients.<sup>247</sup> The practice of chaplain medical record charting has become so commonplace that leaders of an APC conference workshop on electronic documentation stated (more than five years ago) that, “[w]e are not here to discuss if chaplains should chart. That question has been resolved.”<sup>248</sup>

Hospital chaplains are not always viewed as part of the health care team, however. A second view of hospital chaplaincy is a middle view, one in which the hospital chaplain walks between the distinct—sometimes complementary but sometimes contradictory—worlds of religion and health. Massachusetts General Hospital, for example, describes its chaplains as “liaisons, connecting members of the health care team, patients and families, and, if requested, clergy or other religious leaders in the community.”<sup>249</sup> Reverend Lawrence Holst, author of *Hospital Ministry: The Role of the Chaplain Today*, explains this middle approach as follows: “In many hospitals the chaplains’ garb is a white or blue clinical coat inscribed with a cross—symbols of medicine and religion. Often these two worlds are complementary, but sometimes they are contradictory.”<sup>250</sup>

A third view of hospital chaplaincy directly challenges the inclusion of the chaplain in the health care team. In an article published in 2007, Drs. Roberta Springer Loewy and Erich Loewy

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247. See, e.g., ASS’N OF PROF’L CHAPLAINS, STANDARDS OF PRACTICE FOR HOSPITAL CHAPLAINS IN ACUTE CARE, Standard 3, at 6 (Dec. 15, 2009) (“The chaplain enters information into the patient’s medical record that is relevant to the patient’s medical, psycho-social, and spiritual/religious goals of care.”).

248. David B. McCurdy, *Chaplains, Confidentiality, and the Chart*, 28 CHAPLAINCY TODAY 20, 20 (2012) [hereinafter McCurdy, *Chaplains*] (referencing George Handzo, Susan Wintz & Cassie McCarty, *If it’s Not in the Chart, it Didn’t Happen: The Challenges and Opportunities of EMRs*, Workshop, 2012 APC Annual Conference, Schaumburg, IL, June 2012).

249. See *Chaplaincy Department*, MASS. GEN. HOSP., <http://www.mghpcs.org/chaplaincy/> (last visited Sept. 20, 2017) (“As partners in healing, Massachusetts General Hospital chaplains are spiritual caregivers serving patients, families, visitors and staff through comfort, encouragement and prayer.”) (on file with the Washington and Lee Law Review).

250. Lawrence E. Holst, *Hospital Chaplain Between Worlds*, in HEALTH/MEDICINE AND THE FAITH TRADITIONS: AN INQUIRY INTO RELIGION AND MEDICINE 293 (Marin E. Marty & Kenneth L. Vaux, eds. 1982).

argued that it was unnecessary and perhaps even counterproductive for a chaplain to be fully involved in patient care and to have access to a patient's medical record.<sup>251</sup>

In settings in which the hospital chaplain is viewed as part of the health care team, or as a liaison to the health care team, the chaplains' use and disclosure of PHI must comply with the HIPAA Privacy Rule.<sup>252</sup> The HIPAA Privacy Rule contains three rules of

251. See Roberta Springer Loewy & Erich H. Loewy, *Healthcare and the Hospital Chaplain*, 9 MEDSCAPE GEN. MED. 53, 53 (2007) [hereinafter Loewy & Loewy, *Healthcare and the Hospital Chaplain*]

Moreover, many chaplains and chaplaincy programs have begun to assume that chaplains are full-fledged members of the healthcare team, complete with access to patients' medical records both to gather information and to make notations of their own.

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It would appear that such novel activities are being justified by a questionable set of claims and assumptions that includes: (1) the claim that chaplains have a spiritual—as opposed to purely religious—expertise that entitles them to interact with patients and/or significant others (even those who have not requested a chaplain)—presumably without in the least compromising patient autonomy or the confidentiality of the patient/healthcare professional relationship; (2) the assumption that the terms “spirituality” and “religiosity” mutually entail one another; (3) the claim that the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) mandates “spiritual assessments” (which it does not); (4) the assumption that chaplains are full-fledged members of the healthcare team; and (5) the claim that chaplains must, therefore, be permitted access to patients and patients' medical records both to gather information and to make notations of their own. We consider such claims and assumptions disquieting, and suggest that it is high time we revisit the terms ‘chaplaincy,’ ‘healthcare professional,’ and ‘member of the healthcare team’ in reassessing what our professional commitments to respect and protect the bio-psycho-social integrity of patients require.

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We have argued that, aside from the legalities of the issue, it is not necessary—indeed, it may even be counterproductive—for a chaplain to have access to patients' medical records. While it is true that a patient's spiritual needs may differ depending on the diagnosis, it is up to patients to determine what they wish to disclose or to be disclosed to chaplains or other spiritual counselors.

252. See Tovino, *Hospital Chaplaincy*, *supra* note 236, at 53–54 (discussing HHS' Privacy Rule, which implements one section of the Administrative Simplification provisions set forth in the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and regulates both uses and disclosures of protected health information by certain persons and organizations that fall within the definition of a covered entity).

patient permission, one of which must be satisfied before a covered entity, or employee or workforce member thereof, such as a hospital chaplain, uses or discloses PHI.<sup>253</sup>

Under the first rule, no form of prior patient permission is required before a covered entity, or employee or workforce member thereof, may use or disclose a patient's PHI.<sup>254</sup> This rule is limited to uses and disclosures of PHI necessary to carry out treatment, payment, or health care operations activities, or one of twelve public policy activities.<sup>255</sup> In the HIPAA Privacy Rule, HHS carefully defines the terms treatment,<sup>256</sup> payment,<sup>257</sup> and health care operations<sup>258</sup> to include certain clinical activities and necessary administrative and support services.

Under the second rule, a covered entity may conduct five sets of information uses and disclosures once the individual who is the subject of the information has been notified of the use or disclosure and has either agreed or not objected to the use or disclosure.<sup>259</sup> One set of information uses and disclosures permitted under the second rule involves the use and disclosure of directory information, defined to include the patient's name, location in the hospital facility (e.g., Room 421), general condition described in

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253. See, e.g., *id.* at 73–75 (discussing the three rules of individual permission).

254. See 45 C.F.R. § 164.506(a), (c)(1) (2017) (allowing covered entities to use and disclose PHI for treatment, payment, and health care operations without prior patient authorization).

255. See *id.* § 164.512 (identifying the twelve public policy activities for which no prior patient authorization is needed).

256. See *id.* § 164.501 (“[T]reatment [includes] coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.”).

257. See *id.* (defining payment to include the activities undertaken by a “health care provider or health plan to obtain or provide reimbursement for the provision of health care”; setting forth an itemized list of activities that constitute payment).

258. See *id.* (defining health care operations to include six paragraphs’ worth of administrative and other activities necessary to the delivery and financing of health care).

259. See *id.* §§ 164.510, 164.510(a)(2) (requiring a health care provider to give the patient the opportunity to restrict or prohibit certain uses or disclosures of healthcare information before allowing the clergy access to that information).



one word (e.g., good, fair, poor, stable), and religious affiliation (e.g., Catholic).<sup>260</sup>

Under the third rule, a covered entity must obtain the patient's prior written authorization for any use or disclosure that is not permitted under the first two rules of patient permission.<sup>261</sup> The authorization form is heavily regulated by HHS and must include a number of required elements and statements in order to comply with the HIPAA Privacy Rule.<sup>262</sup>

When a hospital chaplain uses or discloses PHI to carry out a religious service, spiritual activity, or other duty of employment, the use or disclosure must fall within one of the three rules of patient permission in order to comply with the HIPAA Privacy Rule.<sup>263</sup> Practicing health care attorneys, hospital chaplains, community clergypersons, health law scholars, and other stakeholders debate the applicability of the HIPAA rules to chaplain uses and disclosures.

The first rule, for example, allows health care providers to use and disclose PHI without prior patient authorization for "treatment," defined to include the provision, coordination, or management of "health care" and related services by one or more "health care providers" as well as the coordination or management of health care by a provider with a third party.<sup>264</sup> It would be legally helpful, then, for hospital chaplains if they fell within the definition of a "health care provider" and if the services they provided constituted "treatment" or "health care" for purposes of the Privacy Rule.<sup>265</sup> However, HHS explained in the preamble to a

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260. See *id.* § 164.510(a) (listing basic patient information that a covered entity can use or disclose as long as the patient has the opportunity to object).

261. See *id.* § 164.508(a)(1) ("Except as otherwise permitted or required by this subchapter, a covered entity may not use or disclose protected health information without an authorization that is valid under this section.").

262. See *id.* § 164.508(c)(1) (listing the core elements of a HIPAA-compliant authorization form); *id.* § 164.508(c)(2) (listing the required statements of a HIPAA-compliant authorization form).

263. See Tovino, *Hospital Chaplaincy*, *supra* note 236, at 58 ("[I]f a hospital-employed chaplain wishes to use PHI maintained by the covered hospital to carry out his or her job duties, the internal use of the information by the employed chaplain also must be made in accordance with the use and disclosure requirements set forth in the Privacy Rule.").

264. See 45 C.F.R. § 164.501 (2017) (defining treatment).

265. The HIPAA Privacy Rule defines health care as "care, services, or supplies related to the health of an individual . . . includ[ing] . . . Preventive,

final rulemaking published on December 28, 2000, that: “[H]ealth care’ as defined under the rule does not include methods of healing that are solely spiritual. Therefore, clergy or other religious practitioners that provide solely religious healing services are not health care providers within the meaning of this rule.”<sup>266</sup> In the sixteen years since HHS authored this preamble language, stakeholders have debated its meaning.<sup>267</sup> For example, does HHS think that all of the services that hospital chaplains and other clergy provide constitute “solely religious” or “solely spiritual” services and, thus, their work never constitutes “health care?”<sup>268</sup> Or, does HHS believe that hospital chaplains and other clergypersons provide a range of services, some of which are religious or spiritual in nature and others that constitute “health care?”<sup>269</sup> If the latter is true, would HHS classify the hospital chaplains who provide counseling and assessment services that fall within the definition of health care as “health care

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diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition . . . of an individual or that affects the structure or function of the body . . .” *Id.* § 160.103.

266. Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462, 82,568 (Dec. 28, 2000).

267. See, e.g., Loewy & Loewy, *Healthcare and the Hospital Chaplain*, *supra* note 251, at 60

So, what are we suggesting? We are suggesting that chaplains visit only those patients who, upon admission to a healthcare facility or at any time thereafter, have indicated—either in a designated space on the admission sheet or by verbal request—that they wish to be visited by a chaplain. It is our position that, if a patient indicates that he or she would not like such a visit, it should be recorded in the medical record and the chaplaincy office should be notified not to visit the patient. If a patient does wish to be visited by a chaplain, it should be recorded in the medical record and a request forwarded to the chaplaincy office. In cases in which it is unclear what the patient’s wishes may be, then a member of the patient’s healthcare team should ask the patient or designated surrogate for clarification.

See also McCurdy, *Chaplains*, *supra* note 248, at 20 (“I maintain that chaplains should have access to patients’ records on a need-to-know basis and the opportunity to write in the chart. I also think chaplains’ approach to confidentiality requires a richer, more nuanced understanding of confidentiality in their complex role than has emerged to date.”).

268. See Tovino, *Hospital Chaplaincy*, *supra* note 236, at 76 (offering these questions).

269. *Id.*

providers”?<sup>270</sup> Or, perhaps, can a hospital chaplain constitute a “third party” (for purposes of the definition of “treatment”) who is permitted to work with a health care provider to provide, coordinate, or manage “health care”? Or, perhaps HHS was simply referring to clergy who are authorized to represent their particular faith groups in the community (known as community clergypersons), rather than hospital chaplains whose job duties include providing requested religious, spiritual, and other services to patients in the hospital facility.<sup>271</sup>

The answers to these questions are legally important. If the preamble is interpreted to mean that HHS believes that hospital chaplains only provide religious or spiritual services, the technical result is that the work of a hospital chaplain does not fit within the first tier of patient permission and someone must obtain the prior written authorization of each patient before the chaplain may use or disclose that patient’s PHI under the third rule, unless the work of the hospital chaplain is limited to that which fits within the second rule.<sup>272</sup>

Under the second rule, hospital chaplains are permitted to receive a patient’s directory information, defined to include the patient’s name, the patient’s location in the hospital, the patient’s general condition described in one word, and the patient’s religious affiliation if the patient has agreed to the disclosure of his or her directory information orally or in writing or has been informed of the use and disclosure and has not objected.<sup>273</sup> Although hospital chaplains who have access to such directory information can identify and locate patients in the hospital for purposes of meeting patients and providing religious or spiritual services at the bedside, many of their other job duties, including participating in hospital ethics committee meetings, institutional review board meetings, patient care rounds, and patient care meetings, would

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270. *Id.*

271. *See id.* at 80–81 (carefully distinguishing community clergypersons from hospital chaplains).

272. *See id.* at 77 (explaining this legal result in more detail). Drs. Loewy would agree with this interpretation. Loewy & Loewy, *supra* note 251.

273. *See* 45 C.F.R. § 164.510(a)(1)(i) (2017) (“A covered health care provider must inform an individual of . . . disclosures to clergy of information regarding religious affiliation and provide the individual with the opportunity to restrict . . . [the] disclosures . . .”).

be severely restricted if not prohibited if their activities only fit within the second rule.<sup>274</sup> Stated another way, if the work of chaplains is limited to that which fits within the second rule, hospital chaplains are relegated to “just visiting the sick.”<sup>275</sup>

These interpretation options are not satisfying to many stakeholders who hold a nuanced understanding of the multidimensional role of the hospital chaplain.<sup>276</sup> I therefore recommend that HHS issue a NPRM proposing to amend 45 C.F.R. § 164.501 in accordance with the italicized language set forth below. The purpose of these amendments would be to allow both health care and religion to coexist in health care settings. Technically, these amendments would add a new definition of “health care chaplain” and would situate the religious, spiritual, and other work of the health care chaplain within the definition of “health care operations.”

The regulatory result of these amendments would be that: (1) the use and disclosure of PHI by a hospital chaplain would be permitted under the first rule of patient permission without the patient’s prior written authorization; and (2) the use and disclosure of directory information by a community clergyperson would remain limited to the second rule. In addition, the placement of the work of hospital chaplains within the definition of “health care operations,” not “treatment,” would respond to those stakeholders who urge distinction between licensed health care providers on the one hand and hospital chaplains and other clergypersons on the other.

45 C.F.R. § 164.501—Definitions

As used in this subpart, the following terms have the following meanings:

Health care chaplain means a priest, pastor, rabbi, minister, or other clergyperson who is employed or contracted by a covered health care institution to provide religious, spiritual, and other

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274. See Tovino, *Hospital Chaplaincy*, *supra* note 236, at 78 (explaining this result).

275. See, e.g., *id.* (examining “Hospital Chaplaincy Under the HIPAA Privacy Rule: Health Care or ‘Just Visiting the Sick?’”).

276. See McCurdy, *Chaplains*, *supra* note 248, at 20 (arguing for a more nuanced understanding of the role of the hospital chaplain and the chaplain’s confidentiality obligations than has emerged to date).

services to patients and families within the covered health care institution. The term does not include community clergypersons, defined as individuals who serve as religious or spiritual leaders of their faith traditions in the community.

Health care operations means any of the following activities of the covered entity to the extent that the activities are related to covered functions:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR § 3.20); population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment, including the provision of religious, spiritual, and other services by health care chaplains.

In the NPRM, HHS should solicit comments from professional chaplains, professional chaplain associations, and other stakeholders with training in religious and spiritual studies. HHS should use the commentary it receives to adjust the text of the final regulations.

## VI. Conclusion

This Article has identified four practical ways in which health, law, and religion intersect, including intersections that have neither been carefully addressed by the courts nor thoroughly examined by legal academics through traditional law review scholarship.<sup>277</sup> Drawing guidance from fields as wide ranging as constitutional law, transportation law, utilities law, criminal law, contract law, tax law, and trusts and wills law, this Article also has proposed draft language for three sets of new federal regulations in the areas of RNHCI law (at 42 C.F.R. §§ 403.720, 403.766), home health care law (at 42 C.F.R. § 484.2), and the HIPAA Privacy Rule (at 45 C.F.R. § 164.501), as well as three guidance documents designed to advise and inform practicing health care attorneys and

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277. *Infra* Parts II–V.

the general public in the areas of RNHCI law, home health care law, and hospice law. This Article also has called on constitutional law and law and religion scholars to bring their significant expertise to bear on the practical yet important questions raised herein.

Religion intersects health law in a number of ways not illustrated in this Article, and these intersections deserve equal study. For example, religion intersects the law governing Medicare payment for nursing home care. As background, public-program reimbursed nursing care<sup>278</sup> can be delivered by a Medicare-participating skilled nursing facility (SNF)<sup>279</sup> or a Medicaid-participating nursing facility (NF).<sup>280</sup> Federal regulations codified at 42 C.F.R. Part 483 govern SNFs and NFs (collectively, long-term care (LTC) facilities) that wish to receive payment from the Medicare and/or Medicaid Programs for their provision of nursing care to beneficiaries (LTC Requirements).<sup>281</sup> The LTC Requirements contain numerous provisions giving SNF and NF residents a wide variety of rights. For example, SNF and

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278. See generally *Nursing Homes*, U.S. DEPT' HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/nhs.html> (last visited Sept. 20, 2017) (providing basic information about certification as a Medicare and/or Medicaid nursing home provider) (on file with the Washington and Lee Law Review).

279. SNF is defined as an institution, or a distinct part of an institution, that is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; that is not primarily for the care and treatment of mental diseases; and that meets other requirements set forth in federal law. See 42 U.S.C. § 1395i-3(a)(1)–(3) (2012) (defining a skilled nursing facility).

280. An NF is defined as an institution, or a distinct part of an institution, that is not primarily engaged in the provision of care and treatment of mental diseases but is primarily engaged in providing to residents either: (1) skilled nursing care and related services for residents who require medical or nursing care; (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; and that meets other requirements set forth in federal law. See *id.* § 1396r(a)(1)–(3) (defining a nursing facility).

281. See 42 C.F.R. pt. 483 (2017) (setting forth requirements for SNFs and NFs (collectively, long-term care facilities who wish to participate in the Medicare and/or Medicaid Programs)).

NF residents have the right to exercise the rights that they have as citizens or residents of the United States,<sup>282</sup> as well as the right to be free of interference, coercion, discrimination, and reprisal from a SNF or NF in the exercise of their rights.<sup>283</sup> By further example, SNF and NF residents have the specific right to participate in religious activities so long as such activities do not interfere with the rights of other residents in the facility.<sup>284</sup>

The LTC Requirements also contain other provisions that implicate religion. For example, the LTC Requirements generally prohibit NFs from charging, accepting, “or receiving any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay of a Medicaid beneficiary in [an NF].”<sup>285</sup>

This rule is designed to ensure that Medicaid beneficiaries are admitted to LTCs on a first-come, first-serve basis as beds become available. However, an NF “may solicit, accept, or receive a charitable ‘religious, or philanthropic contribution’ from an organization or from a person unrelated to a Medicaid-eligible resident or potential resident, but only to the extent that the contribution is not a condition of the resident’s admission, expedited admission, or continued stay in the [NF] for a Medicaid eligible resident.”<sup>286</sup>

During my practice, I used to represent NFs accused of receiving donations from religious organizations, spiritual groups, and secular organizations that may or may not have been in exchange for Medicaid beneficiaries’ expedited nursing home admissions.

Religion also plays a role in the acceptability of state Medicaid managed care options. States that require Medicaid beneficiaries

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282. *See id.* § 483.10(b) (“The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.”).

283. *See id.* § 483.10(b)(2) (“The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.”).

284. *See id.* § 483.15(d) (“A resident has a right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.”).

285. *See id.* § 483.15(a)(4) (“In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive . . . any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility.”).

286. *Id.* § 483.15(a)(4)(ii).

to enroll in a managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) plan generally must give those beneficiaries a choice of at least two managed care entities.<sup>287</sup> However, a state may restrict rural residents to a single MCO, PIHP, PAHP, or PCCM if the state permits the beneficiary to obtain services from any provider if the only plan or provider available to the beneficiary does not provide the services the enrollee seeks because of the plan or provider's religious objections.<sup>288</sup> Medicaid managed care enrollees also must be given the option to disenroll from a plan that does not, because of religious objections, cover the services the enrollee seeks.<sup>289</sup> Along the same lines, state Medicaid agencies "may not require [Medicaid beneficiaries] to undergo any medical service, diagnosis or treatment, or to accept any other health service provided under [a Medicaid] plan if [they] object or, in the case of a child, a parent or guardian objects on religious grounds."<sup>290</sup>

Religion also plays a role in the ability of Medicare Advantage (MA) plans, authorized by Medicare Part C, to refuse to cover services that are objectionable to the plan on religious grounds. As background, an MA plan is a type of Medicare health plan offered by a private organization that contracts with Medicare to provide Medicare beneficiaries with all of their Medicare Part A and Part B benefits.<sup>291</sup> MA plans include health maintenance organizations (HMOs), preferred provider organizations (PPOs), private

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287. See *id.* § 438.52(a) ("Except as [otherwise provided] . . . a State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities."); *id.* § 438.2 (defining MCO, PIHP, PAHP, and PCCM).

288. See *id.* § 438.52(b)(2)(ii)(C) (allowing rural area beneficiaries to obtain services from another provider if the only provider available does not provide the care the beneficiary seeks due to the provider's moral or religious objections).

289. See *id.* § 438.56(d)(2)(ii) ("The following are cause for disenrollment . . . [t]he plan does not, because of moral or religious objections, cover the service the enrollee seeks.").

290. *Id.* § 440.270(a).

291. *Medicare Advantage Plans*, U.S. DEPT HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/medicare-advantage-plans.html> (last visited Sept. 20, 2017) (explaining the requirements to qualify for Medicare Parts A and B insurance) (on file with the Washington and Lee Law Review).



fee-for-service (PFFS) plans, religious fraternal benefit (RFB) plans,<sup>292</sup> special needs plans (SNPs), and Medicare medical savings account (MSA) plans.<sup>293</sup>

In general, MA plans “may not prohibit or otherwise restrict a health care professional . . . from advising, or advocating on behalf of, an [MA enrollee] about the [enrollee’s] health status, medical care, or treatment options . . . the risks, benefits, and consequences of treatment or non-treatment; [and] the opportunity for the enrollee to refuse treatment and to express preferences about future treatment decisions.”<sup>294</sup>

However, this general rule does not require an “MA plan to cover, furnish, or pay for a particular counseling or referral service if the MA organization that offers the plan objects to the provision of the service on religious grounds” and makes available information regarding its coverage policies, including its exclusions, to CMS as well as to prospective enrollees before and during enrollment.<sup>295</sup>

Religion intersects health law in still other ways. Medicare and Medicaid eligibility, for example, is conditioned on United States citizenship or qualified alien status.<sup>296</sup> CMS specifies the documentation that constitutes acceptable evidence of citizenship, and religious documentation provided by a religious institution

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292. Religious fraternal benefit (RFB) societies are nonprofit, tax-exempt organizations that are “affiliated with, carry out the tenets of, and share a religious bond with, a church or convention or association of churches or an affiliated group of churches.” 42 C.F.R. § 422.2 (2017). “An RFB society that offers an RFB plan may offer that plan only to members of the church or convention or group of churches with which the society is affiliated.” *Id.* § 422.57. *See generally id.* § 422.524 (establishing special rules for RFB societies).

293. *See Health Plans—General Information*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., [https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html?redirect=/HealthPlansGenInfo/12\\_HIPAA.asp/](https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/index.html?redirect=/HealthPlansGenInfo/12_HIPAA.asp/) (last visited Sept. 20, 2017) (listing the health plan options available to Medicare beneficiaries under Medicare Part C) (on file with the Washington and Lee Law Review); *see also* U.S. DEP’T HEALTH & HUMAN SERVS., CTRS. MEDICARE & MEDICAID SERVS., MEDICARE MANAGED CARE MANUAL, Chapter 1, at 10, § 30 (Jan. 7, 2011) (listing the types of MA plans).

294. 42 C.F.R. § 422.206(a).

295. *Id.* § 422.206(b).

296. *See id.* §§ 435.406–407 (limiting Medicaid eligibility to citizens and certain qualifying aliens; defining citizens as citizens of the United States as well as non-citizen nationals).

may be permissible in certain circumstances.<sup>297</sup> An individual who does not have primary or secondary evidence of citizenship, such as a United States passport or birth certificate, can present as evidence a religious record that is recorded with a religious institution showing that the individual was born in the United States.<sup>298</sup>

Religion also impacts the distribution of Medicaid identification numbers, which can be tied to Social Security numbers. For example, a state may give a Medicaid identification number to an applicant who, because of a well-established religious objection, refuses to obtain a Social Security number.<sup>299</sup> In this context, CMS defines well-established religious objection to mean “the applicant is a member of a recognized religious sect or division [thereof, the applicant] adheres to the tenets or teachings of the sect or division [thereof] and, for these reasons, [the applicant] is conscientiously opposed to applying for or using a national identification number.”<sup>300</sup>

Religion intersects health law in still other ways. For example, Medicaid benefits are generally conditioned on an applicant’s proof of low income and low resources. Countable income does not include, however, certain payments that certain applicants may receive as a result of ownership interests in, or usage rights to, items that have unique religious significance.<sup>301</sup>

It is my hope that this Article will encourage constitutional law and law and religion scholars to produce scholarship examining these and other topics that lie at the intersection of

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297. See *infra* note 298 and accompanying text (illustrating different ways religion intersects health law).

298. See 42 C.F.R. § 435.407(c)(3) (2017) (accepting as documentary evidence of citizenship a “[r]eligious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual’s age at the time the record was made”).

299. See *id.* § 435.910(h)(1) (“[A] state may give a Medicaid identification number to an individual who . . . [r]efuses to obtain an SSN because of well-established religious objections.”).

300. *Id.* § 435.910(h)(2)(i)–(ii).

301. See *id.* § 435.603(e)(3)(5) (excluding from countable income “[p]ayments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom”).

health, law, and religion. Guidance, relevant to the health care context, on the meanings of “religious contribution,” “religious documentation provided by a religious organization,” “well-established religious objection,” and “items that have unique religious significance” would be extremely helpful for health industry participants, public health care program beneficiaries, and practicing health care attorneys. My request for guidance is especially timely given Neil Gorsuch’s appointment to the Supreme Court. The Supreme Court’s future opinions could impact the legal meaning of these terms.

I would like to conclude by making three administrative and/or procedural recommendations that, if implemented, would improve the counsel provided by regulatory health care attorneys as well as the public’s understanding of issues that lie at the intersection of law, religion, and health care finance. My first administrative recommendation is designed to respond to the limitations of the federal Administrative Procedure Act’s notice and comment rulemaking process. When I first started practicing health law, I subscribed to the HHS listserv and followed a number of other health law listservs and blogs so that I could stay current on HHS activity, including proposed rulemakings that could affect my health industry clients. Now, as a health law teacher, I continue to subscribe to the HHS listserv and other health law-related listservs and blogs so that I can keep my teaching and scholarship up to date. As any health law professor would tell you, staying current in health law is a full-time job. Time considerations prevent me from subscribing to the listservs of other federal agencies and blogs in legal areas outside health law.

For the same reasons, many constitutional law and law and religion scholars do not subscribe to the HHS listserv or other health law update services because pure health law (at first glance) may seem too far afield from the legal issues they teach in the classroom and the substantive areas in which they write. As an illustration, I frequently ask constitutional law and law and religion scholars to opine on recent developments in health law in which I have interest. Many times the scholars will tell me they have absolutely no knowledge of the underlying health law development. That is, the individuals who are best suited to comment on health laws that implicate religion do not even know about such laws.

I have learned that many constitutional law and law and religion scholars do subscribe to listservs and blogs that consider on a regular basis constitutional law and law and religion questions. These blogs include, but certainly are not limited to, *SCOTUSblog*,<sup>302</sup> *Constitutional Law Prof Blog*,<sup>303</sup> *Constitutional Daily*,<sup>304</sup> *The Volokh Conspiracy*,<sup>305</sup> *Legal Scholarship Blog*,<sup>306</sup> *Reproductive Rights Prof Blog*,<sup>307</sup> *The Wall Street Journal's Law Blog*,<sup>308</sup> *Brian Leiter's Law School Reports*,<sup>309</sup> *Religion Clause*,<sup>310</sup> *Religion Law Blog*,<sup>311</sup> and *Law and Religion Forum*.<sup>312</sup> Going forward, I recommend that health law scholars: (1) forward NPRMs, final rules, and other HHS activity that implicate religion to the editors of these blogs; (2) highlight, including by page number within the *Federal Register*, the religion reference or issue implicated by the NPRM, final rule, or other development; and (3) request commentary from individuals who are experts in the implicated topic. It is my hope that this recommendation will

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302. SCOTUSBLOG, <http://www.scotusblog.com/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

303. *Constitutional Law Prof Blog*, L. PROFESSOR BLOGS NETWORK, <http://lawprofessors.typepad.com/conlaw/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

304. *Constitution Daily*, NAT'L CONST. CTR., <http://blog.constitutioncenter.org/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

305. *Volokh Conspiracy*, WASH. POST, <https://www.washingtonpost.com/news/volokh-conspiracy/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

306. LEGAL SCHOLARSHIP BLOG, <http://www.legalscholarshipblog.com/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

307. *Reproductive Rights Prof Blog*, L. PROFESSOR BLOGS NETWORK, [http://lawprofessors.typepad.com/reproductive\\_rights/](http://lawprofessors.typepad.com/reproductive_rights/) (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

308. *Business*, WALL ST. J. L. BLOG, <http://blogs.wsj.com/law/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

309. *Brian Leiter's L. Sch. Rpts.*, L. PROFESSOR BLOGS NETWORK, <http://leiterlawschool.typepad.com/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

310. *Religion Clause*, BLOGGER, <http://religionclause.blogspot.com/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

311. *Religion Law Blog*, BLOGGER, <http://religionlaw.blogspot.com/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

312. *Law and Religion Forum*, ST. JOHN SCH. CTR. L. AND RELIGION, <https://clrforum.org/> (last visited Sept. 20, 2017) (on file with the Washington and Lee Law Review).

improve the quantity and quality of constitutional law and law and religion commentary on health law issues, thereby improving the development of regulatory health law by HHS, the interpretation of health law by health care attorneys, and the application of health law by the health care industry.

Second, many law professors who write in the areas of constitutional law and law and religion have little exposure to the ways in which health care is actually delivered and financed. As such, these academics tend to address in their scholarship and public speaking opportunities the narrow questions presented in highly publicized Supreme Court cases, such as *Zubik*<sup>313</sup> and *Hobby Lobby*,<sup>314</sup> but not the daily operational questions encountered by practicing health care attorneys. To remedy this problem, I recommend that law schools with health law, constitutional law, and/or law and religion programs host symposia to which practicing health care attorneys, members of the clergy, and experts in constitutional law, law and religion, and religion and spiritual studies are invited. The purpose of these symposia would be to expose the more theoretical constitutional law and law and religion scholars to health care operations and to educate regulatory health care attorneys regarding basic constitutional principles, frameworks, and guideposts. The symposia organizers should collect, edit, and publish written proceedings outlining constitutional law principles applicable to daily health care operations that may be distributed to health law scholars and practicing health care attorneys as well as the general public.

Third, HHS itself should issue guidance for health care attorneys and the general public addressing the proper implementation of religious rights, accommodations, and exceptions in the health care finance context, just as HHS issues

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313. See *Zubik v. Burwell*, 136 S. Ct. 1557, 1559 (2016) (examining whether the government could impose taxes or penalties on nonprofit religious employers who had met the requirements for religious exemption from the contraceptives coverage mandate of the Affordable Care Act).

314. See *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751, 2751 (2014) (examining “whether the Religious Freedom Restoration Act of 1993 . . . permits the United States Department of Health and Human Services (HHS) to demand that three closely held corporations provide health-insurance coverage for . . . contraception . . . violate[s] the sincerely held religious beliefs of the companies’ owners”).

guidance on other implementation topics.<sup>315</sup> Parts II, III, and IV of this Article recommended that HHS issue guidance specific to the RNHCI, home health care, and hospice contexts, but there are so many other contexts in which religion intersects health care finance<sup>316</sup> that could benefit from guidance. HHS already publishes a wide variety of guidance documents applicable to a number of different areas within health law,<sup>317</sup> and a review of the content, structure, means of distribution, and Internet accessibility of these other guidance documents would be helpful in designing guidance addressing religion and the law governing health care finance.

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315. Cf. COUNCIL REPORT, *supra* note 88, at 133, Rec. 7 (recommending that the federal government issue guidance to federal employees, service providers, and the general public stating with clarity the distinction between direct and indirect forms of government aid to religious institutions and labeling each program it offers as involving direct or indirect aid).

316. See, e.g., *supra* notes 278–301 and accompanying text (identifying additional illustrative ways in which religion intersects health law).

317. See, e.g., *supra* notes 126–128 and accompanying text (providing three examples of such guidance documents).