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The Broken Medicare Appeals System: Failed Regulatory Solutions and the Promise of Federal Litigation

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The Broken Medicare Appeals System: Failed Regulatory Solutions and the Promise of Federal Litigation

Greer Donley[†]

Abstract

The Medicare Appeals System is broken. For years, the System has been unable to accommodate a growing number of appeals. The result is a backlog so large that even if no new appeals were filed, it would take the System a decade or more to empty. Healthcare providers wait many years for their appeals to be heard before an Administrative Law Judge (ALJ), and because the government recoups providers' Medicare payments while they wait, the delays cause them serious financial harm. Even worse, providers are more likely than not to prevail before the ALJ, proving that the payment should never have been recouped in the first place. The financial pressure on providers creates widespread reverberations in the healthcare market, and consumers ultimately pay the price. Nevertheless, the government appears unwilling or unable to fix the problem.

This Article explores how the System works, why the System broke, and what legal or legislative remedy could solve its problems. The Article articulates the central concern underlying the System's backlog: small providers lack the liquidity and revenue stream to endure the uncertainty and delayed gratification that is now required to participate in the Medicare Program. As a result, these companies collapse or are purchased by larger providers—contributing to the consolidation of the healthcare market. An optimal remedy would relieve the pressure small providers face; it could be achieved by delaying the government's ability to recoup Medicare payments before the provider has received an ALJ determination. Though legislative or administrative action could most easily accomplish this goal, providers have asked the judiciary to step in where the government is failing. Of the various legal challenges that providers have lodged against the government to protest the System's delays, the one most likely to help small providers is under the Due Process Clause. This Article concludes that a due process challenge—though difficult to win—could have merit and might be small providers' best chance of obtaining relief, at least in the short term.

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[†] As of August 1, 2018, Greer Donley will be an Assistant Professor at the University of Pittsburgh School of Law. She would like to thank Rebecca S. Eisenberg, Margo Schlanger, and Nicholson Price for their very helpful feedback on earlier drafts of this Article.

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Introduction

Over the past six years, the Medicare Appeals System (“System”), which handles appeals from Medicare payment determinations, has experienced extreme bureaucratic inefficiency. The problems began in 2010 when Congress implemented a new Medicare auditing program.¹ This program dramatically increased the number of appeals entering the System, but did not expand the budget or modify the System’s structure to accommodate the influx.² By the end of 2015, the Department of Health and Human

1. See, Andrew Wachler and Jessica Forster, *GAO Releases Report Outlining Continued Inefficiencies with the Medicare Appeals System and the Increasing Appeals Backlog*, ABA, https://www.americanbar.org/publications/aba_health_resource/2015-2016/august/appealsbacklog.html (last visited Feb. 28, 2018) and CTRS. FOR MEDICARE & MEDICAID SERVS., *RECOVERY AUDITING IN MEDICARE IN FOR FISCAL YEAR 2014* (2015). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.pdf> [hereinafter RECOVERY AUDITING].

2. RECOVERY AUDITING, *supra* note 1; U.S. GOV’T ACCOUNTABILITY OFF., *GAO-16-366, MEDICARE FEE-FOR-SERVICE OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS 19-20* (2016) [hereinafter MEDICARE FEE FOR SERVICE].

Services (“HHS”) admitted that the System was so backlogged that it could take eleven years for the System’s Administrative Law Judges (“ALJs”) to resolve the appeals pending before them, even assuming no new appeals were filed.³

This backlog has caused enormous delays. Though Medicare providers are statutorily entitled to an ALJ determination within ninety days, the average provider waits at least three years.⁴ And as they wait, the government recoups providers’ money as if it has already won—often totaling millions of dollars per provider.⁵ This early recoupment would be justified by administrative efficiency if the underlying decisions were generally correct, but in reality, a significant proportion of these recoupments are erroneous and eventually returned.⁶ Delays associated with the backlog have hit small providers particularly hard.⁷ Many small providers face insolvency as they wait for an ALJ determination—a dynamic that exacerbates systemic healthcare problems for consumers. Most notably, it contributes to the consolidation of the healthcare market, which reduces competition and increases prices.

Despite the government’s awareness of and attention to the situation, HHS⁸ has been unable to control the increasing number of appeals entering the System. The agency has requested additional funding from Congress for four years in a row, finalized a rule aimed at streamlining the System, and lobbied for legislative solutions.⁹ Nevertheless, Congress has failed to increase the budget or legislate reforms. And there is little evidence that the agency’s administrative reforms will impact the backlog in any significant way.

Once it became clear that lobbying efforts were unlikely to be successful, both large and small Medicare providers took their complaints to the federal courts, pursuing different legal strategies that reflected their various needs. These efforts largely failed early on, but starting in late 2015, the courts became more receptive to these challenges. The litigation

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3. U.S. DEP’T OF HEALTH & HUMAN SERVS., HHS PRIMER, 7, <https://www.hhs.gov/dab/medicare-appeals-backlog.pdf> (last visited Mar. 26, 2018) [hereinafter HHS PRIMER].
 4. MEDICARE FEE FOR SERVICE, *supra* note 2, at 1, 10,18.
 5. *Id.* at 2.
 6. *Id.* at 69.
 7. See Hirschfield, Marc E. & Skapof, Marc, *Healthcare Providers Face Increasing Financial Pressure And Bankruptcy Risk*, MONDAQ,(June 26, 2014), <http://www.mondaq.com/unitedstates/x/323360/Healthcare/Hhealthcare+Providers+Face+Increasing+Financial+Pressure+And+Bankruptcy+Risk>.
 8. HHS is an umbrella agency that oversees many of the agencies at issue in this Article.
 9. MEDICARE FEE FOR SERVICE, *supra* note 2, at 38-39; Medicare Program: Changes to the Medicare Claims and Entitlement, 60 Fed. Reg. 4974 (Jan. 17, 2017).

surrounding the System's delays presents an interesting case study on how the federal courts, though reluctant, can intervene when private parties, agencies, and Congress cannot solve administrative problems on their own. Unlike the legislature, however, the judiciary's solutions are necessarily limited by the nature of the relief sought. One provider group, for instance, obtained a writ of mandamus, which ordered the government to empty the backlog and comply with the System's statutory deadlines. But mandamus is an imperfect remedy: even if the writ reduces the backlog of appeals, it will do so at the expense of small providers and further perpetuate some of the problems associated with the System's delays. A successful due process challenge, on the other hand, could create an optimal remedy by relieving the pressure small providers experience while waiting for an ALJ hearing.

This Article explores how the System became so backlogged, why administrative solutions have failed, and what the best legal remedy could be. In Section I, I explain the process by which CMS or its contractors initially pay Medicare providers and subsequently identify and recoup overpayments. In Section II, I explore the System as Congress initially envisioned it, how it currently functions, and why it became so dysfunctional. Next, in Section III, I discuss how the delays associated with the System's backlog play into problems that affect our healthcare market as a whole. Section IV then discusses the various regulatory and legislative proposals, explaining why these attempted solutions have failed, and how the agency or legislature could create meaningful change.

Finally, in Section V, I explore two different kinds of legal challenges: mandamus and due process. The former aims to force compliance with the ninety-day statutory timeline, while the latter seeks to delay recoupment until after an ALJ hearing. Though only mandamus has been successful thus far, this Article argues a remedy in due process will provide more protection for small businesses, and consequently, consumers. While small providers have achieved some preliminary relief in their due process challenges, they all settled their cases with the agency before the merits were reached. This result is unsurprising given that small providers generally lack the financial capacity or incentive to litigate the issue to finality. This section concludes that a due process challenge has merit, and if small providers can overcome the obstacles inherent in litigating a due process claim, it may present their best chance at achieving the desired result absent legislative action.

I. Billing Medicare: How CMS Pays and Reviews Medicare Claims

The government provides health insurance for individuals over sixty-five or who live with disabilities through the Medicare program.¹⁰ The

10. *An Overview of Medicare*, KAISER FAMILY FOUND. (Nov. 2017), <http://files.kff.org/attachment/issue-brief-an-overview-of-medicare>. Medicare beneficiaries can choose to enroll in either Medicare or Medicare Advantage ("MA") health plans. *Id.* Private health insurers administer MA plans

government is the largest single healthcare payer in the United States, and as a result, it has a large and disproportionate influence on the healthcare market.¹¹ Most healthcare providers and suppliers¹² treat at least some Medicare patients,¹³ though certain providers do not generally service any Medicare enrollees (e.g. pediatricians) and others treat a disproportionately high number Medicare beneficiaries (e.g., hospice providers).¹⁴ Providers can also refuse to accept Medicare patients and, though it remains unusual, it is becoming more common for certain providers to do so.¹⁵

After treating a Medicare patient, a provider submits a claim for payment to the government. If the government approves the claim, then the provider receives compensation.¹⁶ In this way, Medicare functions like any health insurer: it contracts with providers to treat its beneficiaries in exchange for

and the government pays private insurers to cover beneficiaries on behalf of the government. *Id.*

11. Tevi Troy, *How the Government as a Payer Shapes the Health Care Marketplace*, AM. HEALTH POL'Y INST, http://www.americanhealthpolicy.org/Content/documents/resources/Government_as_Payer_12012015.pdf (last visited Mar. 27, 2018).
12. In this Article, I use the term provider to include both providers and suppliers. According to the statute: provider “means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.” 42 U.S.C. § 1395x(u) (2010). The statute defines suppliers to “mean[], unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.” 42 U.S.C. § 1395x(d) (2010). Healthcare “providers” include hospitals and other healthcare facilities, physicians’ groups, and product manufacturers to the extent their services or products are accepted for Medicare, Medicaid, or CHIP reimbursement, see 42 U.S.C. § 1395x(u) (2006).
13. Thomas Beaton, *Providers Seeing Even Mix of Public, Commercially Insured Patients*, HEALTH PAYER INTELLIGENCE (Oct. 30, 2017), <https://healthpayerintelligence.com/news/providers-seeing-even-mix-of-public-commercially-insured-patients>.
14. Greg Bengel, *Doctors Refuse to Accept Medicare Patients*, HEALTH IT OUTCOMES (Aug. 9, 2013), <https://www.healthitoutcomes.com/doc/doctors-refuse-to-accept-medicare-patients-0001>.
15. CTRS. FOR MEDICARE & MEDICAID SERVS., OPTING OUT OF MEDICARE AND/OR ELECTING TO ORDER AND CERTIFY ITEMS AND SERVICES TO MEDICARE BENEFICIARIES (Sept. 2015), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf>; Melinda Beck, *More Doctors Steer Clear of Medicare*, WALL ST. J. (July 29, 2013), <http://www.wsj.com/articles/SB10001424127887323971204578626151017241898>.
16. See e.g., 42 U.S.C. § 1395g(a) (2010); 42 U.S.C. § 1395l(a) (2010).

payment.¹⁷ CMS, however, does not function as the insurer itself; rather, it contracts with Medicare Administrative Contractors (“MACs”) to perform various insurance functions on its behalf.¹⁸ For instance, MACs review providers’ claims for payment and pay providers for approved claims.¹⁹

When a provider submits a claim for payment, MACs conduct a prepayment review to determine whether the claim meets Medicare’s conditions of payment.²⁰ Contractors create a system that automatically pays certain claims, automatically denies certain claims, and tags other claims for additional review.²¹ Whether a claim is automatically paid or queued for further review is determined based on risk—i.e., contractors determine that certain claims are at a high risk for overbilling and are therefore reviewed more thoroughly before payment.²² The vast majority of claims are considered low-risk and may be paid automatically or semi-automatically with little oversight.²³ This assessment is called Non-Complex Review because it does not evaluate the medical documentation supporting the claim, but rather confirms certain conditions of payment are met by computer systems or non-expert coders.²⁴ Such claims can be automatically denied, for instance, if the provider submits the claim with missing, or clearly incorrect information.²⁵ Factors such as device delivery dates and length of stay requirements can also form a more substantive basis to quickly reject or accept the claim.²⁶

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17. *See What’s Medicare?*, MEDICARE.GOV, <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html> (last visited Feb. 23, 2018).
 18. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS REVIEW PROGRAMS, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf (last updated Sept. 2016) [hereinafter MEDICARE CLAIMS REVIEW PROGRAMS].
 19. *What is a MAC*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html> (last visited Feb. 23, 2018).
 20. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PROGRAM INTEGRITY MANUAL, §3.2, <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c03.pdf> (last updated Nov. 9, 2017) [hereinafter MEDICARE INTEGRITY MANUAL].
 21. *Id.* at §3.2.B.
 22. *Id.*, at §3.2.1.
 23. *See e.g.*, *Gulfcoast Med. Supply v. Sec’y, Dep’t of Health and Human Servs.*, Case No. 8:04-CV-2610-T-26EAJ, 2005 WL 3934860 *2 (M.D. Fla. Nov. 16, 2005) (citations omitted), *aff’d* 468 F.3d 1347 (11th Cir. 2006) (“[I]nitial payment for services under Medicare is ordinarily made as long as the [Medicare] claim does not contain glaring irregularities on its face.”).
 24. *See* MEDICARE CLAIM REVIEW PROGRAMS, *supra* note 18.
 25. *Id.* at § 3.2.A.
 26. *Id.* at § 3.2.1.2.

A small number of flagged claims, however, are reviewed under Complex Review prior to payment; this involves a medical professional or claims analyst analyzing the claim to ensure it is “for a service or device that is medically reasonable and necessary.”²⁷ Complex Review is not rote; it involves an assessment of the claim’s medical documentation—such as physician notes, medical charts, and diagnosis codes—by an expert reviewer.²⁸ Contractors reviewing these claims may request additional documentation before approving or denying them.²⁹ Complex Review is time consuming and expensive; contractors cannot use it to review every claim before payment. Instead, contractors “target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources.”³⁰ Contractors flag claims as high risk—and therefore conduct Complex Review—for many reasons. For instance, the claim may be expensive, frequently billed, or use a diagnosis or procedure code with a history of incorrect billing.³¹ Tracking claims in this way allows contractors to review a small number of the riskiest claims in depth while still paying providers quickly for the majority of their services.³²

The result of prepayment review—whether Non-Complex or Complex—is called the Initial Determination.³³ If the Initial Determination approves a claim, the provider is paid according to a price outlined by federal law and regulations.³⁴ If the Initial Determination denies a claim, the provider is not paid, but can resubmit it or challenge the denial through the System.³⁵ Though the Initial Determination forms the basis of payment, it is only the beginning of the government’s review. Following payment—often many years later—different kinds of Medicare contractors or government agencies can review claims again through post-payment audits.³⁶

27. *Id.* at § 3.2.1.1.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.* at § 3.2.1.

33. MEDICARE CLAIM REVIEW PROGRAMS, *supra* note 20.

34. *See e.g.*, MEDICARE CLAIM REVIEW PROGRAMS, *supra* note 20; *see e.g.*, MEDICARE INTEGRITY MANUAL, *supra* note 20.

35. *See infra* Section II.

36. MEDICARE INTEGRITY MANUAL, *supra* note 20, at 52. For an examination of the different kinds of Medicare contractors, *see* Don Romano & Jennifer Colagiovanni, *The Alphabet Soup of Medicare and Medicaid Contractors*, 27 HEALTH L. 6, 1 (2015). Some of the most extensive post-payment reviews are conducted by the Medical Review Program, the Comprehensive Error Rate

Post-payment review is typically Complex, involving a deep dive into the medical documentation to determine whether each claim meets Medicare requirements.³⁷ Errors generally result from insufficient medical documentation to support the intervention, medical documentation that supports a different code than was billed, or lack of medical necessity in the documentation submitted.³⁸ Like prepayment reviews, these post-payment audits usually involve a review of certain high-risk claims as opposed to the provider's entire claim history. Because audits can occur up to three years after payment, the government can target its reviews based on data from an earlier payment year.³⁹ For example, in 2012, the government could retrospectively analyze the 2010 payment data, find a suspicious uptick of the billing for a certain procedure code, and then in 2013, conduct wide-ranging audits of providers' use of that code in 2010.⁴⁰ When a post-payment auditor decides that the claim should never have been paid, the government will issue an overpayment determination, which requires the provider to repay the funds.⁴¹

Post-payment review is a vital part of protecting the Medicare trust funds.⁴² Because MACs cannot review every claim before payment, post-payment review allows the government to retrospectively identify incorrectly paid claims.⁴³ Returning these overpayments to the government helps to ensure the sustainability of the Medicare program.⁴⁴ For instance, in 2016, roughly eleven percent of Medicare claims were improper, corresponding to roughly \$41.1 billion in overpayments.⁴⁵ Without post-

Testing Program, the Recovery Audit Program, and the Office of the Inspector General. MEDICARE CLAIMS REVIEW PROGRAMS, *supra* note 18.

37. MEDICARE INTEGRITY MANUAL, *supra* note 20.
38. MEDICARE CLAIMS REVIEW PROGRAMS, *supra* note 19.
39. RECOVERY AUDITING, *supra* note 1.
40. MEDICARE CLAIMS REVIEW PROGRAMS, *supra* note 19, at 8-9.
41. MEDICARE CLAIMS REVIEW PROGRAMS, *supra* note 19.
42. Medicare is paid for by two trust funds, which are supported through taxes and premiums. See generally *How is Medicare Funded?*, MEDICARE.GOV, <https://www.medicare.gov/about-us/how-medicare-is-funded/medicare-funding.html> (last visited Oct. 2, 2016).
43. MEDICARE CLAIMS REVIEW PROGRAMS, *supra* note 19.
44. See Eleanor D. Kinney, *The Accidental Administrative Law of the Medicare Program*, 15 YALE J. HEALTH POL'Y & ETHICS 1, 130-32 (2015). Because Medicare developed into a procurement program, the government developed mechanisms to help it combat the inevitable fraud that developed. *Id.*
45. CTRS. FOR MEDICARE & MEDICAID SERVICES, MEDICARE FEE-FOR-SERVICE 2016 IMPROPER PAYMENTS REPORT, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2016ImproperPaymentsReport.pdf> (last visited Mar. 27, 2018).

payment review, that money would not have been returned to the government. Post-payment audits can also help the government identify fraud, or the intentional submission of false Medicare claims.⁴⁶ It is important to remember, however, that overpayments are separate and distinct from fraud. Fraud indicates that the provider knowingly deceived the government, whereas an overpayment is the result of the provider's genuine mistake.⁴⁷ Even though the government's ability to conduct post-payment review is vital, in recent years, the nature of post-payment audits has shifted in two fundamental ways that raise questions about the integrity of post-payment audits.

First, post-payment auditors have increasingly chosen to use extrapolation in their reviews. Extrapolation allows auditors to review a small sample of claims and then apply the findings to the provider's entire set of claims for that particular fiscal year ("FY").⁴⁸ For example, assume that a provider submitted—and received payment for—one thousand inpatient hospital claims.⁴⁹ Assume further that the government decided to audit these claims. If a post-payment auditor reviewed only twenty of them, concluding that five of the twenty should not have been paid,⁵⁰ then the provider must repay the government twenty-five percent of the payments it received for all one thousand inpatient claims. In other words, the reviewer will deem 250 claims as overpaid even though it only found five claims deficient.

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46. The False Claims Act, for instance, requires the government to prove that a provider knowingly submitted a false claim for payment. A person acts knowingly under the Act if s/he "(i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b) (2010).
47. *Medicare Overpayments*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 2015), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/overpaymentbrochure508-09.pdf> [hereinafter *MEDICARE OVERPAYMENTS*].
48. See *Chaves County Home Health Servs. v. Sullivan*, 931 F.2d 914 (D.C. Cir. 1991); *OIG Extrapolation in Medicare Compliance Review Triples Hospital's Overpayment*, 22 REP. ON MEDICARE COMPLIANCE 20 (June 3, 2013).
49. This example was chosen intentionally. RACs have focused a great deal of attention on inpatient claims. Hospitals are paid more for inpatient claims than observation claims. If a RAC concludes that a hospital should have observed a patient rather than admitted the patient, then the whole claim is deemed an overpayment, even though the hospital would have been eligible for a portion of that payment had it initially billed the government for observation. This surprising result has been challenged unsuccessfully in federal court. *Bagnall v. Sebelius*, No. 3:11CV1703, 2013 WL 5346659 (D. Conn. Sept. 23, 2013).
50. For instance, the review could determine that the patients should not have been admitted, but rather kept in observation, which the government reimburses at a lower rate to the hospital. See discussion in *supra* notes 52.

This tactic allows the government to commit fewer resources to its audits while at the same time recouping more money.⁵¹ Providers, however, can face enormous financial consequence as a result of these extrapolated audits.⁵² Providers have sued on this issue, claiming that the government should not use extrapolation, or at the very least, should be required to use the most accurate statistical modeling.⁵³ Courts have not been persuaded. Instead, courts have deferred to the agency to dictate the procedures of their audits.⁵⁴ The use of extrapolation itself is less concerning than the fact that the agency is not held accountable to the statistical methods it utilizes, even if it adopts second-tier methods with big financial impact.⁵⁵

Second, Congress created the Recovery Audit Program (“RAP”), implemented in 2010, which generated a new type of post-payment audit and increased the number of post-payment reviews.⁵⁶ The RAP designated Recovery Audit Contractors (“RACs”) to conduct RAP audits.⁵⁷ By statute, RACs are paid on a contingency fee—i.e., they collect a portion of the

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51. DEP’T OF HEALTH AND HUMAN SERVICES & DEP’T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT FOR FISCAL YEAR 2016, (Jan. 2017), <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>
 52. See e.g., *Am. Health Ass’n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016) (“This problem takes a particular toll on hospitals with a large share of patients who rely on Medicare”); Press Release, Am. Orthotic Prosthetic Ass’n, Study: Medicare Audit “Mess” Surging At Rate Of 15,000 New Appeals Per Week, Agency Could Avoid Rapidly Mounting Interest Payments, (Mar. 19, 2015), [http://www.aopanet.org/2015/03/study-medicare-audit-mess-surging-at-rate-of-15000-new-appeals-per-week-agency-could-avoid-rapidly-mounting-interest-payments/\[hereinafter Press Release\]](http://www.aopanet.org/2015/03/study-medicare-audit-mess-surging-at-rate-of-15000-new-appeals-per-week-agency-could-avoid-rapidly-mounting-interest-payments/[hereinafter Press Release]).
 53. MEDICARE INTEGRITY MANUAL, *supra* note 20.
 54. 42 U.S.C. § 1395ddd(f)(3) (2010) (authorizes Medicare contractors to use extrapolation to determine overpayment amounts when the Secretary determines that, “there is a sustained or high level of payment error or documented educational intervention has failed to correct the payment error.” Once this threshold finding is made, the provider has no means of challenging it.) *Gentiva Healthcare v. Sebelius*, 723 F.3d 292, 297 (D.C. Cir. 2013).
 55. Plaintiffs have been unsuccessful at challenging the validity of the sampling and extrapolation method—courts have held that CMS or its contractor need not undertake the most precise sampling methodology so long as the method used is statistically valid. In the case of *Michael King*, No. M.-10-321, 2011 WL 6960267, at *10 (May 10, 2011); *Martin v. Life Care Centers of America, Inc.*, 114 F.Supp.3d 549, 572 (E.D. TN 2014); *Pruchniewski v. Leavitt*, No. 8:04-CV-2200-T-23TBM, 2006 WL 2331071, at *15 (M.D. Fla. Aug. 10, 2006).
 56. *Facts About The Medicare Audit Improvement Act of 2013*, AM. HOSP. ASS’N, 2 (2014), <http://www.aha.org/content/13/fs-hr1250rac.pdf> [hereinafter AM. HOSPITAL ASS’N].
 57. Kinney, *supra* note 47, at 130-32.

overpayments they identify.⁵⁸ CMS currently pays RACs between nine and twelve and a half percent of the overpayments they identify, based on a competitive bidding process.⁵⁹ However, for certain kinds of audits, CMS has increased that percentage to seventeen and a half percent.⁶⁰

This incentive structure has caused providers alarm, and many see RACs as “bounty hunters” looking for overpayments at the expense of physicians and hospitals.⁶¹ Members of Congress have similarly expressed discomfort with the financial incentives imbedded within the RAP. In a letter to the Secretary of HHS, these Congressmen stated: “due to this payment structure, RACs are incentivized to deny claims, even when the claims are correct.”⁶² Moreover, the time and expense providers must incur in hosting auditors and gathering medical documentation further antagonizes the relationship between RACs and providers.⁶³ Expenses associated with RAC audits and appeals can exceed \$100,000 per audit for many hospitals.⁶⁴

Nevertheless, the RAP has been very successful for CMS: in 2014, RACs identified \$2.39 billion in overpayments.⁶⁵ But RAC audits also dramatically increased the number of “overpaid” claims that are later overturned through the Medicare Appeals System.⁶⁶ According to the American Hospital Association (“AHA”), RACs deem nearly half of the claims they review to be invalid overpayments. Of the RAC determinations that are

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58. *Id.* (“RACs are paid by CMS on a ‘contingency fee’ basis, which means they are paid a commission on each claim that they deny. RACs are currently reimbursed 9-12.5 percent of the Medicare payments they deny.”); *Hospital Survey Report: The Real Cost of the Inefficient Medicare RAC Program*, AM. HOSP. ASS’N., 2 (2015), <http://www.aha.org/content/15/hospsurveyreport.pdf> [hereinafter *Hospital Survey Report*].
 59. Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69,037, 69,044 (Nov. 10, 2010).
 60. Medicaid Program; Announcement of Medicaid Recovery Audit Contractors (RACs) Contingency Fee Update, 77 Fed. Reg. 11,127, 11,127 (Feb. 24, 2012).
 61. AM. HOSPITAL ASS’N, *supra* note 57 (“Hospitals Need a Level Playing Field with RAC Bounty Hunters”); AM. MED. ASS’N, AMERICAN MEDICAL ASSOCIATION FACT SHEET MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM APPEALS, https://resourcesforrisk.com/_default/download/download_free_doc.php?file=Recovery+Audit+Contractors+Fact+Sheet.pdf (last visited Mar. 26, 2018) (“The AMA remains deeply opposed to utilization of contingencies for RACs since it is a bounty hunter-like program that creates a financial incentive for RACs to identify overpayments.”).
 62. Letter from Members of Congress, to Kathleen Sebelius, Secretary of Department of Health and Human Services (Feb. 10, 2014) *available at*: <http://www.aha.org/content/14/140210-let-congress-hhs.pdf>.
 63. *Hospital Survey Report*, *supra* note 58, at 3-4.
 64. AM. HOSP. ASS’N, *supra* note 57.
 65. RECOVERY AUDITING, *supra* note 1, at 13.
 66. AM. HOSP. ASS’N, *supra* note 57.

appealed, some estimate that more than seventy percent are overturned on appeal.⁶⁷ Because of the high reversal percentage and the contingency fees paid to contractors, only \$1.6 billion of the \$2.39 billion in RAC-identified overpayments were returned to the Medicare trust fund in 2014.⁶⁸ Fortunately, when a RAC's overpayment determination is overturned, RACs must repay the contingency fee.⁶⁹

The nature of Complex post-payment review makes bias particularly problematic. One of the most subjective conditions of payment that contractors review is medical necessity.⁷⁰ Medical necessity review involves a complex, fact-based assessment, where Medicare contractors—looking for flaws—can scrutinize medical documentation with the benefit of hindsight to identify services they deem medically unnecessary.⁷¹ The reviewer can second-guess the medical judgment of the doctor even if she is not a physician herself or in the same specialty as the original physician.⁷² Other requirements are equally frustrating for providers. For instance, providers may need to wait a certain number of months from the patient's initial complaint before ordering certain interventions, see a patient face-to-face, or record specific facts about the patient in the medical chart to justify ordering a test or procedure.⁷³ The list is extensive and many of these regulations are technical and constantly changing.⁷⁴

In *Caring Hearts Personal Home Services v. Burwell*, the Tenth Circuit questioned the complexity and number of CMS regulations.⁷⁵ The court wondered whether Medicare laws have become so byzantine that the agency has lost control of them.⁷⁶ In this case, the plaintiff challenged a Medicare appeals determination within the Medicare Appeals System.⁷⁷ The

67. *Id.* at 5; Lisa A. Eramo, *RAC Appeals: Should You Bother?*, 25 FOR THE RECORD 10, 14, (July 2013), <http://www.fortherecordmag.com/archives/0713p14.shtml>.

68. RECOVERY AUDITING, *supra* note 1.

69. Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69,037, 69,039 (Nov. 10, 2010).

70. MEDICARE INTEGRITY MANUAL, *supra* note 20, at 27-28.

71. *Id.* at 65.

72. AM. AM. HOSPITAL ASS'N, *supra* note 57 ("Despite protests by the AMA that RAC audits involving complex medical reviews be performed by a physician of the same specialty and the same of the physician under review" RACs will use "nurses, therapists, and certified coders to review claims.").

73. MEDICARE INTEGRITY MANUAL, *supra* note 20, at 34.

74. See CMS, ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING FY 2018, <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf> (last visited March 24, 2018).

75. *Caring Hearts Pers. Home Servs. v. Burwell*, 824 F.3d 968, 976-77 (10th Cir. 2016).

76. *Id.*

77. See *id.*

provider argued that regulations it allegedly failed to meet were not in effect when the claims at issue were submitted; instead, it claimed, the reviewer erroneously applied regulations implemented in 2013 to 2010 claims.⁷⁸ The court agreed and chastised the agency and the four arbiters in the System for failing to keep track of the rules it promulgated:

This case has taken us to a strange world where the government itself—the very “expert” agency responsible for promulgating the “law” no less—seems unable to keep pace with its own frenetic lawmaking. A world Madison worried about long ago, a world in which the laws are “so voluminous they cannot be read” and constitutional norms of due process, fair notice, and even the separation of powers seem very much at stake. But whatever else one might say about our visit to this place, one thing seems to us certain: an agency decision that loses track of its own controlling regulations and applies the wrong rules in order to penalize private citizens can never stand.⁷⁹

This case highlights the expanding regulatory burden that Medicare providers face. Providers must keep track of the government’s voluminous and expanding regulations to defend their right to compensation for the services they provide. The government can review their claims retrospectively using post-payment auditors that have known conflicts of interest. And with extrapolation, a mistake on one claim can cost providers millions of dollars, even if the physician provided the services in good faith. These flaws do not call for an elimination of post-payment audits, but underscore the paramount need for fair appeals with sufficient procedural protections to mitigate any risk of abuse. As explored below, it is not clear that providers are sufficiently protected by the System as it functions today.

II. The Medicare Appeals System

A. *Statutory Framework for Medicare Appeals*

The process for appealing a Medicare overpayment determination involves four steps: Redetermination, Reconsideration, ALJ hearing, and Department of Appeals Board (“DAB”) Review.⁸⁰ MACs and Qualified Independent Contractors (“QICs”), which are both Medicare contractors paid by CMS, render the first two levels of review (Redetermination and

78. *Id.* at 970

79. *Id.*

80. 42 U.S.C. § 1395ff (2010); *see* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE PARTS A & B. APPEALS PROCESS, 3, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLN-Products/downloads/MedicareAppealsprocess.pdf> (last updated June 2017) [hereinafter MEDICARE APPEALS SYSTEM].

Reconsideration respectively).⁸¹ By contrast, the Office of Medicare Hearings and Appeals (“OMHA”), which employs the ALJs and DAB members, is located outside CMS and is therefore more independent from the agency.⁸² These four steps of appeal constitute the Medicare Appeals System, and only after a provider proceeds through them can they challenge the overpayment determination in federal court.⁸³

CMS’s recoupment authority is tied to the System. After CMS conducts a post-payment review and renders an overpayment determination, the government issues a demand letter.⁸⁴ The letter gives the provider thirty days upon receipt to lodge an appeal against some, or all, of the post-payment review results.⁸⁵ Post-payment audit results that are not challenged within thirty days are subject to immediate recoupment.⁸⁶ If a provider challenges the audit, however, the appeal enters the System, and the government cannot recoup those payments until after Reconsideration and Redetermination.⁸⁷ CMS may, however, recoup overpayments before the ALJ determination, even if the Reconsideration decision is being appealed to the ALJ.⁸⁸ Recoupment allows the government to either demand repayment or to withhold future payments from providers to compensate the debt.⁸⁹

The statute creating the System requires completion of each step in the appeals process within a certain timeframe. Redetermination and Reconsideration must be completed within sixty days of the provider’s request for the corresponding level of appeal.⁹⁰ An ALJ must render a determination within ninety days of the provider’s initial request for review.⁹¹ Within this timeframe, the ALJ must conduct and conclude its

81. MEDICARE APPEALS SYSTEM, *supra* note 80, at 6-7; MEDICARE INTEGRITY MANUAL, *supra* note 20, at 4.

82. OMHA is housed under HHS, but not under CMS. HHS PRIMER, *supra* note 3.

83. Statutes prohibit parties from challenging an appeal in court before completing all four steps in the administrative appeals process. 42 U.S.C. § 405(h) (2010).

84. MEDICARE OVERPAYMENTS, *supra* note 47.

85. *Id.*

86. CTRS. FOR MEDICARE & MEDICAID SERVS., LIMITATION ON RECOUPMENT (935) FOR PROVIDER, PHYSICIANS AND SUPPLIERS OVERPAYMENTS (Sept. 29, 2008), <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6183.pdf> [hereinafter LIMITATION ON RECOUPMENT].

87. *Id.*; MEDICARE OVERPAYMENTS, *supra* note 47.

88. *Id.*

89. MEDICARE OVERPAYMENTS, *supra* note 47.

90. 42 U.S.C. § 1395ff(a)(3)(C) (2010); 42 U.S.C. § 1395ff(c)(3)(C) (2010); *see* MEDICARE APPEALS SYSTEM, *supra* note 84.

91. 42 U.S.C. § 1395ff(d)(1)(A) (2010).

hearing and render a decision.⁹² The fourth step—DAB review—must also be completed within ninety days of the provider’s request for it.⁹³ As explored below, these timelines have become meaningless and the System no longer functions as it was designed.

	Name	Arbiter	Deadline
Post-Payment Review Finds an Overpayment, and the Provider Wants to Appeal			
Step One	Redetermination	MAC (under CMS)	60 days
Step Two	Reconsideration	QIC (under CMS)	60 days
CMS May Begin Recoupment within 30 Days of the Reconsideration Decision			
Step Three	Determination by ALJ	ALJ (under OMHA)	90 days
Step Four	Determination by DAB	DAB (under OMHA)	90 days
Provider May Challenge the Overpayment in Federal Court			

B. The System in Practice: Then and Now

Until 2010, the System largely functioned according to the statutory deadlines.⁹⁴ Prior to 2010, processing the ALJ hearing and determination took an average of ninety-five days.⁹⁵ When providers receive timely decisions, the financial burden associated with erroneous recoupment is less significant because the government reimburses the provider quickly—i.e., the provider is not deprived access to its funds for long.⁹⁶ Further, when

92. *Id.*

93. 42 U.S.C. § 1395ff(d)(2)(A) (2010).

94. U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-16-366, MEDICARE FEE-FOR-SERVICE: OPPORTUNITIES REMAIN TO IMPROVE APPEALS PROCESS 69 (2016), <http://www.gao.gov/assets/680/677034.pdf> [hereinafter GOV’T ACCOUNTABILITY OFFICE]; Adjudication Timeframes, Dep’t Health & Human Services., Office of Medicare Hearings & Appeals (last updated Apr. 29, 2015), http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html [hereinafter Adjudication Timeframes].

95. See Adjudication Timeframes, *supra* note 94.

96. When the hearing and determination occurs as the statute requires, then an erroneous denial would deny providers funds for a maximum of five months: providers have 60 days to lodge their appeal and ALJs have 90 days to render a decision. 42 U.S.C. § 1395ff(d)(1)(A) (2010). In practice, this is much shorter given

the System functions according to the statutory timeline, it properly balances the government’s interest in collecting valid overpayments against providers’ harm in having their payments erroneously recouped.

When CMS implemented the RAP in 2010, it caused a dramatic increase in appeals entering the System, clogging it up. There are two reasons that the RAP caused an influx of appeals: first, there were simply more post-payment audits for providers to challenge, and second, providers were more likely to challenge RAC findings because they were suspicious of RACs’ financial incentives.⁹⁷ When Congress created the RAP, it did not expand OMHA’s budget to accommodate the predictable increase in appeals,⁹⁸ and as a result, providers blame this program for the System’s ballooning delays.⁹⁹ CMS concedes that this program has significantly contributed to the increase in appeals, but also points to other factors that have played a role—such as the aging of the baby boomers, which increased the number of Medicare beneficiaries (and therefore the number of claims CMS needs to review, which can be appealed).¹⁰⁰

Providers are particularly troubled by the delays associated with step three of the System, where they receive an ALJ hearing. Between 2009 and 2014, “the number of requests for an ALJ hearing or review increased 1,222%,”¹⁰¹ but the budget for OMHA, the office responsible for Medicare’s ALJ appeals, increased by only sixteen percent from 2010 to 2014.¹⁰² By the end of 2015, OMHA received “more than a year’s worth of appeals every eighteen weeks.”¹⁰³ Assuming it received no new appeals, it would take OMHA eleven years to work through the backlog of appeals.¹⁰⁴ And the “backlog shows no signs of abating as the number of incoming appeals continues to surpass the adjudication capacity at Levels 3 and 4.”¹⁰⁵ As of

that recoupment often does not start immediately, *see* 42 U.S.C. §1395fff(a)(3)(C)(ii) and § 1395ff(d)(1)(A) (2010).

97. AM. HOSP. ASS’N, *supra* note 57, at 2; *see* GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 15.

98. *See* GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 15.

99. Christopher Cheney, *RAC Reforms Leave Providers Skeptical*, MEDPAGE TODAY (Jan. 19, 2015), <https://www.medpagetoday.com/publichealthpolicy/medicare/49612>.

100. HHS PRIMER, *supra* note 3.

101. Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, 81 Fed. Reg. 43,790, 43,792 (July 5, 2016) (to be codified at 42 C.F.R. §§ 401, 405, 422).

102. GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 20.

103. HHS PRIMER, *supra* note 3, at 7.

104. *Id.* at 3.

105. *Id.* at 41, at 7; OFFICE OF MEDICARE HEARINGS & APPEALS, JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEE – FISCAL YEAR 2016 6 (2015).

September 1, 2017, nearly 600,000 appeals are pending at OMHA¹⁰⁶ and OMHA only has capacity to hear 77,000 appeals per year.¹⁰⁷ By 2021, the government expects that there will be nearly one million pending appeals before OMHA, even taking into account all of the agency's efforts to reduce the backlog.¹⁰⁸ OMHA currently resolves appeals within an average of three years¹⁰⁹—already eleven times longer than permitted—but “some already-filed claims could take a decade or more to resolve.”¹¹⁰

Despite this enormous wait to receive an ALJ hearing, providers find ALJ review to be the most important of the System's four steps. According to the Government Accountability Office, providers succeed at overturning challenged denials more than half of the time.¹¹¹ In 2014, for instance, ALJs fully reversed overpayment determinations in fifty-four percent of appeals.¹¹² In previous years, ALJ reversal rates were over sixty percent.¹¹³ And certain providers are historically even more successful before ALJ.¹¹⁴ Two factors, explored in more depth below, explain the high reversal rate: ALJ review is the first time providers (1) receive an evidentiary hearing and (2) are heard before truly neutral arbiter.

Even though an ALJ is more likely than not to find that an alleged overpayment was valid, CMS still recoups and withholds those payments from providers while they wait years for an ALJ hearing.¹¹⁵ Though the government must repay the erroneously recouped payment if the provider

106. Def. Status Report at 2, *Am. Hosp. Ass'n v. Price*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 5, 2017), ECF No. 58.

107. Medicare Program Changes, 81 Fed. Reg. at 43, 792.

108. Def. Status Report at 2, *Am. Hosp. Ass'n v. Price*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 5, 2017), ECF No. 58.

109. *Workload Information and Statistics—Average Processing Time by Fiscal Year*, DEP'T OF HEALTH & HUMAN SERVS. (May 24, 2017), www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html; see also *Am. Hosp. Ass'n v. Price*, 867 F.3d at 171 (D.C. Cir. 2017) (Henderson, J. dissenting).

110. *Am. Hosp. Ass'n*, 867 F.3d at 163; see also *Am. Health Ass'n v. Burwell*, 812 F.3d 183, 187 (D.C. Cir. 2016) (“These figures suggest that at current rates, some already-filed claims could take a decade or more to resolve.”); see also *MEDICARE OVERPAYMENTS*, *supra* note 47.

111. GOV'T ACCOUNTABILITY OFFICE, *supra* note 94, at 20.

112. *Id.*

113. *Id.* at 69.

114. See, e.g., *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 188 (D.C. Cir. 2016) (“[T]he American Hospital Association[] reported that they had appealed 52% of RAC denials, and that 66% of these appeals were successful.”).

115. Press Release, *supra* note 52.

prevails, this is of little benefit to providers whose businesses cannot survive the years-long wait.¹¹⁶

Small healthcare providers, which have less liquidity and tolerance for missing revenue, have been the most notable victims of this process.¹¹⁷ The American Orthotic Prosthetic Association has stated that “small health care providers like orthotic and prosthetic firms have been ‘unable to deal with being bombarded by the uncertainty resulting from long-delayed [RAC] appeals for disputed Medicare payments.’”¹¹⁸ The Association highlighted that the pressure from the appeals backlog have forced over one hundred small health care businesses “to close their doors” and that “many more are in danger of being shuttered.”¹¹⁹ Larger providers, like hospital chains, can weather these delays and do not face the same threat.¹²⁰ But regardless of their size, all providers argue that the System’s delays harm patients because their money is tied up in appeals when it could be used for patient care.¹²¹

The statute offers providers one recourse for the delays: escalation. Escalation allows providers to proceed to the next stage of the appeal when the agency exceeded its deadline in the previous stage.¹²² So if it takes longer than ninety days to receive an ALJ hearing, providers are statutorily entitled to skip the ALJ hearing and move to DAB review.¹²³ This remedy, however, requires a big sacrifice. First, the DAB is only required to provide an evidentiary hearing if an “extraordinary question” is at issue; therefore, escalating beyond an ALJ requires most providers to forfeit their only

116. Press Release, *supra* note 52.

117. Press Release, *supra* note 52; Jessica L. Gustafson and Abby Pendleton, *Medicare Appeals Adjudication Delays: Implications For Healthcare Providers And Suppliers*, 26 No. 5 HEALTH L. 26, 28 (2014) [hereinafter Gustafson and Pendleton] (“Of particular importance, the delay in appeals adjudication results in significant cash flow issues for appellants. These cash flow interruptions can be particularly troublesome for smaller providers and suppliers faced with significant overpayment demands resulting from post-payment audits.”).

118. Press Release, *supra* note 52.

119. *Id.*

120. See Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 5104.

121. See *e.g.*, Memorandum Opinion, *Am. Hosp. Ass’n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38 (“Because of the consequent financial burden, some providers are ‘forced . . . to reduce costs, eliminate jobs, forgo services, and substantially scale back,’ all of which affects the quality and quantity of patient care.”); *D&G Holdings, LLC v. Burwell*, 156 F.Supp. 3d 798, 815 (W.D. La. Jan. 12, 2016); see *Hospice Savannah v. Burwell*, No. 4:15-cv-0253, 2015 WL 8488432 (S.D. Ga. Sept. 21, 2015).

122. *Medicare and Medicaid Fraud, Reimbursement & Exclusion*, SHARP & COBOS <http://sharpcobos.com/expertise/medicare-and-medicaid-reimbursement/> (last visited Mar. 23, 2018).

123. 42 U.S.C. § 1395ff(c)(3)(C)(ii) (2010); Adjudication Timeframes, *supra* note 94.

opportunity for an evidentiary hearing by a neutral arbiter.¹²⁴ Second, the fourth level of appeal, DAB review, is equally backlogged and thus escalation from the ALJ only lands providers into another long queue.¹²⁵ Finally, escalating beyond both the ALJ and the DAB—straight into federal court—creates a different problem. Federal courts will generally give deference to the last agency determination on the record, which invariably found for the government.¹²⁶ As a result, escalation as a remedy would deprive most providers their best chance to overturn the government’s overpayment determination.¹²⁷

The Medicare Appeals System no longer functions as it was designed. It cannot accommodate the number of appeals entering it, and providers are paying the consequences for the government’s bureaucratic failure. Delays deprive providers of access to their money while they wait for an ALJ hearing—a hearing that is more likely than not to prove that the money was wrongfully deprived. In the meantime, small providers in particular suffer serious financial consequences, facing insolvency as their money is temporarily deprived. And any administrative remedy available to them comes with serious sacrifice. But these harms extend beyond small providers. As explored in the next section, the financial implications of the System’s delays are passed onto consumers in various ways.

III. Impact of the System’s Delays on Consumers and the Broader Healthcare System

This Article has focused thus far on the consequences providers face due to the System’s delays. But the consequences exceed far beyond the providers’ experiences. These delays perpetuate systemic problems in the healthcare market, which in turn affect the healthcare that patients receive. In this section, I argue that the System’s delays cause four foreseeable effects: (1) the delays contribute to a consolidation of the healthcare market as small healthcare providers face insolvency and pressure to sell their practices to larger providers; (2) the regulatory burdens perpetuate providers’ frustration with Medicare, which could cause more providers to opt out of Medicare; (3) the lack of access to funds causes providers to cut patient services to accommodate short-term resource constraints; and (4) the increased scrutiny resulting from post-payment review may influence providers to make conservative treatment decisions.

124. *Am. Hosp. Ass’n v. Burwell*, 812 F.3d 183, 186 (D.C. Cir. 2016).

125. *Id.* at 186.

126. *Id.* at 191.

127. *Id.*

First, small healthcare providers are disproportionately impacted by the financial hardships the System's delays cause.¹²⁸ Large providers, like hospital chains, can spread risk across numerous institutions—if a company owns one hundred hospitals with a \$100 million combined operating budget, its operations will not be heavily affected if one hospital's post-payment review ties up \$5 million in the System.¹²⁹ It simply has enough liquidity to endure the delay in getting a portion of that money back after the ALJ determination. Small providers, on the other hand, can face bankruptcy because of one or two bad audits.¹³⁰ If an orthotic manufacturer with a \$2 million operating budget is audited, and \$400,000 of its revenue gets tied up in appeals, then it will struggle to continue business as usual as it waits.¹³¹ This threat increases pressure on small providers to consolidate with larger chains to compete in the market.¹³² And if the small businesses fold entirely, competition in the healthcare market also decreases. Furthermore, if small providers are forced to close their businesses in rural or underserved areas, then large providers may not fill in those gaps, causing those locations to become healthcare deserts.

Recent consolidation of the healthcare market is a well-documented problem.¹³³ Hospital chains are buying up smaller hospitals, insurance

128. Press Release, *supra* note 52; Gustafson and Pendleton, *supra* note 117 (“Of particular importance, the delay in appeals adjudication results in significant cash flow issues for appellants . . . These cash flow interruptions can be particularly troublesome for smaller providers and suppliers faced with significant overpayment demands resulting from post-payment audits.”).

129. See *e.g.*, NICOLE V. CRAIN & W. MARK CRAIN, THE IMPACT OF REGULATORY COSTS OF SMALL FIRMS 8 (2010), available at: [https://www.sba.gov/sites/default/files/The%20Impact%20of%20Regulatory%20Costs%20on%20Small%20Firms%20\(Full\).pdf](https://www.sba.gov/sites/default/files/The%20Impact%20of%20Regulatory%20Costs%20on%20Small%20Firms%20(Full).pdf) (“Considering all federal regulations . . . [compliance c]osts per employee thus appear to be at least 36 percent higher in small firms than in medium-sized and large firms This is the familiar empirical phenomenon known as economies of scale, and its impact is to provide a comparative cost advantage to large firms over small firms.”).

130. See *D&G Holdings*, 156 F. Supp. 3d at 815; see *Hospice Savannah v. Burwell*, No. 4:15-cv-0253, 2015 WL 8488432 (S.D. Ga. Sept. 21, 2015); CTR FOR MEDICARE & MEDICAID SERVICES, PROGRAM HISTORY AND AUTHORITIES, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Program-History-and-Authorities.html> (last updated May 12, 2017).

131. Jessica L. Gustafson & Abby Pendleton, *supra* note 117.

132. See Statement, Paul B. Ginsburg, Professor and Director of Public Safety, University of Southern California, Health Care Market Consolidations: Impacts on Costs, Quality and Access (March 16, 2016), <https://www.brookings.edu/wp-content/uploads/2016/07/Ginsburg-California-Senate-Health-Mar-16-1.pdf>.

133. See Abbe R. Gluck, *Symposium: The New Health Care Industry—Consolidation, Integration, Competition In The Wake Of The ACA*, HEALTH AFFAIRS BLOG (Feb. 24, 2016), <http://healthaffairs.org/blog/2016/02/24/symposium-the-new-health-care-industry-consolidation-integration-competition-in-the-wake-of-the-aca/>;

companies are merging, and service providers are joining forces.¹³⁴ As of 2012, two dialysis companies owned over seventy percent of the national market.¹³⁵ This consolidation negatively impacts consumers because competition disappears, driving up prices, while innovation and patient choice falls.¹³⁶ National healthcare costs are rising, in part, because of this market contraction:

Rising health care costs are a matter of national alarm, and increasing attention has been paid to the growing market power accumulated by health care providers . . . Moreover, much of the recent rise in health care costs is directly attributable to increases in supply-side market power that are products of hospital consolidations and the growth of provider collaborations.¹³⁷

Even more concerning is the fact that large healthcare providers have signaled their intention to use the savings from the 2017 tax reform law to consolidate the market further.¹³⁸

The healthcare market has constricted in recent years for a variety of reasons unrelated to the System.¹³⁹ But the System's delays add another source of pressure to consolidate. If a small provider faces insolvency as it waits for an ALJ determination, an easy solution is to sell its business to a larger provider who may be looking to increase its market share in a particular region or over a new product.¹⁴⁰ In this way, small providers fall

Paul Ginsburg, Health care market consolidations: Impacts on costs, quality and access, BROOKINGS INSTT. (March 16, 2016), <https://www.brookings.edu/testimonies/health-care-market-consolidations-impacts-on-costs-quality-and-access/>.

134. *Id.*

135. *Two Thriving Dialysis Companies*, N.Y. TIMES (Aug. 28, 2013), http://www.nytimes.com/interactive/2013/08/29/us/two-thriving-dialysis-companies.html?_r=1&.

136. See Ginsburg, *supra* note 134.

137. Barak D. Richman, *Antitrust And Nonprofit Hospital Mergers: A Return To Basics*, 156 U. PA. L. REV. 121, 125 (2007).

138. See Caroline Humer and Carl O'Donnell, *U.S. Pharma Executives Expect Deals to Pick Up After Tax Overhaul*, REUTERS (Jan. 9, 2018), https://www.reuters.com/article/us-healthcare-conference-deals/u-s-pharma-executives-expect-deals-to-pick-up-after-tax-overhaul-idUSKBN1EY28E?wpsrc=nl_health202&wpmm=1; Bob Herman, *Health Care Companies Are Thrilled About The Tax Overhaul*, AXIOS (Jan. 9, 2018), https://www.axios.com/health-care-companies-are-thrilled-about-the-tax-ov-1515474626-1dfb8877-d64d-4d3e-a90b-3ac8782a62f0.html?wpsrc=nl_health202&wpmm=1.

139. Gluck, *supra* note 133; see Ginsburg, *supra* note 134.

140. See BakerHostetler, *Healthcare Providers Face Increasing Financial Pressure and Bankruptcy Risk*, JDSUPRA.COM (June 13, 2014),

victims to a regulatory system that favors larger businesses that can withstand near-term financial loss. This is not the only instance where the government has been accused of incentivizing consolidation to consumers' detriment.¹⁴¹

Second, the System's delays may also increase the tendency for small providers to opt out of Medicare.¹⁴² Many providers view the backlog as another instance of regulatory burden and providers have started to opt out of Medicare at higher rates.¹⁴³ Though the government need not disclose the percentage of doctors that refuse to cover Medicare patients,¹⁴⁴ some data exists for earlier years. From 2009-2012, the number of physicians that opted out of Medicare more than doubled.¹⁴⁵ Twenty-eight percent of family doctors have stopped accepting new Medicare patients.¹⁴⁶ Providers reported that Medicare's lower reimbursement rate and administrative burdens largely created this phenomenon.¹⁴⁷

<https://www.jdsupra.com/legalnews/healthcare-providers-face-increasing-fin-70502/>.

141. The Affordable Care Act incentivized providers to form Accountable Care Organizations ("ACOs")— despite their many benefits, ACOs have been criticized for creating pressure to consolidate. Jenny Gold, *Accountable Care Organizations, Explained*, KAISER HEALTH NEWS (Sept. 14, 2015), <http://khn.org/news/aco-accountable-care-organization-faq/> ("Many health care economists fear that the race to form ACOs could have a significant downside: hospital mergers and provider consolidation."); Christopher Pope, *How the Affordable Care Act Fuels Health Care Market Consolidation*, HERITAGE FOUND. (Aug. 1, 2014), <https://www.heritage.org/health-care-reform/report/how-the-affordable-care-act-fuels-health-care-market-consolidation>. *But see* Hannah T. Neprash, Michael E. Chernew, & J. Michael McWilliams, *Little Evidence Exists To Support The Expectation That Providers Would Consolidate To Enter New Payment Models*, 36 HEALTH AFFAIRS 346 (2017).
142. See Virgil Dickson, *Fewer Doctors are Opting Out of Medicare*, MODERNHEALTHCARE.COM (Jan. 30, 2018), <http://www.modernhealthcare.com/article/20180130/NEWS/180139995>
143. *Id.*
144. Andrew Flowers, *We May Finally Learn How Many Doctors are Opting Out of Medicare*, FIVETHIRTYEIGHT, (March 26, 2015), <http://fivethirtyeight.com/datalab/data-transparency-gets-a-win-in-houses-medicare-bill/>.
145. *See id.*
146. *Primary Care Physicians Accepting Medicare: A Snapshot*, KAISER FAMILY FOUND. (2015), <http://files.kff.org/attachment/data-note-primary-care-physicians-accepting-medicare-a-snapshot>. [hereinafter A Snap-shot]; Melinda Beck, *supra* note 15.
147. See Alan Tice, *Access to Care: The Physician's Perspective*, 70 HAWAII MED J. 2011, 33–38. ("One respondent indicated in the survey that they were 'not planning to accept any more new Medicare patients due to numerous problems with reimbursement . . . it actually costs me to see Medicare patients when extra administrative costs are factored in.'").

It is typically the small—and in-demand—physician practice groups that can disengage from the Medicare program; if a provider is popular enough to operate at full capacity without any Medicare patients, it might choose to avoid the hassle.¹⁴⁸ The larger the provider, the more dependent they are on Medicare patients to generate patient base, and certain providers, like hospitals, could never opt out of Medicare.¹⁴⁹ The Medicaid program has faced this problem to a much greater degree for decades. The result: many Medicaid patients struggle to find doctors that will treat them.¹⁵⁰ Not only does this raise questions about accessibility, but also equality of care. When the most in-demand physicians refuse Medicare patients, older populations may struggle to access the best healthcare.¹⁵¹

Third, the System delays cause providers to cut services, fire employees, and delay projects while waiting for the ALJ to return portions of the collected overpayment.¹⁵² The short-term deprivation of needed funds impacts even those providers that can better manage the financial hardship associated with the backlogs.¹⁵³ Providers of all kinds are forced to make sacrifices—often at the expense of patients and employees—to offset the setback.¹⁵⁴ For example, Baxter Regional Medical Center claimed that it had so much money tied up in the appeals process in 2012 that it could not “afford to replace a failing roof over its surgery department, purchase new beds for its Intensive Care Unit, engage in other basic upkeep,

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148. See A Snapshot, *supra* note 146 (“About two-thirds (67 percent) of primary care physicians age 55 or older say they accept new Medicare patients compared with about three-quarters (76 percent) of primary care physicians under age 55 (Figure 3). Younger doctors may be more likely to be building their patient caseloads and, therefore, may be more willing to take new patients.”).
149. For instance, federal law requires hospitals to treat all individuals in need of urgent care, and as a result, it wouldn’t make any sense for hospitals to not accept the insurance of a patient they are required to treat. *Emergency Medical Treatment & Labor Act (EMTALA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/> (last visited April 1, 2018).
150. Sara Rosenbaum, *Medicaid Payments and Access to Care*, 371 N. ENG. J. MED. 2345 (2014); Brigid Goody, *Medicare Dependent Hospitals: Who Depends on Whom?*, 14 HEALTH CARE FINAC. REV. 97, *4 (1992).
151. See Jeffrey P. Harrison & Rachel M. Barksdale, *The Impact of RAC Audits on US Hospitals*, 39 J. HEALTH CARE FINANCE 1, 8 (2013); See AM. HOSPITAL ASS’N FACTS, *supra* note 57.
152. See Statement from Rick Pollack, Exec. Vice President, Am. Hosp. Ass’n, Statement on Medicare Audit Improvement Act of 2013 (Mar. 19, 2013), <https://www.aha.org/system/files/presscenter/pressrel/2013/130319-pr-rac.pdf>.
153. RECOVERY AUDITING, *supra* note 1, at v-vi.
154. Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69,037, 69,039 (Nov. 10, 2010) (codified at 42 C.F.R. pt. 455).

or purchase other necessary capital items.”¹⁵⁵ Other facilities claim that they are forced to turn away patients, cut needed services, and eliminate jobs to endure the short-term loss.¹⁵⁶ While some large providers may be making these cuts to avoid a reduction in their profit margins, small providers may have no other choice.

Finally, on a long-term basis, the post-payment review process in general may cause providers to become increasingly conservative in treatment decisions. To avoid retrospective recoupment of Medicare payments, providers may error on the side of nonintervention for Medicare patients to avoid the hassle of having to appeal the government’s determination that the treatment was not medically necessary.¹⁵⁷ Nonintervention can harm patients when necessary care is delayed or avoided.¹⁵⁸ Providers, of course, face many incentives that pull them in different directions. For example, medical malpractice risk and reimbursement schemes can incentivize providers to both over or undertreat patients.¹⁵⁹ Overtreatment is similarly problematic because it can expose patients to unnecessary risks and lead to overspending.¹⁶⁰ Though physicians are not immune to incentives, professional obligations ethically require them to act in a patient’s best interest at all times, which tempers this general concern.¹⁶¹ It is unclear whether bureaucratic inefficiencies associated with post-payment reviews would impact providers’ decision making, but it’s important to be aware of the possible risk.

The negative, systemic effects of the System’s delays are caused largely by the financial strain small providers face: patients pay more when small providers leave the healthcare market, have fewer choices when small providers opt out of Medicare, and receive worse healthcare when small providers cannot afford to maintain the facilities and services provided to

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155. Complaint at 5, *Am. Hosp. Ass’n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014) (No. 14 Civ. 851).
156. *Id.* at 17; Memorandum Opinion, *Am. Hosp. Ass’n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.
157. 475 Fed. Reg. 69,037, 69,038. (Nov. 10, 2010).
158. See RACs: STRATEGIES TO REDUCE YOUR RISK AND SUCCESSFULLY APPEAL PAYMENT DENIALS 1, 33 (Erin Trompeter ed., 2010).
159. Michael D. Frakes, *The Surprising Relevance of Medical Malpractice Law*, 82 U. CHI. L. REV. 317 (2015).
160. See Chanapa Tantibanchachai, *In Survey, Doctors Say Unneeded Medical Care Is Common, Driven by Fear of Malpractice*, HUB (Sept. 6, 2017), <https://hub.jhu.edu/2017/09/06/unneeded-medical-care-hopkins-survey/>.
161. AM. COLL. OF PHYSICIANS, ACP ETHICS MANUAL SIXTH EDITION (2012), available at: <https://www.acponline.org/clinical-information/ethics-and-professionalism/acp-ethics-manual-sixth-edition-a-comprehensive-medical-ethics-resource/acp-ethics-manual-sixth-edition>.

patients. This is important because the healthcare market still includes many small providers. According to CMS, “most providers and suppliers are small entities, either by nonprofit status or by having revenues of less than \$7.5 million to \$38.5 million in any one year.”¹⁶² To the extent that the System’s delays disproportionately burden small providers—and that burden negatively impacts the price and quality of healthcare—it is important to find a remedy that aids small providers.

IV. Failed Regulatory and Legislative Solutions

CMS is aware of the delays associated with the System and, after public pressure gathered, attempted to ease the backlog through various mechanisms. Settlement has been the agency’s most successful tactic thus far. In 2015, the agency settled roughly 300,000 inpatient-hospital claims that waited for ALJ review.¹⁶³ The agency accomplished this mass settlement by offering to settle all pending inpatient hospital claims if the appellants would agree to pay 68 percent of the over-payment’s value at issue in the appeal.¹⁶⁴ This was a popular solution: the government was able to quickly and easily reduce the number of appeals clogging the System and providers were able to make an informed business decision about whether to continue waiting for the ALJ or accept the deal. In 2016, CMS announced that it would continue the settlement program and settled additional claims.¹⁶⁵

Though settlement on this scale greatly reduced—in the short-term—the appeals backlog, there are three criticisms of this program. First, the program has no effect on the pipeline of appeals entering the System or the System’s capacity to hear appeals; as a result, its impact is temporary.¹⁶⁶ Second, the program was only offered to certain kinds of hospitals and hospital chains; therefore, it excluded many providers, including small

162. Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures, 82 Fed. Reg. 4974, 5105 (proposed Jan. 17, 2017).

163. Memorandum Opinion at 11-13, *Am. Hosp. Ass’n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

164. See *Inpatient Hospital Reviews*, CMS, <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html> (last updated June 6, 2016) [hereinafter CMS, *Inpatient Hospital Reviews*]; see Reed Abelson, *Medicare Will Settle Short-Term Care Bills*, N.Y. TIMES (Aug. 29, 2014), http://www.nytimes.com/2014/08/30/business/medicare-will-settle-appeals-of-short-term-care-bills.html?_r=0.

165. See CMS, *Inpatient Hospital Reviews*, *supra* note 169.

166. See *e.g.*, GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 38 n.64 (“Although the global settlement significantly reduced the backlog, it ended in 2015, and therefore, will not have an effect on the current backlog.”).

providers like physician practice groups, home health-care agencies, and hospices.¹⁶⁷ Third, the structure of the settlement offer creates bad incentives. The less confident an appellant is in the strength of its appeal, the more likely it would be to settle. On the other hand, appellants who believed they were likely to win on appeal—and could withstand the wait—were more likely to reject the offer. As a result, more frivolous claims were settled and CMS may have lost money in the long run by forfeiting portions of valid overpayments. Finally, as explored below, the more desperate the provider is, the more likely it will be to settle with the agency regardless of the strength of its appeal. Large providers can therefore choose to wait if they think they will win before an ALJ, but the more vulnerable small providers will often be forced into settlement.

In addition to settlement, CMS also attempted to improve the backlog through rulemaking. CMS’s rule (the “Rule”), which became effective March 20, 2017, aimed to streamline the appeals process so that its fixed budget could resolve more appeals.¹⁶⁸ The Rule was issued as one prong of a three-pronged approach that, if implemented in its entirety, could eliminate the backlog by 2021.¹⁶⁹ The agency, however, lacks control over the two other prongs: additional funding and legislative reforms. Both require congressional action.¹⁷⁰ The agency can only create regulations aimed to streamline the System so that it becomes more efficient, which is exactly what the Rule aims to do.¹⁷¹ The agency acknowledges that “this final rule makes only minimal changes to the existing appeals procedures” and therefore “[it] would not have a significant economic impact on a substantial number of small entities.”¹⁷²

167. See Amy Kearbey & Nicholas Alarif, *CMS Announces New Settlement Initiative Addressing Medicare Appeals Backlog, Enhancing Provider Appeal Options*, MCDERMOTTWILL&EMERY (Jan. 25, 2018), <https://www.mwe.com/en/thought-leadership/publications/2018/01/cms-announces-new-settlement-initiative>.

168. Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 5104.

169. HHS PRIMER, *supra* note 3, at 10.

170. Medicare Program Changes 81 Fed. Reg. 43, 792 (emphasis added) (“(1) request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; (2) take administrative actions to reduce the number of pending appeals and implement new strategies to alleviate the current backlog; and (3) propose legislative reforms that provide additional funding and new authorities to address the volume of appeals.”).

171. The Rule purports to “address the Medicare appeals backlog and create efficiencies at the ALJ level of appeal by allowing OMHA to reassign a portion of workload to non-ALJ adjudicators and reduce procedural ambiguities that result in unproductive efforts at OMHA and unnecessary appeals to the Medicare Appeals Council.” Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 5104.

172. *Id.* at 5,105.

The Rule's most significant modifications to the System include replacing ALJs with attorney adjudicators in certain circumstances.¹⁷³ OMHA will employ and train these attorney adjudicators.¹⁷⁴ Their decisions would carry the same weight as ALJs, but they could rule only on issues that do not require an evidentiary hearing.¹⁷⁵ This reform, though creative, is unlikely to seriously curb the problem. By the agency's own estimates, this proposal would only redirect roughly 24,500 appeals per year from ALJs to attorney adjudicators.¹⁷⁶ The 600,000 pending appeals heavily overshadow that number.¹⁷⁷ Further, this proposal will incur additional costs as OMHA will need to employ and compensate these attorney adjudicators, so removing the 24,500 appeals per year will cost additional money.

Another of the agency's reforms will give the DAB precedential authority.¹⁷⁸ Unlike the current system—where ALJs and the DAB must look at every appeal in a vacuum—the finalized proposal allows decision-makers to build on previous decisions.¹⁷⁹ Precedential DAB decisions would be published in the federal register and would be binding on the first three levels of the System.¹⁸⁰ An important advantage of this reform is that providers and Medicare contractors would receive better notice of the agency's interpretation of its laws such that they could better predict decisions and conform their conduct to the rules.¹⁸¹ Though the hope is that this proposal would reduce adjudicators' time and effort, the Rule provides no estimate for the impact of precedential decisions.¹⁸² This proposal is unlikely to seriously combat the severity of the appeals backlog, especially in the short term.

173. *Id.* at 4,981-82.

174. *Id.* at 4,983.

175. *Id.* at 4,982 (“[A]ttorney adjudicators [can] issue decisions when a decision can be issued without an ALJ conducting a hearing under the regulations, to dismiss appeals when an appellant withdraws his or her request for an ALJ hearing, and to remand appeals for information that can only be provided by CMS or its contractors or at the direction of the Council, as well as to conduct reviews of QIC and IRE dismissals.”).

176. *Id.* at 5,104.

177. Def. Status Report at 2, *Am. Hosp. Ass’n v. Price*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 5, 2017), ECF No. 58.

178. Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 4,977.

179. *See id.*

180. *Id.*

181. *See* Constance B. Tobias, *DAB Chair Implementing Medicare Appeals Precedent Rule, Welcomes Suggestions*, U.S. DEP’T OF HEALTH & HUM. SERV. (Oct. 27 2017), <https://www.hhs.gov/blog/2017/10/27/medicare-appeals-precedent-rule.html>.

182. Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 5,104-05.

The agency will also limit the instances in which providers can submit new evidence in an ALJ hearing.¹⁸³ If the provider did not submit a piece of evidence at the Reconsideration stage, the provider must show good cause for this omission or the evidence will be excluded at later stages.¹⁸⁴ This proposal could be detrimental to providers that may not be able to gather all of the necessary evidence within the timeframe for a Reconsideration submission.¹⁸⁵ And the government provides no estimate for how this suggestion would reduce the appeals backlog.¹⁸⁶ Though CMS also proposed other administrative tweaks to the System, none of them were associated with a measurable reduction in the appeals backlog.¹⁸⁷

CMS estimated that its Rule would remove fewer than 30,000 appeals per year from the System.¹⁸⁸ This is a disappointing figure—and one that would only have prospective impact without affecting the current backlog of appeals. As a result, the proposed rule alone—without corresponding budget and legislative changes—will be insufficient. As of September 1, 2017, the agency admitted that, even presuming all of its regulatory and settlement proposals are fully implemented, and considering all changes the agency has made in the past few years to combat the problem,¹⁸⁹ the backlog will still grow every year between FY2017 and FY2021. The current estimate is that the appeals backlog will grow to 972,591 by FY2021 (almost 300,000 more than today).¹⁹⁰ The agency’s solutions are failing, and it is impos-sible for the agency to maintain the status quo without legislative intervention. Recognizing the limitations of regulatory solutions, the agency has suggested two legislative proposals that it believes could solve the problem.

The agency’s first legislative proposal was to increase OMHA’s budget. The agency requested a 2017 budget increase of roughly \$270 million dollars for the office responsible for the ALJ and DAB appeals.¹⁹¹ This budget would have required Congress to more than double the current funding at

183. *Id.* at 5,043.

184. *See id.* at 5,045.

185. MEDICARE OVERPAYMENTS, *supra* note 47, at 5.

186. *See* Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 5,104-5.

187. *See id.*

188. *Id.*

189. For a good summary of the changes the agency has already adopted to curb the appeals crisis, see Memorandum Opinion at 11-13, *Am. Hosp. Ass’n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

190. Def. Status Report at 2, *Am. Hosp. Ass’n v. Price*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 5, 2017), ECF No. 58.

191. HHS PRIMER, *supra* note 3.

a time when budgets are strapped.¹⁹² As expected, Congress did not grant this request, and OMHA's budget for 2017 stayed stable at \$107 million.¹⁹³ Congress also refused to grant the agency's request for a funding increase in 2015 and 2016.¹⁹⁴ The agency recently renewed its request for a substantial budgetary increase, which the President's budget endorsed, but there is little evidence that Congress will adopt it.¹⁹⁵

Under the second legislative proposal, the agency suggested that Congress institute legislative reforms to reduce the number of appeals needing review.¹⁹⁶ The agency's suggested legislative fix would include a provision to shift the cost of ALJ and DAB appeals onto the recovery auditors themselves. That is, part of the contingency fee gathered from RACs would pay for the cost of appeals.¹⁹⁷ This proposal would temper the effect of the contingency-fee arrangement: if RACs paid for the additional appeals their audits cause, they might be more likely to avoid controversial overpayment determinations. This suggestion, however, has never been picked up in any proposed legislation.

Instead, in 2015, Congress proposed the Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act (the "AFIRM Act"), which incorporates different legislative recommendations.¹⁹⁸ It is no longer active,¹⁹⁹ but when the bill was introduced, it contained more controversial reforms, such as increasing the amount-in-controversy requirement for an ALJ hearing—from \$150 to \$1,500—and allowing ALJs to render decisions without an evidentiary hearing in certain cases.²⁰⁰ The AFIRM Act did not recommend any substantive changes to the RAP program, a fact that frustrated providers.²⁰¹ It did, however, propose to increase OMHA's

192. *Id.* at 8.

193. *HHS FY 2018 Budget in Brief-OMHA*, HHS, <https://www.hhs.gov/about/budget/fy2018/budget-in-brief/omha/index.html#ftno1> (last updated May 23, 2017) [hereinafter *HHS FY 2018 Budget*].

194. Memorandum Opinion, *Am. Hosp. Ass'n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

195. *HHS FY 2018 Budget*, *supra* note 193; Def. Status Report at 2, *Am. Hosp. Ass'n v. Price*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 5, 2017), ECF No. 58.

196. U.S. DEP'T OF HEALTH & HUM. SERV., *HHS PRIMER: THE MEDICARE APPEALS PROCESS*, <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf> (last visited March 25, 2018).

197. *HHS PRIMER*, *supra* note 3, at 9.

198. *Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015*, S. 2368, 114th Cong. (2015).

199. *Id.*

200. *Id.*

201. *Id.*

budget and track the RAP reversal rates to maintain better quality control over the program.²⁰²

Despite Congress's awareness of the growing problem, the AFIRM Act sat unattended for over a year. In September 2016, D.C. District Court discussed the AFIRM Act's stagnancy in Congress as it reviewed a legal challenge to System's delays:

[I]t has been 21 months since the AFIRM Act was reported by the Senate Finance Committee to the full Senate on December 8, 2015. No debate or vote has been scheduled, and the Secretary offers no evidence that any legislative action is imminent, that the bill has support in the House of Representatives, or that the President would sign it.²⁰³

The court concluded that "Congress is unlikely to play the role of the cavalry here, riding to the rescue of the Secretary's besieged program."²⁰⁴ Two other bills modifying the RAP were introduced in 2012 and 2013 and similarly never made it out of committee.²⁰⁵

On May 23, 2017, the President released his FY2018 President's Budget.²⁰⁶ It included a series of legislative proposals to curb the appeals backlog.²⁰⁷ First, it proposed to remand appeals back to the Redetermination stage if the appellant introduces new evidence.²⁰⁸ Second, like the AFIRM Act, it proposed to increase the amount-in-controversy requirement to \$1,560, with annual increases.²⁰⁹ Third, it proposed to establish magistrate adjudication.²¹⁰ And finally, it proposed to expedite claims that lack material factual disputes.²¹¹ The agency estimated that if Congress adopted all of these proposals, the backlog would shrink to 353,603 appeals by FY2021 (compared to the nearly one million pending appeals by FY2021 without them).²¹² Nevertheless, there has been no indication from Congress

202. *Id*

203. Memorandum Opinion at 15, *Am. Hosp. Ass'n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

204. *Id.* at 16.

205. Medicare Audit Improvement Act of 2012, H.R. 6575, 112th Cong. (2012); Medicare Audit Improvement Act of 2013, H.R. 1250, 113th Cong. (2013).

206. Dec. of Jennifer Moughalian at 4, *Am. Hosp. Ass'n. v. Price*, No. 14-cv-00851 (D.C. Cir. Aug. 11, 2017)

207. *Id.*

208. *Id.* at 5.

209. *Id.*

210. *Id.*

211. *Id.* at 5-6.

212. *Id.* at 6.

that it intends to act on this issue and given the current state of Congressional gridlock, it is unlikely that Congress will step in to fix the problem at any point in the near future.

The agency, acting in a vacuum, is largely powerless to solve the ultimate problem. It cannot increase its budget to process more appeals per year or reform the current programs responsible for the increasing number of appeals entering the System. It is therefore unsurprising that CMS's attempted solutions—mass settlements and rulemaking—have been largely ineffective to cause any real change.

But even if the agency cannot solve the underlying issues that created the backlog, it can improve the financial stress providers' face while they wait.²¹³ For instance, the agency could delay its recoupment until after the ALJ determination. The Social Security Act prevents CMS from recouping overpayments before Reconsideration decisions.²¹⁴ CMS, however, has discretion to delay recoupment beyond Reconsideration without violating the Act. Through rulemaking, it could modify its own guidance to delay recoupment.²¹⁵ This reform could make a big difference because, as discussed above, small providers are disproportionately impacted by the financial strain associated with the delays. As a result, this change would particularly help small businesses endure the wait times and mitigate the broader consequences on the healthcare market discussed in Section III. It would also reduce the administrative cost associated with money changing hands three times, instead of twice.

Delaying recoupment by rulemaking would not cure the problem—at some point, Congress must dramatically change either the pipeline of appeals or the capacity of OMHA to hear them—but it would alleviate the harshest symptoms of this problem until legislation passed. In fact, some small providers have sued the agency, arguing that it should be prohibited from collecting overpayments until after the ALJ hearing, discussed in depth below. CMS, however, has heavily resisted any effort to postpone recoupment, claiming that it would “upset the careful balance of interests accomplished through the present construction of the Medicare statute

213. Some regulatory solutions have been proposed in articles that were published before—or without consideration of—providers' recent legal victories. Kinney, *supra* note 47, at 133 (suggesting an “inquisitorial system” that would allow providers and their counsel to interact directly with reviewers); Michelle Ellis, *The Medicare Appeals Crisis: Why Mediation Is The Medicine*, 16 PEPP. DISP. RESOL. L.J. 61 (2016) (supporting mediation to relieve the backlog); Mary Squire, *RAC: A Program In Distress*, 2015 B.Y.U. L. REV. 219, 253-54 (2015) (proposing various reforms); Matthew J.B. Lawrence, *Procedural Triage*, 84 FORDHAM L. REV. 79, 108 (2017) (arguing that HHS should focus on providing full process to certain non-corporate appellants should).

214. 42 U.S.C. §1395ddd(f)(2) (2010).

215. See LIMITATION ON RECOUPMENT, *supra* note 87; MEDICARE OVERPAYMENTS, *supra* note 47.

and regulations.”²¹⁶ But the government has not explained or substantiated why delaying recoupment would financially harm the agency.²¹⁷ And the evidence might suggest otherwise: CMS has lost as much as \$17.8 million in interest payments to Medicare providers between 2010 and 2015 because it recouped overpayments that ultimately needed to be returned to providers with interest.²¹⁸ Of the \$17.8 million, CMS paid \$13 million to providers in 2014 and 2015 when the delays were the longest.²¹⁹

CMS has also objected to delaying recoupment because it would increase, rather than decrease, the backlog.²²⁰ The idea is that appellants are more likely to appeal to an ALJ and endure the wait times if they are not financially burdened while they wait.²²¹ But this objection misses the mark. Providers are always incentivized to appeal their claims because the alternative is to pay back the full amount immediately.²²² Regardless of whether they appeal, CMS will recoup payments, so the practice is to appeal everything in the hopes that some of the recoupment will be repaid. Indeed, the government frequently laments that providers appeal every claim regardless of its merit.²²³ Because providers are already incentivized to appeal every claim despite financial burden, delaying recoupment will not have the impact the government claims.

CMS may dislike the idea of delayed recoupment for a more nefarious reason: CMS can use time as a weapon once providers start to feel financial pressure. For example, CMS can negotiate harsh settlements with providers

216. Reply Memorandum In Opposition To Preliminary Injunction at 8, *D&G Holdings*, 156 F. Supp. 3d. at 798.

217. *Id.* In another matter, the government did claim that delayed recoupment would have “disastrous” financial implications for the Medicare Trust funds because “CMS collects an average of \$153 million in principal and \$15 million in interest a year after the second level of appeal.” Defendant’s Motion for Summary Judgement at 13, *Am. Hosp. Ass’n*, 812 F.3d.183. However, delaying recoupment would not take away this revenue source, but postpone it. The government failed to give any account for why the government would be significantly harmed by the delay—i.e., why it needs this money in the short term. *Id.*

218. U.S. GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 21.

219. *Id.*

220. Defendant’s Motion for Summary Judgement at 13, *D & G Holding*, 156 F. Supp. 3d. at 798.

221. *Id.*

222. Jacqueline Belliveau, *Can Changes to Medicare Reimbursement Appeals Reduce Backlog?*, REV CYCLE INTELLIGENCE (Aug 31, 2016), <https://revcycleintelligence.com/news/can-changes-to-medicare-reimbursement-appeals-reduce-backlog>.

223. See e.g., HHS PRIMER, *supra* note 84 (3), at 7 (“HHS is aware of two elements of the existing appeals structure that appear to contribute to a growing sense among some appellants and their representatives that appealing every claim is a good business practice.”).

or wait for companies to file for bankruptcy, never able to appear before an ALJ.²²⁴ Judge Henderson on the D.C. Circuit recently worried about this possibility:

[B]argaining power is a two-way street. Subjecting the average claimant to a waiting period more than eleven times longer than the statute permits—and thereby choking off cash flow for basic operational needs—unfairly weakens the *claimant's* position, giving it every incentive to settle for only a fraction of what it might win after years of litigation.²²⁵

CMS should consider delaying recoupment to ease the financial burden on small providers—it is the only administrative remedy that could mitigate the consequences of the System's collapse. And if it refuses to correct this problem itself, courts might step in to demand the same outcome.

Without real solutions on the horizon from either Congress or the agency, providers have pursued creative ways to challenge the status quo through federal litigation. Litigation of this sort is typically very difficult because courts tend to dismiss unexhausted claims and defer to agencies in the administration of their programs. But recently, courts have been willing to consider providers' challenges and question the government's conduct.²²⁶ The next section explores these lawsuits and the impact proposed remedies might have on small providers in particular. It argues that the best legal remedy would be to force to agency to delay recoupment, at least until Congress is able to legislate a long-term solution.

V. The Promise of Federal Litigation

Providers frustrated with the lack of regulatory and legislative solutions have sued the agency in federal court. These lawsuits have largely pursued two challenges. First, providers have brought challenges in mandamus aimed at forcing compliance with the statutory deadlines.²²⁷ Second, providers have brought due process challenges aimed at delaying recoupment until after providers have been afforded an ALJ hearing.²²⁸ The

224. Squire, *supra* note 213, at 247 (“CMS is fully aware of the financial predicament that providers confront when a large portion of their revenue faces the possibility of termination. The agency has nothing to lose by dragging the proceedings on for years. Many providers may be willing to settle claims for a smaller amount than initially demanded out of a fear of losing their entire business as an alternative, even when they believe the denials were made in error.”).

225. *Am. Hosp. Ass'n v. Price*, 867 F.3d at 172 (Henderson, J., dissenting).

226. David Tolley and Greer Donley, *A Favorable, New Climate for Challenging Medicare Appeals*, 27 MEDICARE REPORT (BNA) No. 737 (Aug. 12, 2016).

227. A writ of mandamus orders the government to comply with the law. *See Am. Hosp. Ass'n*, 812 F.3d 183; *see supra* Sections V.A.

228. *See D & G Holding*, 156 F.Supp. 3d at 798; *see supra* Sections V.B.

former would attempt to fix the delays without altering the agency's timeline for recoupment; the latter would attempt to postpone recoupment without altering the length of the delays. These two strategies reflect the types of providers who filed the lawsuits. The main plaintiff in the mandamus lawsuit was the American Hospital Association ("AHA"), a powerful lobbying organization representing a variety of facilities and hospital systems.²²⁹ On the other hand, small providers under threat of bankruptcy have typically sued under the Due Process Clause.²³⁰ AHA has the financial capacity to withstand years of litigation as the D.C. District Court weighs the merits. But the small provider plaintiffs have settled their lawsuits against the agency quickly, even when the courts appeared sympathetic to their arguments by awarding preliminary relief.²³¹

On December 5, 2016, the D.C. District Court granted a writ of mandamus to force the agency to comply with its statute requiring an ALJ hearing within ninety days.²³² The future of the writ is uncertain after the D.C. Circuit recently questioned whether it was possible for the government to comply with it.²³³ But regardless, I argue below that mandamus is not the proper remedy as it fails to protect small providers, especially in the short-term. Instead, the writ may give large providers unique leverage while negotiating with the agency, perpetuating the disproportionate harm small providers experience. A due process remedy, on the other hand, would protect small providers by preventing the agency from recouping a provider's Medicare payments before the provider has received an ALJ determination. Removing this financial strain will help small providers avoid bankruptcy, cut needed patient services, and resist the pressure to consolidate with larger providers or opt out of Medicare—thus helping healthcare consumers. This section explores the feasibility of a due process

229. *About the AHA*, AM. HOSPITAL ASSN., <http://www.aha.org/about/index.shtml> (last visited Feb. 19, 2017).

230. *Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-0253-JRH-GRS, 2015 WL 8488432, at *1 (S.D. Ga. Sept. 21, 2015); *D&G Holdings*, 156 F. Supp. 3d. at 798.

231. *See Order, D&G Holdings, LLC v. Burwell*, No. 5:15-cv-02624-EEF-MLH (W.D. La. Apr. 26, 2016), ECF. 100; *see Order, Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-00253-JRH-BKE (S.D. Ga. Nov. 19, 2015), ECF No. 24.

232. *Am. Hosp. Ass'n v. Burwell*, No. 14-851, 2016 U.S. Dist. LEXIS 167291, at *8 (D.D.C. Dec. 5,

2016).

233. The district court is now reconsidering its decision after the D.C. Circuit required it to determine whether it was possible for HHS to comply with this remedy. *Am. Hosp. Ass'n v. Price*, 867 F.3d 160 (D.C. Cir. 2017). On March 22, 2018, the district court stayed the case for three months and ordered the plaintiff to submit specific proposals for a mandamus order with which the government could possibly comply. Minute Order, *Am. Hosp. Ass'n v. Price*, No. :14-cv-00851-JEB (D.D.C. March 22, 2018), ECF No. 81.

challenge, including the significant legal and practical hurdles providers must overcome to litigate the issue to finality.

A. *Litigation Seeking to Force Compliance with the 90-Day Timeframe*

There are many possible mechanisms to challenge the System's delays based on the agency's failure to abide by the statutory mandate, including a writ of mandamus, *ultra vires*, or through the Administrative Procedures Act. Requesting a writ of mandamus—a strategy AHA adopted in 2014—has been the most successful approach, though its future is currently uncertain. The D.C. District Court initially dismissed the lawsuit for lack of jurisdiction, but in May 2016, the D.C. Circuit reversed and remanded for a decision on the merits.²³⁴ In a strongly worded opinion, the Circuit found that it had jurisdiction and that a writ was warranted if the legislature failed to fix problem itself:

Taking the above factors into account, the district court—more than a year after its first denial and with the problem only worsening—might find it appropriate to issue a writ of mandamus ordering the Secretary to cure the systemic failure to comply with the deadlines Given this, and given the unique circumstances of this case, the clarity of the statutory duty likely will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle.²³⁵

This opinion came after the Fourth Circuit considered the same issue months earlier and held it lacked jurisdiction to hear a mandamus action.²³⁶ The D.C. Circuit's decision revitalized providers that hoped for a legal remedy to cure the System's delays.

As soon as the D.C. Circuit remanded *AHA* to the district court, the agency moved to stay the litigation until September 2017 so that it had more time to fix the problem itself.²³⁷ The district court refused to grant the agency's stay²³⁸ and eventually issued a writ of mandamus, which ordered the agency to comply with its statutory obligation to provide an ALJ hearing within ninety days.²³⁹ The court recognized that compliance could not be immediate, but nevertheless required the agency to eliminate the backlog by 2021 with incremental reductions each year—“*i.e.*, 30% reduction from

234. *Id.*

235. *Am. Hosp. Ass'n v. Burwell*, 812 F.3d at 193.

236. *Cumberland Co. Hosp. Sys. v. Burwell*, 816 F.3d 48 (4th Cir. Mar. 7, 2016).

237. *Am. Hosp. Ass'n v. Price*, 867 F.3d 160 (D.C. Cir. 2017).

238. Memorandum Opinion, *Am. Hosp. Ass'n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

239. *Am. Hosp. Ass'n*, 2016 U.S. Dist. LEXIS 167291, at *1.

the current backlog of cases pending at the ALJ level by December 31, 2017; 60% by December 31, 2018; 90% by December 31, 2019; and 100% by December 31, 2020.”²⁴⁰

In a surprising twist, the D.C. Circuit again reversed and remanded to the district court, finding that it failed to consider whether it was impossible for the agency to legally comply with the writ.²⁴¹ And because the judiciary cannot order the government to do the impossible, the district court was required to first decide possibility.²⁴² The D.C. Circuit raises an important question: how will the agency suddenly be able to drain the backlog after attempting to do so for years with little improvement? The answer: it will not. Judge Boasberg expressed this sentiment in his September 2016 opinion: “the Court, however, does not possess a magic wand that, when waved, will eliminate the backlog. Plaintiffs’ suggestion that the Court simply order HHS to resolve each of the pending appeals by the statutorily prescribed deadlines is extremely wishful thinking.”²⁴³ But while a writ of mandamus cannot suddenly fix the ALJ capacity problem, it pressures Congress to act and the agency to shift priorities even more dramatically to accommodate as many appeals as possible. After all, why should the government’s inability to fix its broken System burden providers instead of the government?

Settlement would be the easiest—and perhaps the only—way for the agency to reduce the backlog and comply with the writ of mandamus. Settlement will allow the agency to quickly reduce the number of pending appeals without fundamentally altering the System’s procedures or the agency’s recoupment timeline. The agency’s mass settlements have thus far been the only improvement that has made any significant impact on the backlog. And in December 2016, CMS decided to extend its mass settlement program.²⁴⁴ As CMS continues to feel the pressure to settle, providers may start to gain leverage against the agency to negotiate highly favorable settlements and dismiss their claims for a portion of the potential overpayment.²⁴⁵ The agency argued recently before the D.C. Circuit that

240. *Id.* at *8.

241. *Am. Hosp. Ass’n v. Price*, 867 F.3d at 160.

242. *Id.*

243. Memorandum Opinion at 15, *Am. Hosp. Ass’n v. Burwell*, No. 1:14-cv-00851-JEB (D.D.C. Sept. 16, 2016), ECF No. 38.

244. *Hospital Appeals Settlement Process 2016*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Hospital-Appeals-Settlement-Process-2016.html> (last modified Jan. 17, 2017).

245. David Tolley and Greer Donley, *Recent Developments in Litigation Challenging the Medicare Appeals Delays: Is Victory Likely for Medicare Providers?*, 27 MEDICARE REPORT (BNA) No. 938 (Oct. 6, 2016).

settlement was its only option for compliance with the writ, and that it might be forced to settle frivolous claims at a significant loss.²⁴⁶

If HHS pursues settlement to clear the backlog, it will likely reinforce the disparity among small and large providers. Large hospital chains with many appeals pending in the System will have more leverage with the agency looking to dismiss a large number of claims. If they are not happy with the agency's offer, they can reject it knowing that they have the financial security to wait for their hearing. Small providers appealing fewer claims will have less leverage to negotiate favorable deals and feel more desperate to accept any offer that will return some portion of their recouped payment.²⁴⁷ As a result, small providers can be pressured into unfavorable settlements, while large providers can harness a writ of mandamus to their advantage.

The AHA—a powerful organization representing both large corporate hospital chains as well as individual facilities—has the financial capacity to litigate the issue fully.²⁴⁸ The primary remedy requested, compliance with the 90-day statute, was not aimed at serving its most vulnerable members, but providing broad relief. As a result, this remedy does not attempt to relieve small providers of the burdens associated with waiting. And while it provides needed recourse to correct the egregious delays, it cannot be the sole solution, at least not in the short term before the backlog is fully emptied.

B. Litigation Seeking to Delay Recoupment Until After the ALJ Hearing

Some providers have pursued another litigation strategy: challenging the agency's conduct under the Due Process Clause. Unlike a mandamus challenge, which would attempt to compel the government to act in accordance with its statutory mandate, a procedural due process claim would ask a court to prevent the government from recouping overpayments until after an ALJ determination. In short, this challenge asks the court to find that recoupment before an ALJ hearing unconstitutionally deprives providers of their property without due process. It would not, however, impact the length of the delays, only the burden associated with waiting. This litigation strategy would be particularly helpful for small providers who could thereby avoid the financial strain of erroneous recoupment. Though two small providers have been successful at winning

246. *Am. Hosp. Ass'n v. Price*, 867 F.3d at 167. The agency argued that it would be illegal to require it to settle frivolous claims. *Id.*

247. *Id.* at 177 (Henderson, J., dissenting) (noting that a provider's financial exigency unfairly weakens its bargaining power).

248. *About the AHA*, AM. HOSP. ASS'N., <http://www.aha.org/about/index.shtml> (last accessed Dec. 22, 2017).

preliminary relief under this theory, their cases settled before the merits could be litigated.²⁴⁹

This section explores whether a due process challenge has merit and the many legal and practical challenges that could prevent a due process claim from being litigated to finality. If a provider could successfully and fully litigate a due process challenge, however, it would force the agency to do what it is refusing to do in its rulemaking: delay recoupment until after an ALJ hearing. Without this pressure, the agency will likely continue to refuse this needed reform.

1. Exploring the Merits of a Due Process Claim

The first step in any due process claim is to identify the liberty or property interest at stake—only then is due process required.²⁵⁰ After demonstrating that a constitutionally protected property interest exists, providers must prove the government deprived them of that property interest without due process. To make this showing, plaintiffs will need to demonstrate that the first two levels of the System provide insufficient procedural protections to justify a deprivation of property. This analysis generally involves a balancing of the government’s burden in providing additional process and the plaintiff’s harm if the additional process is denied.

To prove that a constitutionally protected interest is at stake, plaintiffs must show that they are *entitled* to payment for the services they provide to Medicare beneficiaries.²⁵¹ The Constitution does not create property rights; “[r]ather [property rights] are created and their dimensions are defined by existing rules or understandings that stem from an independent source such as state law—rules or understandings that secure certain benefits and that support claims of entitlement to those benefits.”²⁵² The Medicare statute can be read to create this entitlement, noting the following with respect to Part A providers:

the Secretary shall periodically determine the amount *which should be paid* under this part to each provider of services with respect

249. See Order, *D&G Holdings, LLC v. Burwell*, No. 5:15-cv-02624-EEF-MLH (W.D. La. Apr. 26, 2016); Order, see *Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-00253-JRH-BKE (S.D. Ga. Nov. 9, 2015), ECF No. 24.

250. *Bd. of Regents of State Colleges v. Roth*, 408 U.S. 564, 570-71 (1972) (“But, to determine whether due process requirements apply in the first place, we must look not to the ‘weight’ but to the nature of the interest at stake. We must look to see if the interest is within the Fourteenth Amendment’s protection of liberty and property.”) (internal citations omitted).

251. *Roth*, 408 U.S. at 570-71 (“To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it.”).

252. *Id.* at 577.

to the services furnished by it, *and the provider of services shall be paid*, at such time or times as the Secretary believes appropriate (but not less often than monthly) . . .²⁵³

Perhaps the best evidence of this entitlement is the fact that CMS pays the provider for services rendered before completing its post-payment reviews.

*Mathews v. Eldridge*²⁵⁴ established the modern test for evaluating whether an agency provided due process before it affected a party's liberty or property interest. *Mathews* followed in the footsteps of *Goldberg v. Kelly*—where the Supreme Court held that an agency could not deprive individuals of their welfare benefits without first providing welfare beneficiaries with a pre-deprivation ALJ hearing.²⁵⁵ *Mathews* constrained *Goldberg's* holding by limiting the incidences in which agencies must provide a pre-deprivation hearing.²⁵⁶ Recognizing that such a requirement can come with significant governmental costs, the Court created a balancing test to weigh the various interests at stake:

[1] the private interest that will be affected by the official action; [2] the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional procedural or substitute procedural safeguards; and [3] the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.²⁵⁷

After weighing these factors in a new context—disability benefits—the *Mathews* Court held that it was constitutional to deprive individuals of their disability benefits prior to an ALJ hearing—i.e., that a pre-deprivation hearing was not required for disability beneficiaries as it had been for welfare beneficiaries.²⁵⁸

Mathews did not overturn *Goldberg*.²⁵⁹ Though *Mathews* involved a nearly identical claim to *Goldberg*, the Court distinguished itself from *Goldberg* on three factors. First, it found that the deprivation of welfare benefits was more significant than the deprivation of disability benefits.²⁶⁰

253. 42 U.S.C. 1395g(a) (2010) (emphasis added).

254. *Mathews v. Eldridge*, 424 U.S. 319 (1976).

255. *Goldberg v. Kelly*, 397 U.S. 254, 261 (1970).

256. *Mathews*, 424 U.S. at 342.

257. *Id.* at 335.

258. 43 U.S.C. § 405(5) (2017).

259. *Mathews*, 424 U.S. at 355.

260. *Id.* at 342 (“Still, the disabled worker’s need is likely to be less than that of a welfare recipient. In addition to the possibility of access to private resources, other forms of government assistance will become available where the

Second, it found that a pre-deprivation hearing in the disability context was marginally less beneficial than in the welfare context.²⁶¹ Finally, the Court concluded that the government's burden in providing a pre-deprivation hearing in the disability context was high and outweighed the beneficiaries' interests (unlike in the welfare context).²⁶²

To win a due process challenge, providers would need to argue that their due process claims are more similar to *Goldberg* than *Mathews* and that the balancing test favors them. Courts are generally reluctant to require agencies to provide additional process. Small providers, however, could realistically argue that this is an exceptional circumstance given the severe financial ramifications, high likelihood of success before an ALJ, and low governmental cost. In so doing, they might have to concede that when the System functioned normally, it was not constitutionally deficient.²⁶³

a. The Severity of the Interest Affected

The severity associated with the property deprivation is a significant part of the balancing test. In *Goldberg*, the Court worried that an erroneous deprivation of welfare benefits could render beneficiaries destitute; "thus, the crucial factor in this context . . . is that termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits."²⁶⁴ Conversely, in *Mathews*, the Court relied significantly on its view that an erroneous deprivation of disability benefits would be less likely to threaten a beneficiary's ability to survive, stating: "still, the disabled worker's need is likely to be less than that of a welfare recipient . . . other forms of government assistance will become available where the termination of disability benefits places a worker or his family below the subsistence level."²⁶⁵ In other words, the Court reasoned that because disability beneficiaries could obtain other forms of assistance, like welfare, if they become destitute while waiting for an ALJ determination, they were less

termination of disability benefits places a worker or his family below the subsistence level.").

261. *Id.* at 343-44 ("[A medical assessment] is a more sharply focused [and easily documented] decision than the typical determination of welfare entitlement. In [welfare hearings], a wide variety of information may be deemed relevant, and issues of witness credibility and veracity often are critical to the decision making process.").

262. *Id.* at 347-49.

263. See e.g., Eleanor D. Kinney, *Medicare Coverage Decision-Making And Appeal Procedures: Can Process Meet The Challenge Of New Medical Technology?*, 60 WASH. & LEE L. REV. 1461 (2003) (exploring due process in the Medicare Appeals System long before the delays began in the context of challenging Medicare coverage determinations).

264. *Goldberg*, 397 U.S. at 264 (emphasis added).

265. *Mathews*, 424 U.S. at 342.

likely to suffer extreme hardship if their disability benefits were erroneously deprived in the meantime.

Erroneous deprivation of Medicare payments while providers wait for an ALJ hearing forces many businesses²⁶⁶ to face the corporate equivalent of the harm announced in *Goldberg*: bankruptcy.²⁶⁷ According to *Goldberg*, when a property deprivation threatens the “very means by which to live while [the beneficiary] waits,” the deprivation is severe.²⁶⁸ There is no more severe consequence to a business than facing dissolution as it waits for the government to correct its erroneous deprivation. One practical implication is that small providers genuinely facing dissolution are the best positioned to prove the requisite level of severity under the Due Process Clause. As a result, it is unsurprising that the two plaintiffs who have successfully raised this claim were small providers.²⁶⁹

Another factor that can impact severity is the length of the delay.²⁷⁰ If the delay is so long that a party cannot be heard “at a meaningful time,” then the deprivation is more severe.²⁷¹ In *Mathews*, the Court noted that the average wait for an ALJ hearing was between ten and eleven months. Though the Court found that timeframe “torpid[,],” it was not so severe as to outweigh the court’s findings on the other factors.²⁷² The delays faced by

266. A Medicare provider’s due process challenge affects businesses as opposed to the individuals affected in *Goldberg* and *Mathews*. Because the Supreme Court has held on numerous occasions that corporations and business associations are guaranteed the same Fourteenth Amendment rights as natural persons, the fact that Medicare providers are businesses should not affect the analysis in any legally relevant way. *Pembina Consolidated Silver Mining Co. v. Pennsylvania*, 125 U.S. 181, 189 (1888) (“Under the designation of ‘person’ there is no doubt that a private corporation is included [in the Fourteenth Amendment]. Such corporations are merely associations of individuals united for a special purpose and permitted to do business under a particular name and have a succession of members without dissolution.”); *Nw. Nat. Life Ins. Co. v. Riggs*, 203 U.S. 243 (1906) (“It is true, also, that a corporation of one state, doing business in another state, under such circumstances as to be directly subject to its process at the instance of suitors, may invoke the protection of that clause of the 14th Amendment which declares that no state shall ‘deny to any person within its jurisdiction the equal protection of the laws.’”).

267. Press Release, *supra* note 52. Not all healthcare providers are seriously affected by the property deprivation. In particular, large hospital chains might be well suited to absorb the delays. As a result, this challenge might need to be made on an as-applied basis.

268. *Goldberg*, 397 U.S. at 340.

269. *D&G Holdings*, 156 F. Supp. 3d at 798; see *Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-0253, 2015 WL 8488432 (S.D. Ga. Sept. 21, 2015).

270. *Mathews*, 424 U.S. at 341-42 (quoting *Fusari v. Steinberg*, 419 U.S. 379, 389 (1975)).

271. *Mathews*, 424 U.S. at 333.

272. *Id.* at 341-42.

Medicare providers are years longer than those at issue in *Mathews* and grow every month.²⁷³ Because of them, some small providers may no longer exist by the time of their hearing, which supports the argument that they could not be heard at a meaningful time.

b. The Likelihood That an ALJ Hearing Would Improve Agency Decision Making

The second factor of the *Mathews* analysis “is the fairness and reliability of the existing pretermination procedures, and the probable value, if any, of additional procedural safeguards.”²⁷⁴ The fundamental inquiry is whether adding procedural protections before property deprivation will improve the reliability of the outcomes.²⁷⁵ Here, the additional safeguard would be an ALJ hearing *before* recoupment. ALJs provide two primary procedural protections that are lacking in Reconsideration and Redetermination. First, ALJ hearings provide the initial opportunity for an evidentiary hearing on the merits.²⁷⁶ Second, OMHA—the agency under which ALJ hearings occur—is located under HHS, not CMS, and its ALJs are therefore less susceptible to bias.

A fair hearing “require[s] that a recipient have . . . effective opportunity to defend themselves by confronting any adverse witnesses and by presenting his own arguments and evidence orally.”²⁷⁷ It is undisputed that an ALJ hearing is the first point that providers can present evidence and raise their arguments orally before an arbiter.²⁷⁸ The GAO, for instance, attributed the “high reversal rates at Level 3 [i.e., the ALJ hearing], in part, to the opportunity for hearings and presentation of new evidence . . .”²⁷⁹ As the GAO noted, ALJ hearings “provide an opportunity for appellants to explain the rationale for the medical treatment.”²⁸⁰ For many providers, the chance to present evidence and explain their decisions creates the difference between an “overpayment” and valid claim.

ALJs are also the first instance in which a truly independent decision-maker hears the appeal. When considering neutrality in the agency context, “there is wisdom in recognizing that the further the tribunal is removed from the agency and thus from any suspicion of bias, the less may be the need for other procedural safeguards.”²⁸¹ The arbiters in Reconsideration and Redetermination are Medicare contractors employed by CMS; their

273. *Id.*

274. *Id.*

275. *Id.*

276. *See supra* Section II.

277. *Goldberg*, 397 U.S. at 267-68.

278. *See* GOV'T ACCOUNTABILITY OFFICE, *supra* note 94, at 22.

279. *Id.*

280. *Id.* at 23.

281. Henry Friendly, *Some Kind of Hearing*, 123 U. PA. L. REV. 1267, 1279 (1975).

mission includes protecting the Medicare trust funds and identifying potential overpayments.²⁸² These contractors are essentially asked to judge a conflict where their employer is one of the parties. This creates an incentive adverse to the providers, who want to get paid for all of the services they provide. ALJs, on the other hand, are employed by a different agency—OMHA— and are therefore an external arbiter that is less likely to prioritize CMS’s interests.

One mechanism to assess whether Reconsideration and Redetermination are reliable and fair is the likelihood of a reversal before a tribunal that provides additional process.²⁸³ In *Mathews*, the Court found that ALJs only reverse 3.3 percent of appeals involving a person’s eligibility for disability benefits.²⁸⁴ This is in stark contrast to a provider’s likelihood of obtaining a reversal before an ALJ of their payment’s recoupment. CMS’s 2014 data indicates that 54 percent of ALJ appeals fully reversed the underlying decision. In 2012 and 2013, ALJs overturned more than 60 percent of underlying decisions.²⁸⁵ As the D.C. Circuit has stated: “if the vast majority of these delayed [ALJ Medicare] appeals were ultimately denied, they might amount to little more than an unfortunate nuisance. The record suggests, however, that many have merit.”²⁸⁶ This high reversal rate indicates that Reconsideration and Redetermination are not sufficiently protective of providers’ property interests and an additional safeguard—an ALJ hearing—could be warranted.

c. The Government’s Conflicting Interest

The final *Mathews* factor to consider “is the public interest. This includes the administrative burden and other societal costs that would be associated with requiring, as a matter of constitutional right, an evidentiary hearing upon demand in all cases prior to the termination of disability benefits.”²⁸⁷ In *Mathews*, if the Court had required the government to provide a pre-deprivation hearing before discontinuing disability benefits, it would have forced the government to continue paying disability beneficiaries for ten to eleven months who may have no longer been eligible for benefits. And because the ALJ hearing almost always found for

282. MEDICARE INTEGRITY MANUAL, *supra* note 20, at 4.

283. *Mathews*, 424 U.S. at 319, n.29 (“As we indicated last Term in *Fusari v. Steinberg* [], in order fully to assess the reliability and fairness of a system of procedure, one must also consider the overall rate of error for all denials of benefits.”) (quoting *Fusari v. Steinberg*, 419 U.S. 379, 383 n. 6 (1975)).

284. *Id.* (“Here, that overall rate is 12.2%. Moreover, about 75% of these reversals occur at the reconsideration stage of the administrative process Netting out these reconsideration reversals, the overall reversal rate falls to 3.3%.”).

285. GOV’T ACCOUNTABILITY OFFICE, *supra* note 94, at 21-22.

286. *Am. Hosp. Ass’n*, 812 F.3d at 188.

287. *Mathews*, 424 U.S. at 341-42.

the government, those payments would have been erroneous 96.7 percent of the time.²⁸⁸ The *Mathews* Court relied heavily on the potential cost of these erroneously paid disability benefits, most of which the government could never recoup given the financial circumstances of the population.²⁸⁹ It furthermore worried that this lost money could have been used to provide additional benefits to qualified individuals. This final factor was ultimately the reason the Court held that a pre-termination hearing was not required in the disability context.²⁹⁰

The cost of a pre-termination hearing for Medicare providers would be negligible for two reasons. First, unlike disability beneficiaries who would have been paid monthly sums as they waited for their ALJ hearing,²⁹¹ Medicare providers are challenging a past transaction that the government paid for long before the appeal. In other words, a pre-deprivation hearing for Medicare providers would not cost the government any additional money given that payment had already been made.²⁹² Second, the agency has a strong self-help mechanism against providers to ensure it will be paid back: recoupment.²⁹³ If an ALJ determines that a true overpayment has occurred, the agency can immediately recoup the money by ceasing all future Medicare payments to the provider.²⁹⁴ This is not a remedy available in the disability context, where beneficiaries are receiving government assistance, not payment for services rendered. Finally, given the underlying systemic issues that are perpetuated by these delays, it is in the public's interest to create a reprieve for these small providers.

Taken together, a court could find that the *Mathews* factors balance in favor of small Medicare providers. Because small providers are more severely harmed by the delays than large providers and their financial risk more seriously impacts public interest concerns, they are best positioned to bring a successful due process challenge.

d. Early Victories Suggesting that a Procedural Due Process Challenge Could Be Successful

Two small providers have recently been successful at obtaining preliminary relief to prevent the government from recouping their Medicare payments before an ALJ hearing. In *Hospice Savannah*, the Southern District of Georgia entered a temporary restraining order to prevent the government from recouping a small hospice provider's Medicare payments

288. *Id.* at n.29.

289. *Id.*

290. *Id.*

291. 42 U.S.C. §1395ff(C) (2017) and *MEDICARE APPEALS SYSTEM*, *supra* note 84, at 14.

292. 42 U.S.C. §1395ff(D) (2017).

293. *Id.*

294. *Id.*

prior to an ALJ hearing.²⁹⁵ The court found that the plaintiff was likely to succeed on the merits and be irreparably harmed if the recoupment were not enjoined because “Hospice Savannah will lose 80% of its total revenues and be . . . forced to close.”²⁹⁶

In a similar case a few months later, *D&G Holdings*, the Western District of Louisiana granted a preliminary injunction preventing CMS from recouping overpayments before the ALJ decision:²⁹⁷

[P]laintiff states that if it is not granted a timely administrative hearing and recoupment continues in the interim, it will lose the same amount of revenue, will go out of business, could not care for its rural customer base, and must terminate its employees These are damages not recompensable through retroactive payment. A colorable claim that irreparable harm will result has been made.²⁹⁸

Both cases settled shortly after the injunctions were issued and were therefore not litigated fully on the merits.²⁹⁹ Nevertheless, both providers’ preliminary victories demonstrate that a due process challenge could be ultimately victorious, as the decisions were based on findings that, *inter alia*, the providers were likely to be successful on the merits.

2. Legal and Practical Challenges Associated with a Due Process Challenge

Despite the possibility that a due process challenge could be successful and provide a unique remedy to providers, plaintiffs would need to overcome significant legal and practical hurdles. I explore three of the more pressing obstacles below. Though the legal hurdles are surmountable, the practical challenges will make it difficult to litigate the challenge to finality.

a. Jurisdiction

Providers seeking to bring a due process challenge will face a jurisdiction hurdle right out of the gate. 42 U.S.C. § 405(h) precludes federal jurisdiction prior to administrative exhaustion for claims “arising under” federal statutes, including the Medicare Act, and that base their jurisdiction on the federal question statute, 28 U.S.C. § 1331.³⁰⁰ Under Section 405(h),

295. MEDICARE APPEALS SYSTEM, *supra* note 80, at 13.

296. *Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-0253-JRH-GRS, 2015 WL 8488432, at *1 (S.D. Ga. Sept. 21, 2015).

297. *D&G Holdings*, 156 F. Supp. 3d. at 817.

298. *Id.* at 817.

299. *See Order, D&G Holdings, LLC v. Burwell*, 5:15-cv-02624-EEF-MLH (W.D. La. Apr. 26, 2016), ECF No. 99; *see Order, Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-00253-JRH-BKE (S.D. Ga. Nov. 9, 2015), ECF No. 24.

300. 42 U.S.C. § 405(h) (2006); *Wilson v. United States*, 405 F.3d 1002, 1010 n.9 (Fed. Cir. 2005); *Randall D. Wolcott, MD, P.A. v. Sebelius*, 635 F.3d 757, 764 (5th Cir. 2011). The Administrative Procedures Act does not grant jurisdiction.

providers are generally prohibited from bringing federal litigation to challenge Medicare appeals before completing all four of the System's steps.³⁰¹ This requirement would be quite problematic for those providers that risk bankruptcy while waiting for the delayed ALJ hearing. The provider might no longer be in business by the time it has exhausted and can litigate the due process claim in federal court.

Fortunately, providers should be able to avoid this obstacle to a due process challenge. First, litigants challenging due process can avoid Section 405(h) by arguing that their claim is entirely collateral to the underlying substantive appeal (*i.e.*, that challenging the System's *delays* is unrelated to whether or not the provider is entitled to payment for the underlying service).³⁰² Second, the administrative appeals process may be bypassed—and federal question jurisdiction invoked—if exhaustion would amount to “no review at all” of the claim.³⁰³ Providers could argue that this exception is met because they cannot challenge the System's delays within the System itself, and they may no longer exist to challenge the delays in federal court if required to first exhaust.

Both of these exceptions to Section 405(h) involve a high bar;³⁰⁴ nevertheless, the *D&G* court allowed the plaintiff to bypass 405(h) under the collateral claim exception.³⁰⁵ The court held that a “ruling on the merits of Plaintiff's procedural due process claim will involve this Court in no way with a determination of whether Plaintiff was overpaid by Medicare, to

301. 42 U.S.C. § 405(h) (2006).

302. *Mathews*, 424 U.S. at 330; *see also* *Bowen v. City of New York*, 476 U.S. 467,482 (1986); *V.N.A. of Greater Tift Cty. v. Heckler*, 711 F.2d 1020, 1032 (11th Cir. 1983) (“Eldridge suggests strongly that there is room for a wholly collateral procedural attack, for example, to compel agency action wrongfully withheld. In other words, to the extent that a provider could show that a delay during PRRB review is contrary to the statute, it might well have a cause of action.”) (internal citation omitted); *Crawford & Co. v. Apfel*, 235 F.3d 1298, 1302 (11th Cir. 2000) (“We need not address whether jurisdiction is present under § 405(g), as we conclude, after reviewing the briefs of the parties, that the precedential authority of this circuit establishes that the judgment of the district court, even if not “final” per se, is reviewable under the collateral order doctrine”); *St. Louis Univ. v. Blue Cross Hosp. Serv.*, 537 F.2d 283, 291 (8th Cir. 1976).

303. *Shalala v. Ill. Council on Long Term Care*, 529 U.S. 1, 19 (2000) (“[The Medicare Act] does not apply § 405(h) where application of § 405(h) would not simply channel review through the agency, but would mean no review at all.”); *BP Care v. Thompson*, 398 F.3d 503, 508 (6th Cir. 2005) (“Put another way, “parties affected by Medicare administrative determinations may sue in federal court under 28 U.S.C. § 1331, bypassing § 405 preclusion, only where requiring agency review pursuant to § 405(h) would mean no review at all.”).

304. *See e.g.*, *Triple a Home Care Agency v. Burwell*, No. 4:15CV668 JCH, 2016 WL 728334, at *1 (E.D. Mo. Feb. 24, 2016) (holding that plaintiff provide could not meet the collateral claim doctrine because it sought review of the underlying overpayment determination, which was not “collateral.”).

305. *D&G Holdings*, 812 F. Supp. 3d. at 798.

what degree any overpayment was made, or the suitability of the statistical extrapolation used to assess Plaintiff's alleged overpayment."³⁰⁶ The court, however, was unpersuaded by the "no review at all" exception, holding that the exception required a showing of legal impossibility, which the plaintiffs failed to demonstrate.³⁰⁷

b. Property Interest

Assuming the court finds jurisdiction, plaintiffs will also face negative precedent in proving that a potential overpayment constitutes a constitutionally recognized property interest.³⁰⁸ Providers have historically been unsuccessful in lodging due process claims against the government.³⁰⁹ In particular, courts have not been willing to find a property interest in future Medicaid or Medicare payments that are recouped, frozen, or withheld based on findings of potential Medicare fraud.³¹⁰ No court, however, has examined whether the government's recoupment of previously distributed Medicare payments based not on fraud, but a potential overpayment constitutes an unconstitutional deprivation of property. Though not an easy question, I contend that once the government transfers possession of the payment to the provider, the property interest in the payment shifts from the government to the provider.

306. *Id.* at 815.

307. *Id.* Arguably, exhaustion could involve a legal impossibility: by the time a provider reaches federal court after exhausting the four steps in the System, it no longer has standing to challenge the delays because it is no longer being affected by them.

308. Providers could also attempt to prove that a constitutionally protected liberty interest is at stake when the government threatens providers' ability to continue their chosen profession. Mary Squire proposed that a constitutionally protected liberty interest can be implicated when a Medicare provider faces bankruptcy as a result of agency action. Squire, *supra* note 213, at 240-42. However, this theory is even less supported. The fact that providers have a constitutionally protected liberty interest to pursue their chosen profession does not mean that government action threatening their ability to stay in business impinges on that interest, see James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1390-91 (1981).

309. See *e.g.*, Peterson v. Weinberger, 508 F.2d 45, 50 (5th Cir. 1975); Karnak Educ. Trust v. Bowen, 821 F.2d 1517, 1519-20 (11th Cir. 1987).

310. ABA v. D.C., 40 F. Supp. 3d 153, 167 (D.D.C. 2014) ("In contrast to a provider's right to participate in the Medicaid program, there is no constitutional right to receive Medicaid payments."); Personal Care Products v. Hawkins, 635 F.3d 155, 159 (5th Cir. 2011) ("Nothing in Texas or federal law extends a property right in Medicaid reimbursements to a provider that is the subject of a fraud investigation."); Clarinda Home Health v. Shalala, 100 F.3d 526, 531 (8th Cir. 1996) ("we hold that it is not a violation of due process to temporarily withhold Medicare payments during an ongoing investigation for acts of fraud."); Chaves County Home Health Service v. Sullivan, 931 F.2d 914, 922-23 (D.C. Cir. 1991); Yorktown Med. Lab. v. Perales, 948 F.2d 84, 89 (2d Cir. 1991)..

The Medicare statute clearly creates a right to payment, but the question is whether that right is dependent on the claim successfully passing through post-payment review.³¹¹ The statute and regulations governing overpayments complicate the issue because they create procedures by which the government can recoup payments that it has already made.³¹² Those procedures, however, do not necessarily define the property interest—if they did, then the legislature (as opposed to the Constitution) would be designating the scope of due process. The Supreme Court has found this impermissible.³¹³ The legislature creates property interests, but federal courts define the scope of the Constitution’s due process protection.³¹⁴ The Supreme Court described this distinction in *Cleveland Bd. of Educ. v. Loudermill* by stating: “the categories of substance and procedure are distinct. Were the rule otherwise, the Clause would be reduced to a mere tautology. ‘Property’ cannot be defined by the procedures provided for its deprivation any more than can life or liberty.”³¹⁵ The *Loudermill* court explicitly rejected Justice Rehnquist’s view in *Arnett v. Kennedy*³¹⁶ that when a legislature grants a substantive right, plaintiffs must accept the limitations placed upon it.³¹⁷ Thus, the fact that the government can review and recoup Medicare payments after they are made to providers does not mean that the property interest does not vest at the time of payment.

311. 42 U.S.C. 1395g(a) (2010) (“the Secretary shall periodically determine the amount *which should be paid* under this part to each provider of services with respect to the services furnished by it, *and the provider of services shall be paid*, at such time or times as the Secretary believes appropriate (but not less often than monthly)”) (emphasis added). The statute creates prepayment conditions before payment is made, not post-payment conditions *see* 42 U.S. Code § 1395f. (2010).

312. The statute and provider agreements are not silent about overpayments. The statute permits “necessary adjustments on account of previously made overpayments or underpayments.” 42 U.S.C. §1395g(a) (2010). The right to collect overpayments is also provided in the agreement signed when providers apply to become a Medicare provider. One provision requires providers to agree that “any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.” CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE ENROLLMENT APPLICATION 48 (2011), <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf>.

313. *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 541 (1985).

314. *See id.*

315. *Id.*

316. *Arnett v. Kennedy*, 416 U.S. 134, 153-154 (1974) (“where the grant of a substantive right is inextricably intertwined with the limitations on the procedures which are to be employed in determining that right, a litigant in the position of appellee must take the bitter with the sweet.”).

317. *Loudermill*, 470 U.S. at 541.

Linking a provider's property interest in Medicare payments with the transfer of property is a plausible interpretation of the Medicare statute.³¹⁸ And once the property interest has been created, only the courts can decide under what circumstances that interest can be deprived. Under this theory, the government could still recoup previously distributed Medicare payments, but only after first providing sufficient process: an ALJ hearing.

c. Practical Implications

A final hurdle that plaintiffs must overcome to achieve a victory on the merits of a due process challenge is to avoid the pressure to settle. The plaintiffs in both *D&G* and *Hospice Savannah* settled their lawsuits as soon as they earned preliminary relief.³¹⁹ CMS was motivated to settle so that it could avoid the possibility of negative precedent on the merits that would force it to delay recoupment for all providers. The plaintiffs, facing insolvency and anxious to reduce the burden of recoupment, were not in a financial position to reject a favorable settlement and continue their lawsuit. Of course, it is the very fact that small providers face the threat of bankruptcy that makes their due process claim possible—the interest affected is severe enough to tilt the *Mathews* balance in their favor. CMS can use this reality to its benefit by essentially buying out successful plaintiffs before the merits are reached.

AHA did not face this same financial pressure and was able to endure years of litigation before ultimately winning a writ of mandamus. It was also not suing as an individual provider hoping to win a good result for itself, but as an organization using an impact litigation strategy to win a good result for its members. The *AHA* lawsuit represented a unique case in which private parties were able to use litigation to pressure a reluctant agency to act. A similar outcome based on a due process remedy is possible, so long as a plaintiff can resist the pressure to settle.

VI. Conclusion

The Medicare Appeals System is broken. It cannot accommodate the influx of appeals that are entitled to ALJ review. Despite the government's failure to meet its statutory deadlines, CMS continues to recoup payments on schedule as if the delays are not occurring. This places an extreme burden on providers, whose Medicare payments are recouped while they

318. This interpretation also has some support in recent case law *see ABA*, 40 F.Supp.3d at 167 (distinguishing itself from *Chaves County Home Health Service, Inc. v. Sullivan*, 931 F.2d 914, 922–23 (D.C. Cir. 1991) on the grounds that the Chavez plaintiffs “asserted the right to retain payments already made, circumstances entirely different than those presented here,” noting that “providers had a property interest in the monies they had received.”).

319. *See Order, D&G Holdings, LLC v. Burwell*, No. 5:15-cv-02624-EEF-MLH (W.D. La. Apr. 26, 2016), ECF No. 99; *see Order, Hospice Savannah, Inc. v. Burwell*, No. 4:15-cv-00253-JRH-BKE (S.D. Ga. Nov. 9, 2015), ECF No. 24.

wait years for ALJ hearing, which is more likely than not to determine that the recoupment was erroneous. Small providers in particular cannot accommodate the years-long deprivation of their recouped Medicare payments. Legislative and regulatory solutions have failed thus far. Litigation appears to be the only source of imminent progress for providers. Though providers were initially able to obtain a writ of mandamus, a successful due process challenge would better protect small providers, who may be otherwise forced to face insolvency, sell their businesses to larger companies, opt out of Medicare, or cut patient services to avoid the financial strain associated with the delays.

The ultimate solution to the backlog requires congressional action. Congress must decide to fund additional ALJs to accommodate the influx of appeals or alter the pipeline of appeals entering the System. At this point, Congress seems unmotivated to do either. Litigation is particularly promising because it exerts pressure on the government to enact lasting reforms. However, if the current legal remedy—mandamus—remains in effect, it will perpetuate the disproportionate burdens small providers experience and therefore fail to help the most vulnerable victims of the System's delays. Though the agency has rulemaking authority to relieve some of the pressure on small providers by delaying recoupment, it has been unwilling to do so. A due process challenge would force the government to implement this change, but the litigating plaintiff must first overcome numerous legal and practical obstacles. It might, however, be small providers' best chance at obtaining relief while they wait for Congress to act.