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

Greer Donley
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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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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


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

⁴. MEDICARE FEE FOR SERVICE, supra note 2, at 1, 10,18.
⁵. Id. at 2.
⁶. Id. at 69.
⁸. HHS is an umbrella agency that oversees many of the agencies at issue in this Article.
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. The 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.\textsuperscript{11} Most healthcare providers and suppliers\textsuperscript{12} treat at least some Medicare patients,\textsuperscript{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).\textsuperscript{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.\textsuperscript{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.\textsuperscript{16} In this way, Medicare functions like any health insurer: it contracts with providers to treat its beneficiaries in exchange for


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).


payment. 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. For instance, MACs review providers' claims for payment and pay providers for approved claims.

When a provider submits a claim for payment, MACs conduct a prepayment review to determine whether the claim meets Medicare's conditions of payment. Contractors create a system that automatically pays certain claims, automatically denies certain claims, and tags other claims for additional review. 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. The vast majority of claims are considered low-risk and may be paid automatically or semi-automatically with little oversight. 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. Such claims can be automatically denied, for instance, if the provider submits the claim with missing, or clearly incorrect information. 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.

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.” 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. Contractors reviewing these claims may request additional documentation before approving or denying them. 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.” 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. 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.

The result of prepayment review—whether Non-Complex or Complex—is called the Initial Determination. If the Initial Determination approves a claim, the provider is paid according to a price outlined by federal law and regulations. If the Initial Determination denies a claim, the provider is not paid, but can resubmit it or challenge the denial through the System. 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.

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{41}

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

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\textsuperscript{37.} MEDICARE INTEGRITY MANUAL, supra note 20.

\textsuperscript{38.} MEDICARE CLAIMS REVIEW PROGRAMS, supra note 19.

\textsuperscript{39.} RECOVERY AUDITING, supra note 1.

\textsuperscript{40.} MEDICARE CLAIMS REVIEW PROGRAMS, supra note 19, at 8-9.

\textsuperscript{41.} MEDICARE CLAIMS REVIEW PROGRAMS, supra note 19.

\textsuperscript{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).

\textsuperscript{43.} MEDICARE CLAIMS REVIEW PROGRAMS, supra note 19.

\textsuperscript{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.

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.

\(^{46}\) 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).


\(^{49}\) 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. Providers, however, can face enormous financial consequence as a result of these extrapolated audits. 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. Courts have not been persuaded. Instead, courts have deferred to the agency to dictate the procedures of their audits. 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.

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. The RAP designated Recovery Audit Contractors (“RACs”) to conduct RAP audits. By statute, RACs are paid on a contingency fee—i.e., they collect a portion of the


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).


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

This incentive structure has caused providers alarm, and many see RACs as “bounty hunters” looking for overpayments at the expense of physicians and hospitals. 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.” Moreover, the time and expense providers must incur in hosting auditors and gathering medical documentation further antagonizes the relationship between RACs and providers. Expenses associated with RAC audits and appeals can exceed $100,000 per audit for many hospitals.

Nevertheless, the RAP has been very successful for CMS: in 2014, RACs identified $2.39 billion in overpayments. But RAC audits also dramatically increased the number of “overpaid” claims that are later overturned through the Medicare Appeals System. 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

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].


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

68. RECOVERY AUDITING, supra note 1.
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.
76. Id.
77. See id.
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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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{80} MACs and Qualified Independent Contractors (“QICs”), which are both Medicare contractors paid by CMS, render the first two levels of review (Redetermination and

\textsuperscript{78} Id. at 970

\textsuperscript{79} Id.

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Reconsideration respectively). 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. 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.

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

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. An ALJ must render a determination within ninety days of the provider’s initial request for review. 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.
87. Id.; MEDICARE OVERPAYMENTS, supra note 47.
88. Id.
89. MEDICARE OVERPAYMENTS, supra note 47.
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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.

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

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.


100. HHS PRIMER, supra note 3.


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 OMHA and OMHA only has capacity to hear 77,000 appeals per year. 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. OMHA currently resolves appeals within an average of three years—already eleven times longer than permitted—but “some already-filed claims could take a decade or more to resolve.”

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. In 2014, for instance, ALJs fully reversed overpayment determinations in fifty-four percent of appeals. In previous years, ALJ reversal rates were over sixty percent. And certain providers are historically even more successful before ALJ. Two factors, explored in more depth below, explain the high reversal rate: ALJ review is the first time providers receive an evidentiary hearing and 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. Though the government must repay the erroneously recouped payment if the provider

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.\textsuperscript{116}

Small healthcare providers, which have less liquidity and tolerance for missing revenue, have been the most notable victims of this process.\textsuperscript{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.”\textsuperscript{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.”\textsuperscript{119} Larger providers, like hospital chains, can weather these delays and do not face the same threat.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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

\textsuperscript{116} Press Release, \textit{supra} note 52.

\textsuperscript{117} Press Release, \textit{supra} note 52; Jessica L. Gustafson and Abby Pendleton, \textit{Medicare Appeals Adjudication Delays: Implications For Healthcare Providers And Suppliers}, 26 \textit{No. 5 Health L.} 26, 28 (2014) \textit{[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.”).

\textsuperscript{118} Press Release, \textit{supra} note 52.

\textsuperscript{119} \textit{Id.}

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

\textsuperscript{121} See \textit{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); \textit{see Hospice Savannah v. Burwell, No. 4:15-cv-0253, 2015 WL 8488432 (S.D. Ga. Sept. 21, 2015).}


\textsuperscript{123} 42 U.S.C. § 1395ff(c)(3)(C)(ii) (2010); Adjudication Timeframes, \textit{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.

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. 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. 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. 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. This threat increases pressure on small providers to consolidate with larger chains to compete in the market. 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. 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 (“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.”).


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


134. Id.


136. See Ginsburg, supra note 134.


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/.


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.


145. See id.


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. 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. 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. 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.

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. The short-term deprivation of needed funds impacts even those providers that can better manage the financial hardship associated with the backlogs. Providers of all kinds are forced to make sacrifices—often at the expense of patients and employees—to offset the setback. 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,

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).


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.


153. RECOVERY AUDITING, supra note 1, at v-vi.

or purchase other necessary capital items.” Other facilities claim that they are forced to turn away patients, cut needed services, and eliminate jobs to endure the short-term loss. 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. Nonintervention can harm patients when necessary care is delayed or avoided. 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. Overtreatment is similarly problematic because it can expose patients to unnecessary risks and lead to overspending. 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. 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

158. See RACS: STRATEGIES TO REDUCE YOUR RISK AND SUCCESSFULLY APPEAL PAYMENT DENIALS 1, 33 (Erin Trompeter ed., 2010).
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.” 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. 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. 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.

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. Second, the program was only offered to certain kinds of hospitals and hospital chains; therefore, it excluded many providers, including small


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


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.\(^\text{173}\) OMHA will employ and train these attorney adjudicators.\(^\text{174}\) Their decisions would carry the same weight as ALJs, but they could rule only on issues that do not require an evidentiary hearing.\(^\text{175}\) 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.\(^\text{176}\) The 600,000 pending appeals heavily overshadow that number.\(^\text{177}\) 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.\(^\text{178}\) 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.\(^\text{179}\) Precedential DAB decisions would be published in the federal register and would be binding on the first three levels of the System.\(^\text{180}\) 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.\(^\text{181}\) Though the hope is that this proposal would reduce adjudicators’ time and effort, the Rule provides no estimate for the impact of precedential decisions.\(^\text{182}\) This proposal is unlikely to seriously combat the severity of the appeals backlog, especially in the short term.

\(^{173}\) Id. \(\text{at} \) 4,981-82.

\(^{174}\) Id. \(\text{at} \) 4,983.

\(^{175}\) Id. \(\text{at} \) 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. \(\text{at} \) 5,104.


\(^{178}\) Medicare Program: Changes to the Medicare Claims, 82 Fed. Reg. at 4,977.

\(^{179}\) See id.

\(^{180}\) Id.


\(^{182}\) 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.\(^\text{183}\) 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.\(^\text{184}\) 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.\(^\text{185}\) And the government provides no estimate for how this suggestion would reduce the appeals backlog.\(^\text{186}\) Though CMS also proposed other administrative tweaks to the System, none of them were associated with a measurable reduction in the appeals backlog.\(^\text{187}\)

CMS estimated that its Rule would remove fewer than 30,000 appeals per year from the System.\(^\text{188}\) 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,\(^\text{189}\) 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).\(^\text{190}\) The agency’s solutions are failing, and it is impossible 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.\(^\text{191}\) This budget would have required Congress to more than double the current funding at

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183. Id. at 5,043.

184. See id. at 5,045.

185. MEDICARE OVERPAYMENTS, supra note 47, at 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.


191. HHS PRIMER, supra note 3.
a time when budgets are strapped.\textsuperscript{192} As expected, Congress did not grant this request, and OMHA’s budget for 2017 stayed stable at $107 million.\textsuperscript{193} Congress also refused to grant the agency’s request for a funding increase in 2015 and 2016.\textsuperscript{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.\textsuperscript{195}

Under the second legislative proposal, the agency suggested that Congress institute legislative reforms to reduce the number of appeals needing review.\textsuperscript{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.\textsuperscript{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.\textsuperscript{198} It is no longer active,\textsuperscript{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.\textsuperscript{200} The AFIRM Act did not recommend any substantive changes to the RAP program, a fact that frustrated providers.\textsuperscript{201} It did, however, propose to increase OMHA’s

\textsuperscript{192} Id. at 8.
\textsuperscript{197} \textit{HHS PRIMER}, \textit{supra} note 3, at 9.
\textsuperscript{199} \textit{Id}.
\textsuperscript{200} \textit{Id}.
\textsuperscript{201} \textit{Id}.
budget and track the RAP reversal rates to maintain better quality control over the program.\textsuperscript{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:

[\textit{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.\textsuperscript{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.”\textsuperscript{204} Two other bills modifying the RAP were introduced in 2012 and 2013 and similarly never made it out of committee.\textsuperscript{205}

On May 23, 2017, the President released his FY2018 President’s Budget.\textsuperscript{206} It included a series of legislative proposals to curb the appeals backlog.\textsuperscript{207} First, it proposed to remand appeals back to the Redetermination stage if the appellant introduces new evidence.\textsuperscript{208} Second, like the AFIRM Act, it proposed to increase the amount-in-controversy requirement to $1,560, with annual increases.\textsuperscript{209} Third, it proposed to establish magistrate adjudication.\textsuperscript{210} And finally, it proposed to expedite claims that lack material factual disputes.\textsuperscript{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).\textsuperscript{212} Nevertheless, there has been no indication from Congress

\textsuperscript{202} Id.


\textsuperscript{204} Id. at 16.


\textsuperscript{207} Id.

\textsuperscript{208} Id. at 5.

\textsuperscript{209} Id.

\textsuperscript{210} Id.

\textsuperscript{211} Id. at 5-6.

\textsuperscript{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).


215. See LIMITATION ON RECOUNPMENT, 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 Judgment 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.
219. Id.
220. Defendant’s Motion for Summary Judgment at 13, D & G Holding, 156 F. Supp. 3d. at 798.
221. Id.
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. 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.

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. 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. Second, providers have brought due process challenges aimed at delaying recoupment until after providers have been afforded an ALJ hearing. 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.”).


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. On the other hand, small providers under threat of bankruptcy have typically sued under the Due Process Clause. 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.

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. 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. 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 remedy.


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.
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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. 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.

This opinion came after the Fourth Circuit considered the same issue months earlier and held it lacked jurisdiction to hear a mandamus action. 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. The district court refused to grant the agency’s stay 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. 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.
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.”

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. And because the judiciary cannot order the government to do the impossible, the district court was required to first decide possibility. 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.” 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. 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. The agency argued recently before the D.C. Circuit that

240. Id. at *8.
242. Id.
settlement was its only option for compliance with the writ, and that it might be forced to settle frivolous claims at a significant loss.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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

\textsuperscript{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.

\textsuperscript{247} Id. at 177 (Henderson, J., dissenting) (noting that a provider’s financial exigency unfairly weakens its bargaining power).

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


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) . . . .

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* 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. *Mathews* constrained *Goldberg*'s holding by limiting the incidences in which agencies must provide a pre-deprivation hearing. 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.

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.

*Mathews* did not overturn *Goldberg*. 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.

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256. Mathews, 424 U.S. at 342.
257. Id. at 335.
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.  

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).  

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.

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.” 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.” 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

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261. Id. at 343-44 (“[A medical assessment] is a more sharply focused and easily documented decision than the typical determination of welfare entitle-ment. 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.  


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

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 businesses\textsuperscript{266} to face the corporate equivalent of the harm announced in \textit{Goldberg}: bankruptcy.\textsuperscript{267} According to \textit{Goldberg}, when a property deprivation threatens the “very means by which to live while [the beneficiary] waits,” the deprivation is severe.\textsuperscript{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.\textsuperscript{269}

Another factor that can impact severity is the length of the delay.\textsuperscript{270} If the delay is so long that a party cannot be heard “at a meaningful time,” then the deprivation is more severe.\textsuperscript{271} In \textit{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.\textsuperscript{272} The delays faced by

\begin{itemize}
\item \textsuperscript{266} A Medicare provider’s due process challenge affects businesses as opposed to the individuals affected in \textit{Goldberg} and \textit{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.’”).
\item \textsuperscript{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.
\item \textsuperscript{268} \textit{Goldberg}, 397 U.S. at 340.
\item \textsuperscript{269} \textit{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).
\item \textsuperscript{270} \textit{Mathews}, 424 U.S. at 341-42 (quoting Fusari v. Steinberg, 419 U.S. 379, 389 (1975)).
\item \textsuperscript{271} \textit{Mathews}, 424 U.S. at 333.
\item \textsuperscript{272} \textit{Id.} at 341-42.
\end{itemize}
Medicare providers are years longer than those at issue in Mathews and grow every month. 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.” The fundamental inquiry is whether adding procedural protections before property deprivation will improve the reliability of the outcomes. 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. 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.” It is undisputed that an ALJ hearing is the first point that providers can present evidence and raise their arguments orally before an arbiter. 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...” As the GAO noted, ALJ hearings “provide an opportunity for appellants to explain the rationale for the medical treatment.” 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.” 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.
mission includes protecting the Medicare trust funds and identifying potential overpayments. 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. In Mathews, the Court found that ALJs only reverse 3.3 percent of appeals involving a person’s eligibility for disability benefits. 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. 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.” 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.” 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%.”).
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. 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. 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.

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, 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. Second, the agency has a strong self-help mechanism against providers to ensure it will be paid back: recoupment. 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. 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 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.
293. Id.
294. Id.
prior to an ALJ hearing. 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.”

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:

Plaintiff 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.

Both cases settled shortly after the injunctions were issued and were therefore not litigated fully on the merits. 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. Under Section 405(h),

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

298. Id. at 817.


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. 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). 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. 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; nevertheless, the D&G court allowed the plaintiff to bypass 405(h) under the collateral claim exception. 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


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. 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. 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. The legislature creates property interests, but federal courts define the scope of the Constitution’s due process protection. 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.” The *Loudermill* court explicitly rejected Justice Rehnquist’s view in *Arnett v. Kennedy* that when a legislature grants a substantive right, plaintiffs must accept the limitations placed upon it. 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.


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.”).

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 \textit{D&G} and \textit{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 \textit{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 \textit{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.”).

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.