THE COLLATERAL-CLAIM EXCEPTION: A UNIQUE SOLUTION TO THE HARMFUL BACKLOG OF MEDICARE APPEALS

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I. INTRODUCTION

Providers and suppliers billing under Medicare are subject to audits when they submit claims for payment.[1] When an overpayment determination has been made and the recoupment process has begun, providers and suppliers are often desperate to appeal.[2] However, because of aggressive initiatives to strengthen the Medicare program, the appeals process has become backlogged, causing what was once a speedy and simple process to become lengthy and economically damaging.[3]

The backlog has trapped providers between the second and third stage of the appeals process for three to five years—in blatant violation of 42 U.S.C. § 1395ff(d)(1)(A).[4] Simply put, because providers and suppliers are unjustifiably being recouped during the three to five year waiting period, they are scrambling to seek redress. A recent court decision, *Family Rehabilitation v. Azar*, posed an interesting and novel solution to the prolonged recoupment period stemming from the backlog: using the collateral-claim exception.[5]

By showing that a constitutional violation has occurred and is entirely collateral to the backlog of appeals, and that full relief would not be attainable at a post-deprivation hearing, providers and suppliers have an avenue to lessen the severe economic damage arising from the

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1. 42 U.S.C. § 1395ff *et seq.* (2014).

2. *MLN Fact Sheet: Medicare Overpayments*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2019), https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/overpaymentbrochure508-09.pdf [http://web.archive.org/web/20200307144544/https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/overpaymentbrochure508-09.pdf] ("A Medicare overpayment is a payment that exceeds amounts properly payable under Medicare statutes and regulations.").

3. In 2014, the Centers for Medicare and Medicaid Services (CMS) acknowledged that a backlog of appeals was beginning to form. The Department of Health and Human Services (HHS) identified four primary reasons for the backlog: (1) more beneficiaries; (2) updates to Medicare and Medicaid coverage and payment rules; (3) growth in appeals from state Medicaid agencies; and (4) national implementation of the Medicare Fee-For-Service (FFS) Recovery Audit Program. The preceding four reasons plus the lack of funds from Congress to increase the average number of administrative law judges (ALJs) have all contributed to this significant backlog of appeals. *HHS Primer: The Medicare Appeals Process*, U.S. DEP'T OF HEALTH & HUM. SERVS. 4–6, https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf [http://web.archive.org/web/20200307153151/https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf].

4. 42 U.S.C. § 1395ff(d)(1)(A). An ALJ must render a decision within 90 days of the request for hearing. *Id.*

5. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *3 (N.D. Tex. June 28, 2018).

backlog.[6] This Note will focus on the collateral-claim exception and how the exception can grant providers and suppliers jurisdiction into a federal district court prior to exhausting all the administrative remedies—a requirement set forth in the Social Security Act.[7] This Note will also discuss why escalation to the Medicare Appeals Council is not a sufficient alternative to the collateral-claim exception.

II. BACKGROUND

A. Medicare Appeals Process

Although Medicare overpayments are relatively common, they can lead to steep penalties if not dealt with after they are discovered. Any discovered overpayment over $25 will trigger the provider's or supplier's Medicare Administrative Contractor (MAC)[8] to initiate the overpayment recovery process. Generally, a MAC will send a demand letter to the provider or supplier, requesting that the overpaid amount be returned.[9] However, while a MAC has the authority to initiate the overpayment recovery process, it is generally understood by every provider and supplier that they must self-monitor payments from Medicare, and report and return any overpayment within 60 days of identifying the overpayment.[10]

While not every provider chooses to appeal a determination of overpayment, and there are other avenues to address an overpayment,

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6. *Id.* at *4.

7. 42 U.S.C. § 405(g)–(h) (2018).

8. A MAC is a private health care insurer that has been assigned a geographic "jurisdiction" to oversee. MACs process Medicare Part A, B, and Durable Medical Equipment (DME) claims for FFS beneficiaries. Because they process all Medicare FFS claims, they are the ones responsible for beginning the Medicare appeals process. *What is a MAC and What do they do?*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html [http://web.archive.org/web/20200307154143/https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC] (last modified Dec. 13, 2019).

9. *CMS Manual System: Recovery Audit Program MAC-issued Demand Letters*, DEP'T OF HEALTH & HUM. SERVS. & CTRS. FOR MEDICARE & MEDICAID SERVS. (2012), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R202FM.pdf [http://web.archive.org/web/20200307154418/https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R202FM.pdf] ("While [MACs] have been responsible for the issuance of demand letters throughout the demonstration . . . this Change Request shifts the responsibility to the MACs.").

10. 42 U.S.C. § 1320a-7k(d)(1)–(2) (2010).

this Note specifically addresses the issues arising out of appealing an overpayment. An appeal occurs when a provider or supplier disagrees with an overpayment determination by the MAC.[11] When a provider has been audited for overpayment, the provider may go through as many as five levels of appeal:

(1) Redetermination by a MAC;[12]

(2) Reconsideration by a Qualified Independent Contractor (QIC);[13]

(3) An Administrative Law Judge (ALJ) hearing;[14]

(4) A hearing before the Medicare Appeals Council (hereinafter, "Council");[15] and

(5) Judicial Review in a federal district court.[16]

Redetermination is the first level in the appeals process.[17] A request for redetermination must be filed within 120 days of receiving notice of an initial determination.[18] MAC personnel not involved in the initial determination conduct redetermination.[19] Reconsideration is the second level of appeals and is conducted by a QIC.[20] Reconsideration must be filed within 180 days of receiving notice of the redetermination decision.[21] The third level of appeals is an ALJ hearing, administered by the Office of Medicare Hearings and Appeals (OMHA), where providers,

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11. *First Level of Appeal: Redetermination by a Medicare Contractor*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor.html [http://web.archive.org/web/20200307154824/https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/RedeterminationbyaMedicareContractor] (last modified Nov. 15, 2019) ("Any party . . . that is dissatisfied with the decision may request a redetermination.").

12. 42 U.S.C. § 1395ff(a)(3)(A) (2014).

13. 42 U.S.C. § 1395ff(c), (g); 42 C.F.R. § 405.904(a)(2) (2017).

14. 42 U.S.C. § 1395ff(d); 42 C.F.R. § 405.1000(d) (2017).

15. 42 C.F.R. § 405.1100 (2017).

16. 42 U.S.C. § 1395ff(b)(2)(C).

17. 42 U.S.C. § 1395ff(a)(3)(A) (2014).

18. 42 U.S.C. § 1395ff(a)(3)(C)(i).

19. 42 C.F.R. § 405.948 (2005) ("A redetermination consists of an independent review of an initial determination . . . . An individual who was not involved in making the initial determination must make a redetermination.").

20. 42 U.S.C. § 1395ff(c)(3)(B)(i).

21. 42 U.S.C. §§ 1395ff(b)(1)(A), 1395ff(b)(1)(D)(i).

attorneys, and expert witnesses participate on behalf of the audited provider.[22] The request for an ALJ hearing must be filed within 60 days following receipt of the reconsideration decision.[23] The fourth level of appeal—and the final administrative remedy—is the Council review, which is held within the Department Appeals Board of the U.S. Department of Health and Human Services (HHS).[24] This appeal must be filed within 60 days following receipt of the ALJ decision and must meet a specific amount in controversy.[25] The fifth and final level of appeal is to a federal district court, which must be filed within 60 days from the receipt of the Medicare Administrative Council's decision.[26]

The Centers for Medicare and Medicaid Services (CMS) is statutorily required to provide an appellant an ALJ hearing—the third level of appeal—within 90 days of the hearing being requested.[27] However, due to an extreme backlog, ALJ hearings are now occurring three to five years post-filing for appeal.[28] Though recoupment can be stayed during the first two levels of appeal, CMS may begin recouping during the waiting period for the ALJ hearing.[29]

Recoupment is the recovery by CMS of any outstanding Medicare debt—in this instance, debt caused by overpayments to providers and suppliers—by reducing Medicare payments and applying the amount withheld to the amount the provider owes in debt.[30] With the ever-increasing waiting period for an ALJ hearing—in clear violation of the statute—providers are being put at risk of serious financial deprivation.[31] It is difficult for providers to seek redress when the Social Security Act prohibits judicial relief until all administrative remedies have been

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22. *Office of Medicare Hearings and Appeals (OMHA)*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/agencies/omha/index.html [http://web.archive.org/web/20200307170816/https://www.hhs.gov/about/agencies/omha/index.html] (last reviewed Jan. 8, 2019).

23. 42 C.F.R. § 405.1014(a)(3)(ii) (2019).

24. 42 U.S.C. § 1395ff(d)(2)(A) (2014).

25. 42 C.F.R. § 405.1102(a)(1) (2017); Medicare Program; Medicare Appeals; Adjustment to the Amount in Controversy Threshold Amounts for Calendar Year 2019, 83 Fed. Reg. 47,619 (Sept. 20, 2018) (noting that the current amount in controversy for Council review is $1000).

26. 42 U.S.C. § 1395ff(b)(2)(C)(ii)(I)–(II).

27. 42 U.S.C. § 1395ff(d)(1)(A).

28. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *2 (N.D. Tex. June 28, 2018) ("[A]s of September 1, 2017, there were 595,000 outstanding claims for adjudication. Family Rehab contends that its appeal will not be heard by an ALJ for three to five years."); *see also* Infinity Healthcare Serv., Inc. v. Azar, 349 F. Supp. 3d 587, 597 (S.D. Tex. 2018).

29. 42 U.S.C. § 1395ddd(f)(2) (2016); 42 C.F.R. § 405.371(a)(3) (2019).

30. 42 C.F.R. § 405.370(a) (2011).

31. *Family Rehab.*, 2018 WL 3155911, at *5.

exhausted (the first four levels of appeal) and the Secretary of HHS has rendered a final decision on the claim.[32] These provisions arising under the Social Security Act that require a full administrative appeal prior to judicial appeal create an exception to the general grant of federal question jurisdiction from 28 U.S.C. § 1331.[33]

In the prolonged period in which providers and suppliers must wait to exhaust all those remedies, they may be deprived of income that keeps their businesses operational. Up to five years of withheld payments is extremely detrimental to providers who primarily rely on Medicare payments for their business.[34]

B. Collateral-Claim Exception

The collateral-claim exception is the proper way in which a judicial tribunal may obtain jurisdiction over a Medicare claim before all the administrative remedies have been exhausted.[35] The judicial tribunal may then grant a temporary restraining order (TRO) and preliminary injunction against CMS, ordering CMS to stay the recoupments until an ALJ hearing has occurred.[36] In a sense, the collateral-claim exception is the key for providers and suppliers to obtain quick relief from a judicial tribunal while in the prolonged waiting period for the ALJ hearing. The collateral-claim exception was first set out in *Mathews v. Eldridge*, where the United States Supreme Court held that the collateral-claim exception applies to claims (1) "that are 'entirely collateral' to a

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32. 42 U.S.C. § 405(g)–(h) (2019).

33. By enacting 42 U.S.C. § 405(h), Congress limited the otherwise proper federal court jurisdiction permitted by 28 U.S.C. § 1331. "No action against the United States, the [Commissioner], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter."

34. *Medicare Fin. Mgmt. Manual: Chapter 4 – Debt Collection*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2019), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c04.pdf [http://web.archive.org/web/20200307171410/https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c04.pdf]. In addition to withholding payments as a form of collecting overpayments, CMS will sometimes also offer an Extended Repayment Schedule (ERS). However, ERSs are discretionary, and many overpayments are so large that a payment plan will not be sufficient. Thus, this Note is looking specifically at providers and suppliers who will not be able to have a payment plan.

35. Family Rehab., Inc. v. Azar, 886 F.3d 496, 501 (5th Cir. 2018) ("[Collateral-claim] jurisdiction may lie over claims (a) that are 'entirely collateral' to a substantive agency decision and (b) for which 'full relief cannot be obtained at a postdeprivation [sic] hearing.'") (citation omitted).

36. *Family Rehab.*, 2018 WL 3155911, at *7.

substantive agency decision" and (2) for which "full relief cannot be obtained at a post-deprivation hearing."[37]

Furthermore, for a claim to be collateral, the judicial intervention must not require the court to become involved with the merits of the underlying Medicare claim.[38] Additionally, the relief sought must be relief unavailable through the administrative process.[39] Attorneys should keep in mind recent court decisions when structuring arguments for clients who are going through a Medicare audit and experiencing extreme hardship while being recouped for a prolonged period of time. The next section of this Note examines recent cases that discuss the backlog and have applied the collateral-claim exception.

C. Recent Rulings and Court Decisions

1. American Hospital Association v. Burwell

In 2014, the American Hospital Association (AHA) filed suit against the Secretary of HHS, asking the court to issue a writ of mandamus to compel ALJs to comply with statutorily imposed deadlines.[40] Plaintiffs suggested that the administrative appeals process did not have any issues with meeting deadlines until the implementation of the Medicare Recovery Audit Program, which aimed to more diligently identify Medicare overpayments and recoup them.[41] Plaintiffs contended that although the program may have been successful, it led to a large influx of

37. Family Rehab., Inc., 886 F.3d at 501 (citations omitted); Mathews v. Eldridge, 424 U.S. 319, 330–32 (1976).

38. 42 U.S.C. § 405(g)–(h) (2019); 42 U.S.C. § 1395ff(b)(1)(A) (2014).

39. 42 U.S.C. § 405(g)–(h); 42 U.S.C. § 1395ff(b)(1)(A).

40. Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43 (D.D.C. 2014). Throughout the history of this case, the named defendant has changed multiple times. After the 2014 case, the following cases emerged: *American Hospital Ass'n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016) reversed the 2014 D.C. District Court case and remanded to *American Hospital Ass'n v. Burwell*, No. 14-851, 2016 WL 7076983 (D.D.C. Dec. 5, 2016), which reversed the 2016 D.C. Circuit Court case. *American Hospital Ass'n v. Burwell*, No. 14-851, 2017 WL 6209175 (D.D.C. Jan. 4, 2017) refused reconsideration of the 2016 D.C. District Court case. *American Hospital Ass'n v. Price*, 867 F.3d 160 (D.C. Cir. 2017) vacated the 2017 D.C. Circuit Court case and vacated and remanded the 2016 D.C. District Court case. *American Hospital Ass'n v. Azar*, No. 14-851, 2018 WL 5723141 (D.D.C. 2018) is the most recent case. The most current case has the defendant listed as "Azar" rather than "Burwell," the defendant named in the initial proceedings. For the sake of consistency, the text of this Note will refer to "*AHA v. Burwell*," but the endnotes will indicate the various stages of this case with different named defendants.

41. *Burwell*, 76 F. Supp. 3d at 47.

Medicare appeals—more than OMHA was able to process in the statutorily allotted time frame.[42]

On November 1, 2018, after the AHA matter had already been remanded from the D.C. Circuit Court twice, the district court finally came to a decision.[43] The final ruling imposed a timetable for reducing the backlog of appeals.[44] The timetable required 19% of the appeals to be cleared by the end of fiscal year (FY) 2019; 49% cleared by the end of FY 2020; 75% cleared by the end of FY 2021; and the complete elimination of the backlog by the end of FY 2022.[45] The district court was tasked by the D.C. Circuit Court with hearing from HHS and deciding whether HHS could lawfully comply with the timetable order.[46] In March 2018, Congress appropriated over $182 million to address the backlog, leading to the court's conclusion that HHS could meet the timetable.[47]

With this recent ruling, it is expected that CMS will likely continue to reduce the backlogs. However, there will still be four years before the backlog is completely eliminated, assuming that HHS can comply with the order.[48] The order also indicated that if Congress reduces HHS funding such that it could no longer comply with the timetable, HHS may seek a modification of the order.[49] If the funding is reduced, that could lead to the backlog lasting longer than the order's timetable currently sets forth.

With the uncertainty of the backlog looming, attorneys and audit providers and suppliers need guidance on how to approach Medicare audit appeals that may lead to bankruptcy—an irreparable injury. Even if the backlog is resolved by 2022, that still leaves a significant portion of time where providers and suppliers may face imminent bankruptcy and can be recouped.

2. Family Rehabilitation, Inc. v. Azar

Family Rehabilitation provides guidance on what providers and suppliers should do when the prolonged recoupment period is causing

42. *Burwell*, 812 F.3d at 187.
43. *See American Hosp. Ass'n v. Azar*, 2018 WL 5723141.
44. *Id.* at *4 (granting mandamus relief of imposing the timetable against HHS).
45. *Id.* at *3.
46. *Burwell*, 812 F.3d at 193.
47. *American Hosp. Ass'n v. Azar*, 2018 WL 5723141, at *2.
48. *Id.* at *1.
49. *Id.* at *3 ("Should a change in circumstances—not limited to an appropriations shortfall—render lawful compliance with the order impossible, therefore, Defendant can return and request modification at that time.").

irreparable harm.[50] *Family Rehabilitation* was decided on June 28, 2018, after nearly a year of legal hurdles.[51] Family Rehabilitation, Inc. (hereinafter, "Family Rehab") is a home health agency (HHA) that relies primarily on Medicare for its income.[52] A MAC determined that CMS overpaid Family Rehab by $7.5 million and issued a demand letter against Family Rehab.[53] Family Rehab timely appealed through the redetermination and reconsideration process—the first two phases of administrative appeal.[54] On October 24, 2017, Family Rehab requested a hearing in front of an ALJ, the third step in the Medicare appeals process.[55] Though the ALJ hearing was not held within the statutorily prescribed 90-day period, CMS nevertheless began recouping the alleged overpayments.[56] Soon thereafter, Family Rehab filed a motion for a TRO and preliminary injunction against CMS to stay recoupment.[57] Although the district court originally denied the motion, the Fifth Circuit reversed, citing the "collateral-claim exception" as an avenue for jurisdiction.[58]

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50. *See* Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911 (N.D. Tex. June 28, 2018).

51. The original case was filed on October 31, 2017 in the Northern District of Texas. The motion for a preliminary injunction and a temporary restraining order (TRO) was denied, and the case was dismissed for lack of jurisdiction. Family Rehab., Inc. v. Hargan, No. 3:17-CV-3008-K, 2017 WL 6761769 (N.D. Tex. Nov. 2, 2017). Family Rehab then appealed to the Fifth Circuit, where the court reversed and remanded Family Rehab's due process claims on the basis that the collateral-claim exception permitted jurisdiction. Family Rehab., Inc. v. Azar, 886 F.3d 496 (5th Cir. 2018). The Northern District of Texas then heard the case again, holding that Family Rehab is entitled to a TRO, but it did not immediately decide on the issue of a preliminary injunction. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 2670730, at *3 (N.D. Tex. June 4, 2018). A few weeks after the June 4 decision granting the TRO and after a hearing, the Northern District of Texas also granted the preliminary injunction. *Family Rehab.*, 2018 WL 3155911, at *7.

52. *Family Rehab.*, 2018 WL 3155911, at *3.

53. *Id.* at *2–3. There were originally 43 claims at issue, with an alleged overpayment of $124,107.53. After an extrapolation was conducted, it was determined that Family Rehab owed CMS about $7.8 million in overpayments. Family Rehab eventually made its way through the redetermination and reconsideration levels of appeal, and the number dropped to $7,622,122.31. Family Rehab appealed to the ALJ on October 24, 2017, and CMS began recouping the large sum on November 1, 2017.

54. *Id.* at *2.

55. *Id.* at *3.

56. *Id.* at *4.

57. *Id.* at *1.

58. *Id.*

a. Family Rehabilitation's Four-Step Analysis to Determine Whether a Preliminary Injunction is Proper[59]

i. Substantial Likelihood of Success on the Merits

Family Rehab claimed that because CMS failed to provide an ALJ hearing within the statutorily prescribed 90-day period, but nonetheless began recouping, Family Rehab would likely succeed on the underlying claim of inadequate procedural due process.[60] An ALJ hearing three to five years from the point of recoupment would render a post-deprivation hearing useless because the damage would be substantial by then.[61] The court weighed three factors to be certain about the success on the procedural due process claim: (1) the private interests that will be affected; (2) the risk of an erroneous deprivation of such interest; and (3) the Government's interest.[62] The court found that Family Rehab had a clear property interest in the Medicare payments for services rendered, that the fact that Family Rehab would go out of business before the ALJ hearing occurs showed an erroneous deprivation of the property interest, and that the Government's small interest did not outweigh Family Rehab's ongoing deprivation of property interest.[63]

ii. Irreparable Injury

Family Rehab claimed irreparable injury if the recoupment was not stayed because it would force Family Rehab to close its business before the ALJ hearing even takes place.[64] In order for a motion for preliminary injunction to be granted, there must be "a significant threat of injury . . . the injury [must be] imminent, and . . . money damages would not fully repair the harm."[65] The prolonged recoupment of Medicare funds had caused Family Rehab to lay off the majority of its employees and it could now only afford to provide home healthcare to eight patients, leaving 281

59. *Id.* at *4–7; Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 2670730, at *2–3 (N.D. Tex. June 4, 2018). Both cases went through the analysis required for a preliminary injunction and came to the same conclusion that the plaintiff was deprived of procedural due process. The 2018 WL 2670730 case only granted the TRO and set a later date for determination on the preliminary injunction. The 2018 WL 3155911 case subsequently granted the preliminary injunction.

60. *Family Rehab.*, 2018 WL 3155911, at *4.

61. *Id.* at *5.

62. Mathews v. Eldridge, 424 U.S. 319, 335 (1976).

63. *Family Rehab.*, 2018 WL 3155911, at *4–6; *see infra* Section III.D.

64. *Family Rehab.*, 2018 WL 3155911, at *6.

65. *Id.* (citing Humana, Inc. v. Jacobson, 804 F.2d 1390, 1394 (5th Cir. 1986)).

of its previous patients to find a new HHA.[66] This demonstrated to the court that Family Rehab had suffered a clear irreparable injury, and thus the irreparable injury requirement was met.[67]

iii. Weighing the Balance of Injury to the Parties

If the recoupment was not stayed, Family Rehab would go bankrupt—having to close its business, lay off employees, and force hundreds of patients to find a new HHA.[68] There is no doubt that Family Rehab would suffer a harm far greater than the Government would.[69] The Government would suffer no harm, because if the ALJ decides in its favor, it will be able to recoup the alleged overpayments after the hearing. If the ALJ decides in favor of Family Rehab, then the Government would have to refund the money rightfully owed to Family Rehab, leaving no loss to the Government. It was very clear to the court that the harm presented to Family Rehab was much more significant than the harm presented to the Government.[70]

iv. Public Interest

The court was brief in the public interest analysis, stating that "no public interest would be adversely affected by granting the preliminary injunction. If anything, the public would benefit from continued access to Family Rehab's home healthcare services."[71]

b. The Family Rehabilitation Holding

Because Family Rehab would likely be forced to immediately and permanently close if the injunctive relief was not granted, the court granted the preliminary injunction and ordered CMS to be restrained and enjoined from withholding Medicare payments and receivables until the ALJ had heard the case and rendered a decision.[72] This decision was the first of its kind, where the judiciary successfully intervened in the administrative process with injunctive relief. Following the success of *Family Rehabilitation*, two more cases surfaced holding in the same

66. *Id.*
67. *Id.* at *7.
68. *Id.* at *6.
69. *Id.* at *7.
70. *Id.*
71. *Id.*
72. *Id.*

way.[73] *Adams EMS* and *Accident, Injury & Rehab* both based their decisions on the *Family Rehabilitation* analysis and granted the TRO and preliminary injunction against CMS to stay recoupment until an ALJ hearing has occurred.[74]

3. Adams EMS v. Azar

The *Adams EMS* opinion came out shortly after the *Family Rehabilitation* opinion.[75] Adams EMS was an ambulance company that participated as a supplier for Medicare.[76] Medicare began recouping the alleged overpayment of $418,035 from Adams EMS, which led Adams EMS to seek injunctive relief.[77]

The court discussed the escalation option, which is available when an ALJ fails to hear a case within 90 days.[78] If escalation is invoked, the provider or supplier can escalate an appeal to the Council.[79] However, after the escalated appeal to the Council occurs, the Council then has another 180 days to issue a final decision.[80] As the *Adams EMS* court stated, this could still lead to 270 days of recoupment, which may be extremely detrimental to a business.[81] The *Adams EMS* court found that the escalation procedures[82] would not provide the type of constitutional protection that the ALJ hearing would, because the escalation procedures do not require the Council to conduct a hearing.[83] Thus, because the escalation might lead to a high likelihood of deprivation of property, and because Adams EMS met all of the four *Family Rehabilitation* factors,[84] the court granted the TRO.[85]

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73. Adams EMS, Inc. v. Azar, No. H-18-1443, 2018 WL 3377787 (S.D. Tex. July 11, 2018); Accident, Injury and Rehab., PC v. Azar, No. 18-cv-02173-DCC, 2018 WL 3980212 (D.S.C. Aug. 21, 2018).

74. *Adams EMS*, 2018 WL 3377787; *Accident, Injury & Rehab.*, 2018 WL 3980212.

75. *See Family Rehab.*, 2018 WL 3155911, at *1 (decided on June 28, 2018); *Adams EMS*, 2018 WL 3377787, at *1 (decided on July 11, 2018).

76. *Adams EMS*, 2018 WL 3377787, at *1.

77. *Id.*

78. *Id.* at *1–2 (citing Family Rehab., Inc. v. Azar, 886 F.3d 496, 499–500 (5th Cir. 2018)).

79. 42 C.F.R. § 405.1016(f)(1) (2017).

80. 42 C.F.R. § 405.1100 (2017).

81. *Adams EMS*, 2018 WL 3377787, at *2.

82. 42 U.S.C. § 1395ff(d)(3)(A) (2014).

83. *Adams EMS*, 2018 WL 3377787, at *4; 42 C.F.R. § 405.1108(d) (2017).

84. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *4–7 (N.D. Tex. June 28, 2018).

85. *Adams EMS*, 2018 WL 3377787, at *6.

4. Accident, Injury and Rehabilitation v. Azar

Accident, Injury and Rehabilitation v. Azar came out shortly after *Adams EMS*.[86] In this case, plaintiff was a chiropractic practice which allegedly received overpayments totaling $6,648,877.92.[87] By the time plaintiff requested a hearing before an ALJ, CMS had already recouped over $1.8 million in Medicare payments.[88] The plaintiff not only lost around $6 million in gross revenue, but it also had to terminate twenty employees, and it was on the path to bankruptcy if the recoupments were not stayed.[89]

The court held that all four *Family Rehabilitation* factors were satisfied, and thus, granted the motion for a TRO.[90] The *Family Rehabilitation* line of cases leads to a pressing question: can similarly situated plaintiffs use the collateral-claim exception as a new viable option for obtaining redress?

III. ANALYSIS

When a provider or supplier is being audited by CMS and becomes trapped in the backlog of appeals, causing them to be recouped to the point of bankruptcy, the collateral-claim exception creates federal jurisdiction.[91] Collateral-claim cases do not require the court to examine factual determinations relating to the underlying Medicare claim, and courts can provide relief that is otherwise unavailable in the administrative process.[92] The relief sought in these cases is not a determination of whether the provider or supplier actually owed money to CMS, but rather a preliminary injunction and TRO are sought to prevent CMS from unconstitutionally depriving providers and suppliers of due process.[93]

If these providers and suppliers were not permitted to seek judicial relief prior to bankruptcy, then they would not be able to fully obtain

86. *See* Accident, Injury and Rehab., PC v. Azar, 336 F. Supp. 3d 599 (D.S.C. 2018).

87. *Id.* at 604 (noting $5,627,263.87 in part B claims and $1,021,614.05 in Durable Medical Equipment (DME) claims, totaling $6,648,877.92).

88. *Id.*

89. *Id.* at 605–06.

90. *Id.*

91. Family Rehab., Inc. v. Azar, 886 F.3d 496, 501 (5th Cir. 2018).

92. *Id.* ("For a claim to be collateral, it must not require the court to 'immerse itself' in the substance of the underlying Medicare claim or demand a 'factual determination'. . . .") (citations omitted).

93. *Id.* at 503 (noting that where providers and suppliers must close down their businesses—because of the prolonged recoupment period—there is a deprivation of due process because their property interest is being taken away from them).

relief at a post-deprivation hearing.[94] Courts need to provide relief to a provider or supplier who is looking at recoupment and interminable delay. The collateral-claim exception creates an avenue for providers and suppliers to sue the government and get an injunction.

AHA v. Burwell has significant implications for the backlog of appeals.[95] The court order requiring HHS to eliminate the Medicare appeals backlog by the end of FY 2022 could potentially end the prevalence of the collateral-claim exception with regard to these types of cases.[96] However, it should be noted that *AHA v. Burwell* did not impose a requirement to prevent backlogs in the future, after the current backlog is resolved.[97]

The caveat remains that HHS may be able to receive an extension for the backlog elimination if it runs out of sufficient funds to promulgate the efforts for backlog reduction.[98] This leaves the chance for backlog resolution to remain an issue indefinitely. Therefore, attorneys must be prepared to craft a collateral-claim case in the meantime. Attorneys should advise their clients to consider pursuing the collateral-claim exception avenue, especially if they have already been trapped in the backlog for a long period of time.

A. Why Does Mandamus Jurisdiction Not Work?

Some plaintiffs have attempted to seek mandamus relief, but courts have failed to recognize it as an appropriate form of relief for plaintiffs waiting in the backlog.[99] Mandamus jurisdiction does not exist when an adequate remedy in the administrative system is available.[100] Mandamus jurisdiction only exists if the action is an attempt to compel an officer or employee of the United States to perform a duty owed to the plaintiff.[101] Essentially, mandamus relief allows the court to order the defendant to complete an act.[102]

Despite the benefits that come with mandamus relief, it is not appropriate when all administrative remedies have not been exhausted—

94. *Id.* at 501.

95. Am. Hosp. Ass'n v. Azar, No. 14-851, 2018 WL 5723141, at *1 (D.D.C. Nov. 1, 2018).

96. *Id.* at *1.

97. Am. Hosp. Ass'n v. Burwell, 209 F. Supp. 3d 221 (D.D.C. 2016).

98. *Am. Hosp. Ass'n v. Azar*, 2018 WL 5723141, at *3.

99. *See Family Rehab.*, 886 F.3d at 506–07.

100. 55 C.J.S. *Mandamus* § 36 (2019).

101. 28 U.S.C. § 1361 (1962) ("The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.").

102. *Id.*

unless an exception has been statutorily carved out.[103] This is because one element of mandamus relief is the lack of other adequate remedies, which imposes the exhaustion requirement onto plaintiffs.[104] *Family Rehabilitation* rejected the precedent that in order to gain mandamus jurisdiction under the Mandamus Act,[105] *all* administrative remedies must be exhausted.[106] The court's concern was that this requirement would conflate jurisdiction with the merits of the case, which the courts staunchly avoid when reviewing a collateral-claim case.[107]

However, the court in *Family Rehabilitation* found that even if Family Rehab had exhausted all administrative remedies, it would still not have mandamus relief because it was not requested in Family Rehab's original complaint.[108] Family Rehab initially sought to enjoin CMS from recouping payments and did not seek compulsion of CMS to provide them with an ALJ hearing.[109] This leaves open the question whether the appellants would have been able to initially seek mandamus relief. Based on the uncertainty of whether mandamus jurisdiction would be appropriate in Medicare appeals cases, however, attorneys should use a proven method for establishing jurisdiction: the collateral-claim exception.

B. Why is the Collateral-Claim Exception Necessary?

The Administrative Procedure Act (APA) prevents individuals from seeking judicial review until all levels of administrative appeal have been exhausted.[110] An agency action only becomes judicially reviewable after a final agency action; however, this provision of the APA is not the sole consideration in determining whether someone *must* exhaust all forms of

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103. *Family Rehab.*, 886 F.3d at 506 (citing Jones v. Alexander, 609 F.2d 778, 781 (5th Cir. 1980)).

104. *Id.*

105. 28 U.S.C. § 1361.

106. *Family Rehab.*, 886 F.3d at 506.

107. *Id.*

108. *Id.*

109. *Id.* Although *Family Rehabilitation* took away the requirement of exhaustion for mandamus jurisdiction, the Fifth Circuit still did not permit mandamus jurisdiction in this instance because Family Rehab only requested injunctive relief in its complaint. Where relief is not requested in a complaint, the court will not allow new relief requested upon appeal. *See id.* at 507.

110. Darby v. Cisneros, 509 U.S. 137, 154 (1993) (holding that federal courts do not have the authority to require an aggrieved party to exhaust all administrative remedies before seeking judicial review under the APA, unless a relevant statute or agency rule specifically mandates exhaustion as a prerequisite to judicial review).

administrative remedies.[111] The APA makes clear that the exhaustion requirement is presumed applicable unless it is "expressly required by statute [or] by rule . . ." that exhaustion is not required.[112] Thus, one must look towards the agency rules or statutes that govern a particular administrative proceeding.[113]

Section 405(g) of the U.S. Code specifically requires a final decision of the Secretary after the last level of administrative appeals (the Council) before an administrative action can make its way to a federal district court.[114] Thus, the collateral-claim exception is one of the very few ways in which an appellant can make its way into district court before exhausting its administrative remedies.[115]

After the *Family Rehabilitation* line of cases,[116] only one case, *Infinity Healthcare Services, Inc. v. Azar* from the Southern District of Texas, has explicitly rejected the collateral-claim exception as a way around the exhaustion requirement because of the escalation option.[117] However, the court in *Family Rehabilitation* determined that escalation was not an adequate remedy for the providers and suppliers trapped in the backlog.[118]

Providers and suppliers have the option to escalate to the Council when an ALJ fails to issue a decision within the required 90 days.[119] The Council will review the reconsideration decision de novo.[120] If the

111. 5 U.S.C. § 704 (1966) ("Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review. A preliminary, procedural, or intermediate agency action or ruling not directly reviewable is subject to review on the review of the final agency action.").

112. *Id.* ("Except as otherwise expressly required by statute, agency action otherwise final is final for the purposes of this section whether or not there has been presented or determined an application for a declaratory order, for any form of reconsideration, or, unless the agency otherwise requires by rule and provides that the action meanwhile is inoperative, for an appeal to superior agency authority.").

113. *See id.*

114. 42 U.S.C. § 405(g) (2018).

115. Family Rehab., Inc. v. Azar, 886 F.3d 496, 503 (5th Cir. 2018).

116. *See* Accident, Injury and Rehab., PC v. Azar, 336 F. Supp. 3d 599 (D.S.C. 2018); Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911 (N.D. Tex. June 28, 2018); *see also* Adams EMS, Inc. v. Azar, No. H-18-1443, 2018 WL 3377787 (S.D. Tex. July 11, 2018).

117. Infinity Healthcare Serv., Inc. v. Azar, 349 F. Supp. 3d 587 (S.D. Tex. 2018).

118. *Family Rehab.*, 2018 WL 3155911, at *5.

119. 42 U.S.C. § 1395ff(d)(3)(A)–(B) (2014).

120. 42 C.F.R. § 405.1108(a) (2017). A plain reading of the language in this regulation makes it clear that the escalating party still does not have a right to a hearing before the Council.

Council also fails to provide a decision within the statutory period, then the provider or supplier may seek judicial review.[121]

Family Rehab did not see the escalation option as an alternative to the collateral-claim exception for two reasons: First, the requirement for an ALJ hearing to be held and for a decision to be rendered within 90 days is mandatory, whereas the escalation option is purely discretionary, thus, it cannot satisfy procedural due process.[122] Second, the escalation option takes away the opportunity for a provider or supplier to have an evidentiary hearing, so the Council would be forced to rely on the written record the QIC established in the reconsideration stage.[123]

The *Infinity* court wrongfully disagreed with this reasoning. It stated that the escalation option would get the provider or supplier to a federal court faster than the collateral-claim exception would,[124] and that it would allow the federal district court to review the merits of the claim.[125] Due to the escalation option and the incorrect determination that the plaintiff failed to meet the *Eldridge* requirements to demonstrate need for a preliminary injunction, Infinity Healthcare's motion for preliminary injunction and TRO was denied.[126]

The logic of *Infinity* is flawed because the court was content with declaring that a deprivation of an evidentiary hearing is not a violation of procedural due process. The court held that the plaintiff had redetermination and reconsideration to submit evidence, and an "oral hearing is not vital."[127] The court came to this conclusion by improperly comparing the facts and issues of *Eldridge* with the facts and issues in *Infinity*.[128]

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121. 42 U.S.C. § 1395ff(d)(3)(B).

122. *Family Rehab.*, 2018 WL 3155911, at *5.

123. *Id.*

124. Infinity Healthcare Serv., Inc. v. Azar, 349 F. Supp. 3d 587, 591 (S.D. Tex. 2018).

125. *Id.* at 597.

126. *Id.* at 605. Specifically, the court in *Infinity* held that the plaintiff did not meet the *Eldridge* standard because the plaintiff did not have a private interest affected by the official action. *Infinity* disagreed with the *Family Rehabilitation* holding that a plaintiff "has a property interest in the Medicare payments for services rendered." However, the *Family Rehabilitation* court also held that the plaintiff does not "have a property interest in a level of benefits that is greater than Congress provided." *Id.* at 596 (citation and internal quotation omitted). The *Infinity* court determined that the property interest is based on whether the plaintiff had or had not lawfully earned Medicare payments, which is beyond the scope of the constitutional issue that was before the court at the time. Further, even if the plaintiff had a private interest, the risk of deprivation was extremely small and thus not enough to satisfy the *Eldridge* factors. *Id.* at 598.

127. *Id.* at 599.

128. *Id.*

Eldridge was a case regarding a man, George Eldridge, who was disabled because of chronic anxiety and back strain.[129] His benefits were terminated because physicians attested to his improved condition through his medical records.[130] In *Eldridge*, the court determined that medical records indicating physicians' narratives, certifications, and treatment plans were "more amenable to written than to oral presentation," and so the lack of a pre-termination hearing was not a violation of procedural due process.[131] *Infinity* compared the holding from *Eldridge* and applied it to an entirely distinguishable factual scenario.[132] *Eldridge* was a case involving disability benefits and not one based on "financial need [or] issues of credibility and veracity," so the denial of benefits in that case could be adequately shown by medical records and documentation.[133]

Infinity overlooked a key distinction from *Eldridge*: an overpayment determination is a far more complex analysis than whether someone is eligible for disability or not. Overpayment determination requires an examination of numerous patients, the ability to learn numerous medical diagnoses, and an understanding of complex reimbursement rules.[134] This makes these types of decisions far more amenable to oral presentation. For example, 42 U.S.C. § 1395y(a) provides an exhaustive list of factors that providers and suppliers must consider before billing Medicare as a secondary payer, many of which force the providers and suppliers to make reasonable and necessary determinations.[135] Thus, a paper record is simply insufficient to convey the relevant information, such as why a provider or supplier made or did not make a medically necessary determination, to a court.

Further, *Infinity* states that the plaintiff failed to offer evidence as to why it needed an evidentiary hearing.[136] The plaintiff should not need to

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129. Mathews v. Eldridge, 424 U.S. 319, 324 n.2 (1976).

130. *Id.* at 324.

131. *Infinity*, 349 F. Supp. 3d at 599 (quoting *Eldridge*, 424 U.S. at 345).

132. *Id.* at 597. The court in *Infinity* was incorrect in using the written record standard from *Eldridge* as evidence that a written record would also be sufficient in the present matter. *Eldridge* was a plain and simple case as to whether a person was still disabled; it was not a delicate balance between qualifying for welfare or being recouped to the point of bankruptcy. Thus, the holding of *Eldridge* should be narrowly tailored to Social Security benefit cases where the sole question is whether or not a person is disabled.

133. *Eldridge*, 424 U.S. at 325.

134. *Medicare Fin. Mgmt. Manual: Chapter 3 - Overpayments*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2020), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf [http://web.archive.org/web/20200128015025/https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf].

135. 42 U.S.C. § 1395y(a) (2018).

136. *Infinity*, 349 F. Supp. 3d at 599 ("Plaintiff offered no plausible explanation why a live evidentiary hearing is necessary or helpful . . . .").

bring forth evidence as to why an evidentiary hearing is necessary when the hearing is statutorily required.[137] To suggest that a plaintiff must prove why they are entitled to a statutorily proscribed hearing is a dangerous precedent the *Infinity* court set, especially because the court used that logic to deprive the plaintiff of procedural due process, a fundamental right.

The *Family Rehabilitation* court reminds the Government that the escalation option is purely discretionary and not compulsory.[138] An in-person hearing is absolutely mandatory for providers and suppliers to explain their case.[139] Even *Infinity* contends that recourse in a federal court after escalation is questionable, but still declared that it is sufficient merely because the court can review the merits.[140]

AHA v. Burwell directly disagrees with that assertion and explicitly stated that escalation is not the proper solution for these types of plaintiffs.[141] While escalation may be adequate in other instances, the backlog of appeals is a systemic issue that must be addressed on a broad level. Further, escalation to the Council will not necessarily result in a timely hearing, because the Council is also facing a backlog.[142] Escalation to a district court would also be insufficient because a deferential review by a district court is not an adequate substitute for a de novo hearing before an ALJ.[143]

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137. 42 U.S.C. § 1395ff(d) (2014); 42 C.F.R. § 405.1000(d) (2017).

138. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *5 (N.D. Tex. June 28, 2018).

139. For a redetermination hearing, the information that may be submitted is: the contested beneficiary names, Medicare Health Insurance Claim number, specific services or items at issue, specific dates of the service, name and signature of the party or party representative, and a position paper. The same information is submitted at reconsideration but also includes the name of the contractor who made the redetermination and any missing documentation not introduced in redetermination. The issue is that at neither of these phases can plaintiffs appeal to a judge to explain why they made the mistake they made. Although a position paper is submitted, some mistakes of documentation can only be explained in person. *See Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals (OMHA)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing.html [http://web.archive.org/web/20200307181406/https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/OMHA-ALJ-Hearing] (last modified Nov. 15, 2019).

140. *Infinity*, 349 F. Supp. 3d at 597 (citing AHA v. Burwell, 812 F.3d 183, 191 (D.C. Cir. 2016) for the proposition that "[n]othing suggests that Congress intended escalation to service as an adequate or exclusive remedy where . . . a systemic failure causes virtually all appeals to be decided well after the statutory deadline.").

141. *Burwell*, 812 F.3d at 191.

142. *Id.*

143. *Id.*

Thus, the collateral-claim exception is far superior to escalation, because it allows a district court to stay recoupment while still allowing the provider or supplier to obtain its guaranteed evidentiary hearing in front of an ALJ. The collateral-claim exception must be inextricably linked to the Medicare appeals process in order to bypass the exhaustion of administrative remedies requirement. It is the single best way to ensure a provider or supplier is not deprived of procedural due process. The escalation procedure set forth in the Social Security Act is not a sufficient remedy for the providers and suppliers being recouped during the ceaseless backlog of appeals.[144]

C. Why Alternatives to the Collateral-Claim Exception Do Not Provide the Same Level of Relief as the Collateral-Claim Exception

After the influx of collateral-claim cases stemming from the *Family Rehabilitation* decision, it is clear that the exception is now a legitimate and viable avenue around the prolonged recoupment process.[145] However, CMS has pursued innovative ways to reduce the backlog and has created alternatives to the appeals process altogether.[146] On June 15, 2018, CMS released criteria for its new Settlement Conference Facilitation (SCF) program.[147]

SCF is an alternative dispute resolution process that allows appellants and CMS to resolve claims that would otherwise be appealed

144. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *5 (N.D. Tex. June 28, 2018).

145. *See id.*; Sahara Health Care, Inc. v. Azar, 349 F. Supp. 3d 555 (S.D. Tex. 2018); Adams EMS, Inc. v. Azar, No. H-18-1443, 2018 WL 3377787 (S.D. Tex. July 11, 2018); Accident, Injury and Rehab., PC v. Azar, No. 18-cv-02173-DCC, 2018 WL 3980212 (D.S.C. Aug. 21, 2018). In all of these cases, the collateral-claim exception was utilized to some degree. Each case, except for *Sahara Health Care*, granted the injunctive relief requested. The *Sahara Health Care* court did not grant injunctive relief because Sahara Health Care failed to show that there was a substantial likelihood that they would prevail on the merits, which is a requirement for injunctive relief. *Sahara Health Care*, 349 F. Supp. 3d at 579.

146. *Appeals Settlement Initiatives*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/medicare/appeals-and-grievances/orgmedffsappeals/appeals-settlement-initiatives/index.html [https://web.archive.org/web/20200128044103/https://www.cms.gov/medicare/appeals-and-grievances/orgmedffsappeals/appeals-settlement-initiatives/index] (last modified Feb. 14, 2018).

147. *Settlement Conference Facilitation*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html [https://web.archive.org/web/20200128192117/https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html] (last visited June 7, 2019).

to the ALJs.[148] The SCF takes one day, involves an OMHA facilitator, and allows CMS and the appellant to negotiate a lump-sum settlement on eligible claims.[149] SCF was created to assist in reducing the backlog because parties may only request SCF where there is a pending, but not yet concluded, ALJ hearing or Council review.[150] In addition to SCF, CMS has set forth other initiatives to help reduce the backlog.[151]

While these alternative measures are having a small impact on the backlog, they still fail to provide an option that affords the appellant relief from payment until a proper hearing by an ALJ has been conducted. For example, SCF requires appellants to pay *some* amount of money,[152] whereas the collateral-claim exception allows a federal district court to stay recoupment until the ALJ hearing occurs, which relieves providers and suppliers from paying *any* money until after the hearing.[153] Having a reconsideration decision overturned by an ALJ will not only

148. *Id.*

149. *Id.*

150. *Id.*

151. The Low Volume Appeals initiative, the Serial Claims initiative, the Statistical Sampling initiative, and the Targeted Probe and Educate program are all measures HHS has implemented to reduce the backlog of appeals. *See Low Volume Appeals Initiative*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative.html [https://web.archive.org/web/20200128192616/https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative] (last modified June 10, 2019); *Improvements to the Adjudication Process of Serial Claims*, MLN MATTERS (2017), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17010.pdf [https://web.archive.org/web/20200128192742/https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE17010.pdf]; *Statistical Sampling Initiative Update*, U.S. DEP'T OF HEALTH & HUM. SERV., https://www.hhs.gov/about/agencies/omha/about/special-initiatives/statistical-sampling/index.html [https://web.archive.org/web/20200128193035/https://www.hhs.gov/about/agencies/omha/about/special-initiatives/statistical-sampling/index.html] (last visited Aug. 10, 2016); *Targeted Probe and Educate (TPE)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/targeted-probe-and-educatetpe.html [https://web.archive.org/web/20200128193220/https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/medical-review/targeted-probe-and-educatetpe] (last modified Dec. 16, 2019).

152. *Settlement Conference Facilitation*, *supra* note 147.

153. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *7 (N.D. Tex. June 28, 2018).

prevent CMS from taking more money than it already has, but it will force CMS to completely reimburse the appellant all that has already been taken—so it may be better to wait until the ALJ hearing rather than prematurely settling.[154]

Near the end of December 2018, OMHA released its first status report to show its progress on meeting the timetable set forth in *AHA v. Burwell*.[155] By the end of the fourth quarter of 2018, there were still 417,198 appeals pending.[156] In order to meet the 2019 deadline of a 19% reduction, OMHA must reduce the backlog by another 71,656 by the end of FY 2019.[157] While not an impossible goal, it is extremely burdensome for ALJs to keep up with the demands of the order.[158]

Thus, the backlog reduction is slow-moving and underwhelming. The collateral-claim exception creates jurisdiction that allows intervention between the second and third stages of appeal and can completely halt the recoupment of monies until a true hearing has been held, which can lead to fiscal relief for a Medicare appellant.[159]

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154. 42 U.S.C. § 1395ddd(f)(2)(B) (2016) ("Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest . . . .").

155. Order, Am. Hosp. Ass'n v. Azar, No. 14-851, 2018 WL 5723141 (D.D.C. Nov. 1, 2018) (compelling defendant to file status reports every quarter).

156. Defendant's Status Report, Am. Hosp. Ass'n v. Azar, No. 14-cv-00851 (D.D.C. Dec. 21, 2018), ECF No. 91-1.

157. *Id.*

158. *See Administrative Law Judges*, U.S. OFF. OF PERS. MGMT., https://www.opm.gov/services-for-agencies/administrative-law-judges/#url=ALJs-by-Agency [https://web.archive.org/web/20200117185132/https://www.opm.gov/services-for-agencies/administrative-law-judges/] (last modified Mar. 2017). There are currently 1,655 ALJs working for the Social Security Administration. Medicare audits are not the only appeals that SSA ALJs hear; thus, there is a strong likelihood that these ALJs will not be able to keep up with the ordered timetable.

159. *See Decision Statistics*, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/about/agencies/omha/about/current-workload/decision-statistics/index.html [https://web.archive.org/web/20200128193352/https://www.hhs.gov/about/agencies/omha/about/current-workload/decision-statistics/index.html] (last visited Feb. 4, 2020). At the third stage of appeals, claims are often found fully or partially favorable for the appellant. In FY 2012, 53.2% of appeals were found favorable upon ALJ review and 12.5% of appeals were dismissed. In FY 2018, only 14.4% of appeals were found fully favorable, with an astonishing 60.7% of cases dismissed. Dismissals occur when a settlement has occurred, thus, with the SCF expansion, it follows that more dismissals would occur. This demonstrates the issue of more providers going towards SCFs and being forced to pay a lump sum rather than going to a federal district court through collateral-claim jurisdiction, which would halt payments altogether until an ALJ can properly adjudicate the matter at hand. In sum, although SCF and other alternative measures created by HHS will help reduce the backlog of appeals, it is not a solution for those providers and suppliers who feel they were wrongfully audited and owe no money at all.

D. How Attorneys Can Bring the Collateral-Claim Exception to Their Clients

When attorneys are presented with a client who was audited by CMS, made it through the first two stages of appeal, and is now waiting for an ALJ hearing, they should view the *Family Rehabilitation* case as an instruction manual.[160] After requesting jurisdiction through the collateral-claim exception, the original complaint prayed for a TRO and a preliminary injunction staying recoupment of Family Rehab's Medicare payments.[161] The complaint alleged four counts: (1) procedural due process, (2) substantive due process, (3) ultra vires, and (4) preservation of status of rights under section 704 of the APA.[162] The only claims that were discussed in *Family Rehabilitation* were the procedural due process claim and the ultra vires claim.[163]

1. Due Process

The *Family Rehabilitation* court found that Family Rehab had a "substantial likelihood of success on the merits of its procedural due process claim because of the extreme backlog of cases on appeal to ALJs."[164] "Procedural due process imposes constraints on governmental decisions which deprive individuals of 'liberty' or 'property' interests within the meaning of the Due Process Clause of the Fifth or Fourteenth Amendment."[165]

A procedural due process claim requires courts to determine "whether [plaintiff] was deprived of a protected interest, and if so, what process was [plaintiff] due."[166] In order to determine if a plaintiff has been deprived of a protected interest, one must look at *Eldridge's* three-step analysis: (1) the private party's interest; (2) the risk of erroneous deprivation of the private party's interest; and (3) the government's

160. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911 (N.D. Tex. June 28, 2018).

161. *Id.* at *1.

162. Complaint at 21–24, Family Rehab. Inc., v. Hargan, No. 3:17-cv-3008-K, 2017 WL 6761769 (N.D. Tex. Nov. 2, 2017), ECF No. 1.

163. *Id.*

164. *Family Rehab*., 2018 WL 3155911, at *7.

165. Mathews v. Eldridge, 424 U.S. 319, 332 (1976).

166. Sahara Health Care, Inc. v. Azar, No. 7:18-CV-203, 2018 WL 6073564, at *17 (S.D. Tex. Nov. 1, 2018) (citing Logan v. Zimmerman Brush Co., 455 U.S. 422, 428 (1982)).

interests, including any burdens the government may feel if additional procedures were to be included.[167]

Family Rehab's private interest is the property interest in the Medicare payments of services rendered.[168] This is because Family Rehab rendered services to Medicare patients, and until there is a final determination from the Secretary, it cannot be fully declared that Family Rehab was overpaid.[169] The second factor requires a determination of whether there is a high risk of a deprivation of interest.[170] *Family Rehabilitation* found a high risk of erroneous deprivation because there was a high chance that the ALJ would overturn the reconsideration decision finding alleged overpayments.[171] Last, the court found that the Government's interests would not be adversely affected.[172] After going

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167. *Eldridge*, 424 U.S. at 335 (citing Goldberg v. Kelly, 397 U.S. 254, 263–71 (1970)).

168. *Family Rehab*., 2018 WL 3155911, at *4.

169. *Id. But see Sahara Health Care*, 2018 WL 6073564, at *11–12 ("[H]ome health care agencies who have received overpayments 'are not entitled to retain such overpayments, for they have no property interest in Medicare overpayments.'") (citations omitted). There appears to be a split between the Northern District of Texas and the Southern District of Texas. The Northern District found a property interest in the Medicare payments despite defendant's claim that Family Rehab has no right to participate in Medicare. The Southern District agrees with the idea that there is no absolute right to participate in Medicare, thus, there is no property interest in Medicare payments. It appears the biggest difference between the two cases is that Family Rehab relies on Medicare payments for 88–94% of its revenue—no Medicare payments would mean an almost instant shut down. *Family Rehab*., 2018 WL 3155911, at *3. While it is unknown how much Sahara Health Care relies on Medicare, the public policy argument that Family Rehab would be deprived of a property interest is quite strong.

170. *Eldridge*, 424 U.S. at 335 (citing *Kelly*, 397 U.S. at 263–71).

171. *Family Rehab.*, 2018 WL 3155911, at *5 ("Family Rehab alleges 60%–72% of cases are overturned at the ALJ hearing stage of the review process."); *see also* Complaint at 11, Family Rehab. Inc., v. Hargan, No 3:17-cv-3008-K, 2017 WL 6761769 (N.D. Tex. Nov. 2, 2017), ECF No. 1 ("Before an April 2015 United States Senate hearing before the Committee on Finance, the Honorable Orrin Hatch testified that over 60% of the claims are overturned in favor of the providers when heard by an administrative law judge.").

172. *Family Rehab.*, 2018 WL 3155911, at *6. The Government's argument for an adverse impact is rooted in hypotheticals. First, it must be assumed that the Government will prevail at the ALJ level. Second, the Government argues that if the recoupment is stayed but the Government still prevails at the ALJ level, Family Rehab would still declare bankruptcy and not pay the alleged overpayments. The court did not agree with the assertion that the Government would be adversely affected based on a series of assumptions.

through the *Eldridge* analysis, the *Family Rehabilitation* court held that the procedural due process claim was meritorious.[173]

2. Ultra Vires

Family Rehab's complaint also alleged an ultra vires violation.[174] An ultra vires claim is generally asserted when the government acts beyond its scope of power allowed by law.[175] The complaint alleged that CMS was acting contrary to the Medicare Act by not providing the ALJ hearing in the statutorily allotted time frame.[176] However, attorneys should be sure that their client's claim is ripe for review. If an attorney is overzealous and, for example, files in district court before the statutorily required 90 days have passed, then a court will likely strike down an ultra vires claim, because no law has technically been violated yet.[177] Unfortunately, it was never decided whether Family Rehab would have a likelihood of success on the ultra vires claim.[178] The Fifth Circuit reversed and remanded so that the district court could decide on both the procedural due process and ultra vires issues, but the district court failed to do so.[179]

Why does the government's failure to abide by the statute not immediately constitute an ultra vires violation the moment after the 90-day time limit has passed? Although the *Family Rehabilitation* court ultimately did not rule on this issue, the existence of the escalation option may be the source of the court's hesitancy. The escalation option is not mandatory, but the 90-day provision is mandatory.[180] The mandatory 90-day provision suggests that, ordinarily, the failure to provide the plaintiff

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173. *Id.*; *see also supra* Section II.C.2.i.a–d (covering the rest of the preliminary injunction analysis). Section III.D.1 only sought to focus on the due process analysis required in the first step of the preliminary injunction analysis.

174. Complaint at 23, *Family Rehab.*, 2017 WL 6761769, ECF No. 1.

175. Compton v. Alpha Kappa Alpha Sorority, Inc., 64 F. Supp. 3d 1 (D.C. Cir. 2014); *see also* Schroer v. Billington, 525 F. Supp. 2d 58, 65 (D.C. Cir. 2007) ("'[J]udicial review is available when an acts *ultra vires*,' even if a statutory cause of action is lacking.").

176. Complaint at 23, *Family Rehab.*, 2017 WL 6761769, ECF No. 1.

177. Sahara Health Care, Inc. v. Azar, No. 7:18-CV-203, 2018 WL 6073564, at *13 (S.D. Tex. Nov. 1, 2018).

178. Family Rehab., Inc. v. Azar, No. 3:17-cv-3008-K, 2018 WL 2670730, at *2–4 (N.D. Tex. June 4, 2018). The court went through the *Eldridge* analysis with only the procedural due process claim, so it is still unresolved whether the ultra vires claim would have a substantial success on the merits. *But see Sahara Health Care*, 2018 WL 6073564, at *7–8 (S.D. Tex. Nov. 1, 2018) (holding that the ultra vires claim was too conclusory and devoid of fact to have a substantial success on the merits).

179. Family Rehab., Inc. v. Azar, 886 F.3d 496, 507 (5th Cir. 2018).

180. 42 U.S.C. § 1395ff(d)(1)(A) (2014); 42 U.S.C. § 1395ff(d)(3) (2014).

with a hearing within that time period is ground for an ultra vires claim. However, the escalation option was created because CMS anticipated backlogs to occur.[181] Thus, the court was likely hesitant to set precedent that would impede on an administrative regulation and focused its holding on the procedural due process claim instead.

E. Family Rehabilitation's Final Application of the Collateral-Claim Exception

The court in *Family Rehabilitation* held that both the procedural due process and ultra vires claims were entirely collateral to the substantive agency decision.[182] Only the procedural due process argument was found to have a substantial likelihood of success on the merits, so attorneys should allege a procedural due process violation with similarly situated plaintiffs.[183]

Although Family Rehab sought a preliminary injunction and a TRO to prevent CMS from recouping alleged overpayments until the ALJ hearing had occurred, mandamus relief is not entirely out of the question.[184] Providers and suppliers who rely on Medicare payments as their main source of revenue, and who will go bankrupt if recoupments are not stayed, should use the collateral-claims exception as a lifeline. The success of *Adams EMS* and *Accident Injury* shows that the *Family Rehabilitation* formula will almost always provide gainful results for a provider or supplier.

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181. Infinity Healthcare Servs., Inc. v. Azar, 349 F. Supp. 3d 587, 602 (S.D. Tex. Nov. 19, 2018) (citing Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 54 (4th Cir. 2016), which states, "[w]hile the [Medicare] statute imposes deadlines . . . it also anticipates that the deadlines may not be met and thus gives the healthcare provider the option of . . . escalating the claim . . . .").

182. *Family Rehab.*, 886 F.3d at 503 (5th Cir. 2018) ("If the court must examine the merits of the underlying dispute, delve into the statute and regulations, or make independent judgments as to plaintiffs' eligibility under a statute, the claim is not collateral."). Family Rehab only sought suspension of recoupment until an ALJ hearing, and the merits of recoupment were not at issue. *Id.* The two requirements for a collateral-claim exception allows jurisdiction over claims that are "'entirely collateral' to a substantive agency decision and . . . for which 'full relief cannot be obtained at a post deprivation hearing.'" *Id.* (citations omitted).

183. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *4 (N.D. Tex. June 28, 2018).

184. *See supra* Part III.A. Because the Fifth Circuit rejected the notion that exhaustion is required for mandamus jurisdiction and stated that all that is needed is the goal of compelling an officer to perform a duty to a plaintiff, mandamus relief may be another type of relief a plaintiff can seek from a collateral-claim jurisdiction case.

IV. CONCLUSION

The backlog of appeals is unquestionably a detriment and obstacle to providers and suppliers being audited by the government for Medicare overpayments. All alternatives to waiting in the backlog that exist, such as escalation or SCF, deprive providers and suppliers of their right to have an evidentiary hearing by an ALJ. As such, if providers and suppliers want to exercise their statutorily afforded right to an ALJ hearing, they must wait three to five years and suffer recoupment throughout the entire time. This is a harmful practice that might not be solved for a long time.

However, there is a way around the harms caused by the backlog. Providers and suppliers should ask a federal district court to order a stay on recoupment so that they will not be recouped to the point of bankruptcy and can still be afforded their ALJ hearing. Although this method for seeking redress is still in its infancy and is not well-developed across the country, it is clear that when a provider or supplier can successfully allege a violation of procedural due process or ultra vires, they will gain federal jurisdiction through the collateral-claim exception. Every provider similarly situated to the one in *Family Rehabilitation* now has a viable method that has proven successful for moving forward and moving out of the backlog.