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Family Rehabilitation, Inc. v. Azar: Caring for the Caretakers - A Path for Providers Trapped in the Medicare Appeals Backlog

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FAMILY REHABILITATION, INC. V. AZAR: CARING FOR THE CARETAKERS - A PATH FOR PROVIDERS TRAPPED IN THE MEDICARE APPEALS BACKLOG

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In *Family Rehabilitation, Inc. v. Azar*[1], the United States District Court for the Northern District of Texas held that the withholding of Medicare payments by federal health care programs to effectuate the recoupment of alleged overpayments infringes on the due process rights of a health care entity. In the June 2018 opinion, the court concluded that the plaintiff, Family Rehabilitation Clinic, demonstrated both the required standards for a procedural due process claim as well as the threat of "irreparable harm", and thus granted their motion for a preliminary injunction.[2] This ruling prevented the defendants, Alex Azar[3] and Seema Verma[4], "from withholding Medicare payments and receivables to Family Rehab to effectuate the recoupment of the alleged overpayments," before the plaintiffs were afforded their full due process rights. The court's decision was correct and implicates policy concerns that will not be solved by throwing more

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1. No. 3:17-CV-3008-K, 2018 WL 3155911, (N.D. Tex. June 28, 2018).

2. *Id.* In fact, since the first drafting of this case note and its publication, the court returned another favorable opinion for the health care providers by granting a permanent injunction in favor of Family Rehab. *See* Family Rehabilitation, Inc. v. Azar, 2020 WL 230615 (N.D. Tex., 2020*)*. The court's decision to ultimately grant a permanent injunction only serves to strengthen the case made in this note that the court's first decision was correctly decided, and that health care providers should use the argument's adopted by the court to protect themselves from improper recoupments.

3. Mr. Azar was sued in his official capacity as the Secretary for the Department of Health and Human Services (HHS).

4. Administrator for the Centers for Medicare and Medicaid Services (CMS).

money to the Office of Medicare Hearings and Appeals (OMHA).[5] In reaching its conclusion, the court correctly determined that Medicare payments are a property interest in the context of due process proceedings and consequently ensured protections for health care providers who base their business models on these payments.[6] The reasoning found in this seemingly innocuous slip opinion can serve as protection for health care providers mired in the Medicare appeals process and thus illustrates the process by which providers in other federal districts can protect themselves from the Department of Health and Human Service's ("HHS") improper means of recoupment during post-payment reviews.[7]

I. THE CASE

A. Factual History

Family Rehabilitation, Inc. (Family Rehab) is a small, Medicare-certified home health agency located in Waxahachie, Texas.[8] Before the action in this case, Family Rehab provided services to over 289 patients across all of its facilities, with its revenue stream primarily consisting of Medicare reimbursements.[9] During a post-payment review process, a third-party contractor, known as a Zone Program Integrity Contractor ("ZPIC"), determined, from a randomized sampling of claims, that the Centers for Medicare & Medicaid Services ("CMS") had overpaid Family Rehab by over $7.8 million.[10] Family Rehab requested a redetermination by a Medicare Contractor (MAC), which concluded that the initial determination was correct on all but one of the claims and thus lowered the amount owed in overpayments to $7.6 million.[11]

Family Rehab appealed this redetermination to a Qualified Independent Contractor (QIC), which affirmed the claims, and Family Rehab was subsequently sent a demand letter for the remaining $7.6 owed in overpayments.[12] Family Rehab filed a timely appeal to an Administrative Law Judge (ALJ) but did not receive an evidentiary hearing within the statutorily mandated 90 days.[13] During this waiting process, CMS began recouping the alleged overpayments by withholding Medicare reimbursements for current

5. *See infra* Section IV.C.

6. *See infra* Section IV.A.

7. *See infra* Section IV.B.

8. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *1 (N.D. Tex. June 28, 2018).

9. *Family Rehab., Inc.,* 2018 WL 3155911, at *1.

10. *Id.* at *5–6.

11. *Id.* at *6.

12. *Id.* at *6.

13. *Id.* at *6.

Family Rehab clients.[14] This waiting period proved extremely detrimental to Family Rehab, as the health agency was forced to lay off over 88% of its workforce and terminate care to 281 of 289 patients.[15]

B. Procedural History

The United States District Court for the Northern District of Texas first ruled on the dispute between Family Rehab and CMS in late 2017,[16] holding that 42 U.S.C § 405 precluded Family Rehab from bringing its challenge against "Medicare's administrative action."[17] On appeal, the Fifth Circuit Court of Appeals reversed and remanded the lower court's opinion regarding Family Rehab's due process complaint, yet affirmed the decision in all other respects.[18]

In reaching its decision, the Fifth Circuit agreed with Family Rehab's argument that this action was outside, or collateral to, the substantive limits of the guiding statute.[19] The court reasoned that preclusion would be proper if Family Rehab was challenging the substantive decision underlying its Medicare claim.[20] However, because Family Rehab's claim was "entirely collateral," and one where full relief could not be granted at a post-deprivation hearing, the court remanded the case to the lower court.[21] On remand, the United States District Court for the Northern District of Texas initially granted Family Rehab's motion for a preliminary restraining order and enjoined CMS and HHS from continuing to withhold Family Rehab's Medicare payments.[22] The court held hearings for Family Rehab's preliminary injunction before deciding the current case.[23] Since the first authoring of this case note, the court returned another decision in this matter granting permanent injunctive relief in favor of Family Rehab.[24]

II. LEGAL BACKGROUND

To better understand how the court reached its decision in the present case, it is imperative to first review the means by which the plaintiff can bring this suit. This legal background section will thus first address the concerns with procedural due process and the grant for injunctive relief. Next, this section will delve into

14. *Id.* at *6.

15. *Id.* at *6–7.

16. Family Rehab., Inc. v. Hargan, No. 3:17-cv-3008-K, 2017 WL 6761769 (N.D. Tex. Nov. 2, 2017).

17. *Family Rehab., Inc.*, 2017 WL 6761769 at *2.

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

19. 886 F.3d 496, 503 (5th Cir. 2018).

20. *See id.* at 504 (dismissing the claim for lack of subject matter jurisdiction).

21. *Id.* at 507.

22. Family Rehab., Inc. v. Azar, No. 3:17-cv-3008-K, 2018 WL 2670730 (N.D. Tex. June 4, 2018).

23. *Id.*

24. Family Rehab., Inc. v. Azar, 2020 WL 230615 (N.D. Tex., 2020*)*.

the Medicare statutes and case law that authorize and outline the process of post-payment review. Further, this section will focus on how ongoing and recently decided cases highlight diverse issues with the Medicare appeals backlog and finally address judicially-created solutions to the problem.

A. Procedural Due Process

1. Mathews v. Eldridge

In *Mathews v. Eldridge*[25], the Supreme Court narrowly held that the government is not required to hold evidentiary hearings prior to terminating a person's disability benefits, and that the administrative procedures employed by the Department of Health, Education, and Welfare (presently known as the Department of Health and Human Services) for these disability termination proceedings fully comported with due process.[26] In *Eldridge*, respondent Eldridge received disability payments from the government, as administered by a state agency, beginning in 1968 and continuing for the several years leading up to the action in the case.[27] However, after consulting with Eldridge's physicians and evaluating a survey he submitted, the state agency revoked his disability status and began the process to terminate his benefits with the Social Security Administration.[28]

Eldridge then circumvented the administrative appeals process and brought action against the Department, alleging that its procedures violated his due process rights by failing to provide him the opportunity for an evidentiary hearing before terminating his benefits.[29] The District Court ruled that the administrative procedures utilized for these proceedings violated Eldridge's due process rights.[30] On appeal, the Fourth Circuit relied upon the reasoning of the District Court and upheld the lower court's ruling.[31] The Supreme Court granted certiorari and subsequently reversed the decisions of the two lower courts, ruling that the Department did not infringe upon Eldridge's due process rights.[32]

While inherent differences exist between disability payments for individuals and Medicare payments for health care agencies, the Court developed a general standard in *Eldridge* for determining whether the government serves adequate due process in similar deprivation proceedings.[33] Writing for the

25. 424 U.S. 319 (1976).
26. *Id.* at 349.
27. *Id.* at 323.
28. *Id.* at 323–24.
29. *Id.* at 324–25.
30. *Id.* at 326.
31. *Id.* at 327.
32. *Id.*
33. *See id.* at 335.

majority, Justice Powell clarified the important three-part test used to determine if the government afforded a party their right to due process:

> "First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."[34]

The *Eldridge* court further elaborated on indicia that a court may look for to adjudge if these factors are met in a case. Referencing the Court's decision in *Goldberg v. Kelly*[35], Justice Powell clarified that "the degree of potential deprivation that may be created by a particular decision is a factor to be considered in assessing the validity of any administrative decision-making process."[36] The Court emphasized the importance of the government maintaining a fair and reliable procedural process when making these determinations.[37]

Further, *Eldridge* addressed the public interest at stake, the final factor in the due process calculus.[38] The Court spoke to the importance of preserving the public's interest in efficient proceedings to lower administrative costs, while also ensuring judicial intervention in administrative action be used sparingly.[39] The Court ultimately held that the Social Security Administration followed proper procedure and that Eldridge was not entitled to an evidentiary hearing prior to the termination of his disability benefits.[40] Nonetheless, the factors laid out by the Court have guided further judicial interpretation of due process claims across varying contexts.

2. The Fifth Circuit's View on Injunctive Relief

The judicial process can be long and fraught with delays and continuations, often putting the very same private interests the courts are protecting at risk. At times, courts look to prevent such administrative injustice through the granting

34. *Id.* at 335.

35. Goldberg v. Kelly, 397 U.S. 254 (1970).

36. 424 U.S. at 341.

37. *See id. at* 343 (noting that "[a]n additional factor to be considered here is the fairness and reliability of the existing pre-termination procedures, and the probable value, if any, of additional procedural safeguards.").

38. *Id.* at 347.

39. *Id.* at 348 ("The ultimate balance involves a determination as to when, under our constitutional system, judicial-type procedures must be imposed upon administrative action to assure fairness.").

40. *Id.* at 349.

of injunctive relief. This section addresses the approach embraced by the Fifth Circuit in such instances.

The first rule of the Federal Rules of Civil Procedure (FRCP) commands for the ensuing rules to be administered in pursuit of a "just, speedy, and inexpensive determination of every action and proceeding."[41] While not codified in the FRCP, courts have utilized injunctive relief to preclude substantial and detrimental outcomes for plaintiffs as they proceed through the judicial system awaiting their final judgements.[42] The judicial mechanism allows for courts to properly adjudicate claims based on the merits of the case, and protects against outside factors that can have a tendency to persuade the decision-making of the court.

In examining how the Fifth Circuit has previously dealt with injunctive relief, courts have spoken to the requirements that the moving party must demonstrate to succeed in a motion for preliminary injunctive relief. In *Canal Authority of State of Fla. v. Callaway*[43], the Fifth Circuit heard the appeal of a motion for injunctive relief that sought to help preserve a rare species of trees in the area by preventing the defendants from lowering the water levels in a nearby lake.[44] The court held that the four relevant factors in determining whether to grant a preliminary injunction were:

> "(1) a substantial likelihood that plaintiff will prevail on the merits, (2) a substantial threat that plaintiff will suffer irreparable injury if the injunction is not granted, (3) that the threatened injury to plaintiff outweighs the threatened harm the injunction may do to defendant, and (4) that granting the preliminary injunction will not disserve the public interest."[45]

While the specific factual circumstances and ultimate holding in a case concerning endangered trees situated on a flood plain are not particularly relevant to the adjudication of Medicare appeals, the four factors established by the Fifth

41. FED. R. CIV. P. 1. The Rule states in part that, "[The rules] should be construed, administered, and employed by the court and the parties to secure the just, speedy, and inexpensive determination of every action and proceeding."

42. Family Rehab., Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *7–8 (N.D. Tex. June 28, 2018) ("'The purpose of a preliminary injunction is to preserve the status quo and thus prevent irreparable harm until the respective rights of the parties can be ascertained during a trial on the merits.'; Serna v. Tex. Dep't of State Health Servs., Vital Statistics Unit, No. 1-15-CV-446-RP, 2015 WL 6118623, at 13 (W.D. Tex. Oct. 16, 2015) (quoting Exhibitors Poster Exch., Inc. v. Nat'l Screen Serv. Corp., 441 F.2d 560, 560 (5th Cir. 1971))."

43. Canal Auth. of State of Fla., 489 F.2d 567 (5th Cir. 1974).

44. *Id.* at 569–70.

45. *Id.* at 572-73 (citing Di Giorgio v. Causey, 488 F.2d 527 (5th Cir. 1973); Blackshear Residents Org. v. Romney, 472 F.2d 1197 (5th Cir. 1973)).

Circuit in *Canal Authority of State of Fla.* are vital in shaping the Circuit's common law and procedural due process jurisprudence.[46]

In applying the four-factor test articulated in *Canal Authority of State of Fla.*, courts are tasked with weighing the relative probability of success of the movant's claims on the merits when deciding whether to grant injunctive relief.[47] The Fifth Circuit continues to emphasize the movant's burden of demonstrating a high likelihood of success on the merits.[48] This standard affords courts the ability to provide relief to the movant without causing unnecessary judicial action or hindrance of a swift and final ending. The standard guarantees fairness for all parties involved in the proceedings and allows the court to weigh factors, such as severity of injury, on a sliding scale to ultimately decide when to rule on a motion.[49] Finally, courts may look prospectively in determining whether awards resulting from the adjudication of the case are sufficient to make amends for the harm caused by refusing to grant the motion for injunction.[50]

In the context of proceedings involving Medicare payments, the Fifth Circuit has recently spoken to the specific factors relevant in determining whether injunctive relief is proper. In *Maxmed Healthcare, Inc. v. Burwell*,[51] the District Court for the Western District of Texas held in denying plaintiff's motion for preliminary injunction that "[i]n the Medicare withholding context, going out of business can be sufficient evidence of irreparable injury."[52] In weighing the relevant factors to determine whether to grant the motion for preliminary injunction, the court ultimately concluded that the health care provider had not fully explored the feasibility of a payment plan with the Secretary of HHS.[53] Much like Family Rehabilitation Inc, the plaintiff in *Maxmed* was a Medicare-certified home health care provider located in Texas that faced substantial debt caused by a post-payment investigation and statistical sampling.[54] While much of the case centers around the methodology of extrapolation for reviewed claims to assess the full monetary penalty assessed by the Secretary, the factors relied upon in the order for preliminary injunction are helpful for understanding future Medicare repayment cases.[55] Of note, the Secretary was ultimately successful on

46. *Id.*

47. State of Tex. v. Seatrain Intern., 518 F.2d 175, 180 (5th Cir. 1975).

48. *Id*.

49. *Id.*

50. Humana, Inc. v. Avram A. Jacobson, 804 F.2d 1390, 1394 (5th Cir. 1980) ("The plaintiff need show only a significant threat of injury from the impending action,20 that the injury is imminent, and that money damages would not fully repair the harm.").

51. No. SA:14-CV-988-DAE, 2015 WL 1310567 (W.D. Tex. Mar. 23, 2015).

52. *Id.* at *6.

53. *Id.* at *7.

54. Maxmed Healthcare, Inc. v. Burwell, 152 F.Supp.3d 619 (W.D. Tex. 2016). In particular, the plaintiff's owed over $773,967 after the review from the MAC.

55. *See id*; *supra* note 49.

a motion for summary judgement in a ruling that was subsequently affirmed by the Fifth Circuit.[56]

B. Medicare and the Courts: Recent and Ongoing Challenges Against the Program

The current situation with the backlog in Medicare appeals has produced relevant litigation, which derive from recent agency actions effectuated by HHS that may have aggravated the problem, as well as proposed solutions for the federal government to consider in moving forward. These solutions may lead to a growing dichotomy between addressing the problem at its root source in the appellate process proscribed to HHS and passing on the final decision-making power in these appeals to the federal judiciary.

1. Background: Medicare Appeals Process and the Mounting Backlog of Appeals

Signed into law as a provision of the Social Security Act in 1965, the Medicare program helps pay for the costs of covered medical procedures for individuals who meet program requirements.[57] This initial determination on a claim is conducted by different Medicare Administrative Contractors (MACs) that process the claims using statutory guidelines.[58] Beyond the MACs, there are additional steps in the appellate process that a claimant can utilize, beginning with evidentiary hearings before an ALJ and ultimately ending with the Departmental Appeals Board (DAB) and the Medicare Appeals Council.[59] There are also statutory guidelines in place to help ensure the efficient and timely review of claims at each stage of the appeals process.[60]

While there are statutory standards guiding this process, the process of appealing a claim recently became more time consuming than the original framework that was set forth in the statutory guidelines. As of September 1, 2017, there were 595,000 outstanding claims for adjudication.[61] Further, a party waiting for his or her appeal to be heard by an ALJ could be stuck waiting for three to five years.[62] HHS did not always face this daunting Medicare appeals backlog; however the process has slowed considerably since the introductions of

56. Maxmed Healthcare, Inc. v. Burwell, 152 F.Supp.3d 619 (W.D. Tex. 2016); Maxmed Healthcare, Inc. v. Price, 860 F.3d 335 (5th Cir. 2017).

57. Family Rehab. Inc. v. Azar, No. 3:17-CV-3008-K, 2018 WL 3155911, at *1 (N.D. Tex. June 28, 2018).

58. *See* U.S.C. 42 § 1395kk-1 (2015)

59. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185–86 (D.C. Cir. 2016).

60. *See id.* at 186 (detailing the different statutory deadlines associated with the Medicare appeals process, including but not limited to the timeframes for MAC, QIC, and DAB decision, but also the penalties for failing to meet those deadlines).

61. *Family Rehab., Inc.*, 2018 WL 3155911, at *2.

62. *Id.* at *2.

the Medicare Recovery Audit Program and Recovery Audit Contractors (RACs).[63] The program was aimed at stopping and containing overpayments and underpayments on claims, as well as recouping the overpayments from the providers and beneficiaries.[64] The Medicare Recovery program has done good things for HHS, but it has also created a heavy load of new appeals for RACs to determine.[65]

2. The American Hospital Association Saga

There is a no more instructive window into the realm of Medicare payments and the appeals process than the examination of the ongoing litigation involving the American Hospital Association and HHS. In 2014, the U.S. District Court for the District of Columbia (the district court) issued the initial decision in this matter with *American Hospital Ass'n v. Burwell*.[66] Plaintiffs sought a writ of mandamus against HHS to compel the agency to enforce the statutory guidelines of the Medicare Act by adjudicating their respective administrative appeals.[67] The district court ruled in favor of HHS, ultimately acknowledging that the court did not have mandamus jurisdiction.[68] Further, while the appeals system was not completing its proper functions, the district court held that only Congress could offer the proper resolution.[69]

Following the district court's decision, the D.C. Circuit, in a unanimous 2016 opinion, reversed and remanded the decision back to the district court.[70] The D.C. Circuit held that the statutory guidelines presented firmer guidance than the lower court's decision, and that escalation was an inadequate remedy in the immediate case.[71] Answering the D.C. Circuit's remand, the district court subsequently issued a succinct memorandum opinion that directly addressed strategies HHS should pursue to efficiently solve the backlog problem.[72]

After addressing both parties' contentions, the district court held that HHS should strive to fully ameliorate the appeals backlog meaning a one-hundred

63. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 186–87 (D.C. Cir. 2016).

64. 812 F.3d at 186.

65. *See id.* at 186–87 (identifying $2.3 billion in overpayments in the fiscal year 2012, and $3.65 billion in overpayments in the fiscal year 2013. While identifying claims that were overpaid is positive for the Department, these new claims can be appealed using the same process as a regular underpayment appeal and have added a volume of new cases to the process).

66. 76 F.Supp.3d 43 (D.D.C. 2014).

67. Am. Hosp. Ass'n, 76 F.Supp.3d at 48 (D.D.C. 2014).

68. *Id.* at 56.

69. *Id.*

70. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016).

71. *Am. Hosp. Ass'n*, 812 F.3d at 192.

72. Am. Hosp. Ass'n v. Burwell, No. CV 14-851 (JEB), 2016 WL 7076983, at *1 (D.D.C. Dec. 5, 2016), *reconsideration denied*, No. CV 14-851 (JEB), 2017 WL 6209175 (D.D.C. Jan. 4, 2017), *vacated sub nom;* Am. Hosp. Ass'n v. Price, 867 F.3d 160 (D.C. Cir. 2017), *vacated and remanded sub nom*. Am. Hosp. Ass'n v. Price, 867 F.3d 160 (D.C. Cir. 2017).

percent reduction in backlogged appeals by 2021, with remaining claims subject to declaratory judgement upon the claimant's petition.[73] On appeal in the D.C. Circuit, a divided three judge panel directly addressed the guideline structure ordered by the district court.[74] With their opening line, "*Ought* implies *can*," the court introduced the premise of the remainder of their opinion at its very beginning.[75]

Following this opening salvo, the court addressed the Secretary's argument that the judicial guidelines imposed impossible measures and, as such, would force the Secretary to bend or break the law to meet the rigid January 1, 2021 date.[76] The D.C. Circuit remanded the district court's decision to further consider the Secretary's dilemma, with an emphasis on establishing and evaluating the plausibility for the Secretary to meet deadlines using methods that can be mandated, as opposed to those measures that are out of the Secretary's control.[77]

Most recently, the district court answered the D.C. Circuit's demand for a permissible solution for the Secretary to fix the backlog problem.[78] In light of new appropriations from Congress that allow the Secretary to properly address the backlog at the OMHA level, the district court ruled to reissue a similar tiered deadline approach that the court previously set forth in their 2017 decision.[79] While it is likely the final chapter in this epic judicial saga, the district court's opinion identifies the government actor who may be best equipped to end this long and winding road.

A primary factor influencing the district court's holding was the passage by Congress of appropriations for HHS, which allowed the Secretary to drastically increase its adjudicatory output, thus making the seemingly impossible task of eliminating the backlog no longer out of reach.[80] Addressing this appropriations legislation, the court explained that while such a funding increase may normally persuade the court to refuse to issue a writ, this appropriation would simply make

73. *Id.* at *5–6.

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

75. Am. Hosp. Ass'n, 867 F.3d at 161 (D.D.C. 2017).

76. *Id.* at 167 ("The Secretary essentially asserted that the timetable placed him between a rock and a hard place: either violate the Medicare statute by settling reimbursement claims en masse without regard for their merit, or violate the Court's mandamus order by missing the court-ordered deadlines."

77. *Id.* at 169–70.

78. Am. Hosp. Ass'n v. Azar, No. CV 14-851 (JEB), 2018 WL 5723141 (D.D.C. Nov. 1, 2018). This is the most recent update in the case as of the drafting of this case note.

79. *See Am. Hosp. Ass'n*, No. CV 14-851 (JEB), 2018 WL 5723141, at *3 (changing the framework for the deadline to one year later than was previously set, thus changing the final deadline for 100% of the backlog to be adjudicated by January 1, 2022).

80. *Id.* at *2 ("On March 23, 2018, Congress appropriated for that purpose $182.3 million, which the agency projects will 'more than doubl[e] its FY 2017 disposition capacity.' *Id.* In fact, HHS now 'projects that, at current funding levels, OMHA's adjudication capacity will increase over FY 2017 levels by 23% in FY 2018, 42% in FY 2019, 108% in FY 2020, and approximately 122% in FY 2021 and 2022,' meaning that 'the Secretary will be able to eliminate the backlog entirely in FY 2022.'") *Id.*

compliance with the law possible and that this possibility was adequate to decide against issuing a mandamus order.[81] Only time, and the D.C. Circuit, will tell if this deadline proves feasible or, perhaps more importantly, judicially enforceable.

3. A Split on Escalation? — The Fourth Circuit Diverges on the Backlog

The Fourth Circuit reached a contrary holding when confronted with a similar case involving health care providers mired in the Medicare appeals backlog. In *Cumberland County Hospital System v. Burwell*[82], the Fourth Circuit's ruling encompassed a troubling determination directly affecting the interests of private health care providers as it related to the appeals backlog. Cape Fear Health Systems (the System), based out of eastern North Carolina, brought the action in the federal district court seeking a writ of mandamus to order the Secretary of HHS (the Secretary) to assign the System's appeals to an ALJ at OMHA.[83] The System's claim dated back to several denials of payment by the Secrerary from 2012 and 2013; as of late 2014, the System had hundreds of claims awaiting an evidentiary hearing before the ALJ with the total dollar amount for the claims reaching $12.3 million.[84]

In a pretrial brief, the Secretary noted that, as of the filing, over 800,000 appeals were awaiting adjudication, amounting to ten times the work that could be accomplished annually at the Secretary's present funding levels.[85] The System's argument in favor of a grant of mandamus focused on the statutory intent behind the Medicare Act, which required the Secretary to provide reviews within the statutorily mandated 90 days.[86] In further support of its argument, the System emphasized the "terrible choice" any provider would face when awaiting an administrative appeal at the ALJ level: a choice between waiving "its right to due process" or suffering "interminably until the Secretary feels like affording [it] a hearing.'"[87]

The System's argument fell on unsympathetic ears with the Fourth Circuit, in a unanimous panel opinion, agreeing with the Secretary and affirming the ruling below.[88] In answering the System's due process concerns that the current regime encourages a system where escalation is the ultimate answer to administrative delays, the Fourth Circuit provided an answer that may trouble

81. *Id.* at *4.

82. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 49 (4th Cir. 2016).

83. *Cumberland Cty. Hosp. Sys., Inc.*, 816 F.3d at 50.

84. *Id.* at 50 (the Secretary initially denied over 900 claims in 2012 and 2013, and by 2014 there were still over 750 claims awaiting a hearing past the 90-day statutory limit).

85. Br. for Appellee, 9, Sept. 3, 2015.

86. *Id.*

87. *Cumberland Cty. Hosp. Sys., Inc.*, 816 F.3d at 52, 55.

88. *Id.* at 57.

health care providers similarly situated to the System.[89] Although it recognized that the current system was ill-equipped to handle the number of backlogged appeals, the court declined to compel the Secretary to amend their administrative functions.[90] Rather, the court stated that health care providers should accept the delays inherent in the process and admit evidence the provider may anticipate needing upon escalation at the earlier appeal stages.[91] The panel's opinion addressed the due process concerns as it related to escalation; however, the opinion does not address the financial concerns of a provider being subject to monetary recoupments while awaiting administrative appeal. These two cases highlight recent litigation stemming from the issues surrounding the Medicare appeals backlog. The case demonstrates that, while courts have considered due process concerns relating to escalation as a remedy, courts have failed to consider the devastating financial losses suffered by providers at the sake of the appeals backlog.

III. THE COURT'S REASONING

The court in *Family Rehabilitation, Inc. v. Azar* held that the withholding of Medicare payments by federal health care programs to effectuate the recoupment of alleged overpayments infringes on the due process rights of a health care entity.[92] Writing for the court, Judge Ed Kinkeade granted Family Rehab's preliminary injunction.[93] In doing so, the court prohibited HHS from continuing to withhold Medicare reimbursements in an effort to recoup payments from Family Rehab, while the provider was forced to wait on their subsequent administrative appeals with HHS.[94] The court emphasized the importance and probative weight of the movant's ability to demonstrate the sufficient likelihood it will succeed on the merits of its claim before providing injunctive relief.[95]

The court cited to *Matthews v. Eldridge*[96] and proceeded to analyze the three factors used by the Supreme Court in determining whether the due process provided by HHS was adequate.[97] The court identified the disputed payments made for the services rendered as the exact property interest at stake in the case,

89. *Id.* at 55–56.

90. *Id.*

91. *Id.*

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

93. *Family Rehab., Inc.,* 2018 WL 3155911 (N.D. Tex. June 28, 2018).

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

95. *Id.*

96. 397 U.S. 254 (1970).

97. *Family Rehab., Inc.,* 2018 WL 3155911 (N.D. Tex. June 28, 2018).

and then it distinguished this from 6th Circuit precedent.[98] The court weighed Family Rehab's claim that it would go out of business before receiving the procedural due process it is owed in order to determine the risk of erroneous deprivation of resources.[99] The court found it significant that Family Rehab was a small provider, usually serving 289 patients, and relies on Medicare reimbursements for services rendered for approximately 94% of its revenue stream.[100] Due to the aggressive recoupment of overpayment, the court reasoned that CMS would essentially be forcing Family Rehab to subsist off only a small fraction of its usual revenue.[101] Ultimately, the court relied upon this and the fact that alleged overpayments are overturned at the ALJ level 60 to 72 percent of the time to determine that the risks of an erroneous deprivation would be too grim.[102] For the final factor, the court determined that the defendants' interest will not be adversely affected by delaying recoupment of alleged overpayments until after the ALJ hearing and determination.[103] After weighing the relevant factors, the court ultimately found that the withholding of Medicare payments had substantially impacted Family Rehab's business, and that the alternative solutions offered by HHS did not adequately protect Family Rehab's interests.[104] The court's subsequent grant of permanent injunction in favor of Family Rehab on similar grounds only further strengthens the analysis provided by the court in this immediate case.[105]

IV. ANALYSIS

In *Family Rehabilitation, Inc. v. Azar*[106], the United States District Court for the Northern District of Texas held that the withholding of Medicare payments by HHS and CMS infringed on the home-health agency's due process rights by failing to provide the opportunity for an evidentiary hearing before an Administrative Law Judge.[107] The court reached the correct decision in this case by accurately applying *Eldrige*'s three-part test controlling due process proceedings, and by properly concluding that injunctive relief is warranted in situations where home-health agencies are awaiting their hearings before

98. *See id.* at *4 (contrasting Family Rehab's interests in receiving the payments for treatment already administered with those interests of an agency in being a Medicare provider for prospective benefits in *Cathedral Rock of North College Hill, Inc. v. Shalala*).

99. *Id.* at *5.

100. *Id.* at *5.

101. *Id.* at *5.

102. *Id.* at *5.

103. *Id.* at *6.

104. *Id.*

105. *See* Family Rehab., Inc. v. Azar, 2020 WL 230615 (N.D. Tex., 2020*)*.

106. *Id.*

107. *Id.*

ALJs.[108] While arguments presented by HHS and CMS relied on the adequacies of the current administrative appeals process, the court gave an honest reading of the problems inherent in the waiting game effectuated by the Medicare appeals backlog. Furthermore, even after considering the relative precedential weight of a district court decision, the legal reasoning articulated in this case will provide a comprehensive roadmap for other health care providers bogged down in the appeals backlog. Finally, the court's decision will have vast policy implications that will positively affect the Medicare scheme as a whole, shaping the backlog's effect on the public interest and alternative strategies employed by HHS and CMS in reducing the backlog.

A. The Court's Unwillingness to Adopt Defendant's Position Favoring Escalation Protects the Interests of Both Providers and the Federal Judiciary

The court correctly rejected HHS and CMS's arguments asserting that current procedures for escalating cases beyond the administrative appeals process a sufficiently address the due process rights of health care providers.[109] While the regulatory framework of Medicare appeals typically involves a five-step process, the defendants in this case would have the court effectively eliminate ALJ and Medicare Appeals Council review in favor of escalation.[110] Though this measure could potentially ease the administrative burden for OMHA and HHS, there is uncertainty as to whether escalation would accomplish the intended goal of reducing wait times for health care providers and beneficiaries in the Medicare appeals process. Further, escalation would have the effect of shifting the administrative burden to the federal judiciary, an empty victory that would only increase the caseload facing district court judges across the country. While statistics published in 2018 indicate that the number of filings in district courts declined from previous years, the federal judiciary continues to face over four-hundred thousand pending civil cases and criminal defendants.[111]

A decision favoring escalation as a remedy to ameliorate delays in the Medicare appeals process would not only impose potential burdens on judicial economy, but would deprive providers and beneficiaries ample opportunities to enter evidence into the record.[112] Evidentiary hearings before independent ALJs provide those parties appealing Medicare decisions the ability to bring their claims in front of professionals well-versed in the regulations governing national

108. *Id.*

109. *Id.* at *6.

110. *Id.*

111. FEDERAL JUDICIAL CASELOAD STATISTICS 2018 (2018), https://www.uscourts.gov/statistics-reports/federal-judicial-caseload-statistics-2018.

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

and local coverage determinations.[113] While the federal judiciary may very well have the ability to process these Medicare appeals at an acceptable rate, the administrative appeals process would most effectively be reformed from the inside as opposed to shifting the costs outward.

B. The Court's Holding is Correct Because it is Consistent with Other Courts' Reasoning in Due Process Proceedings and Protects Private Interests in Granting Injunctive Relief

The court justifiably emphasized the dangers inherent in allowing the appeals process to endure for multiple years while HHS and CMS recoup the allegedly overdue Medicare payments from providers and beneficiaries.[114] Statutory law establishing the Medicare appeals process sets the timeline for an adjudication process that may take up to a year, and more pertinent to this case, the law also establishes a statutory deadline of ninety days for both the ALJ and MAC-level appeals.[115] The court properly acknowledged how the changed timeframe may potentially impact present-day due process calculations for the adjudication of these claims.[116] While Family Rehab and other providers are not overly burdened by this normal schedule for the appellate process, the court was correct in recognizing that "three to five years"[117] is far too extensive to expect providers to wait in line with OMHA while their Medicare payments are withheld.[118]

The extensive delays in the Medicare appeals process are sufficient to implicate both the factors for due process claims established in *Eldridge* and those identified by the Fifth Circuit in *Canal Auth. of State of Fla. v. Calloway* for determining whether to grant injunctive relief.[119] These delays encourage providers to circumvent the statutory framework for adjudicating such disputes to create a secondary means of resolving claims through the federal judiciary. This appeals process will continue to fail providers by forcing those like Family Rehab to wait multiple years in a system not designed to take that long, which

113. *See generally* U.S.C. 42 § 1395 for statutory regulations that establish the Medicare program and set forth the guiding methods for bringing forward appeals.

114. *Family Rehab., Inc.,* 2018 WL 3155911 (N.D. Tex. June 28, 2018).

115. Am. Hosp. Assoc. v. Price, 867 F.3d 160, 162–63 (D.C. Cir. 2017).

116. *See Family Rehab., Inc.,* No. 3:17-CV-3008-K, 2018 WL 3155911, at *5 (N.D. Tex. June 28, 2018) ("While the statute allows CMS to begin recouping the alleged overpayments before the ALJ renders a decision, Congress likely did not anticipate that decision being delayed much longer than the statutorily prescribed 90 days and certainly not a delay of three to five years.").

117. Family Rehab., Inc. v. Azar*,* No. 3:17-CV-3008-K, 2018 WL 3155911, at *2 (N.D. Tex. June 28, 2018).

118. *Family Rehab, Inc.,* 2018 WL 3155911.

119. Mathews v. Eldridge, 424 U.S. 319 (1976); Canal Auth. of State of Fla. v. Callaway, 489 F.2d 567, 572 (5th Cir. 1974).

will drag them through a process that outgrew its original structure.[120] While statutory guidelines sufficiently ensured the reasonable progression through the appeals process in the past, the court was correct to hold that the current system has not kept up with the demands that face OMHA and HHS.[121] Though the delays are not fully attributable to any one factor, they seem to have been exacerbated by the introduction of the Medicare Recovery Audit Program.[122] This decision is part of an ongoing litigation process, and the holding should be considered in light of the relative precedential weight of a district court decision.[123] However, Family Rehab's argument is sound and may offer providers a framework for bringing forward further proceedings in other districts.

C. The Court's Decision Has Potential Policy Implications on the Future of the Medicare Program as a Whole

In addition to posing potentially significant legal implications, the court's decision also implicates broader and otherwise important policy concerns central to the future of the Medicare program as a whole. Specifically, the court's decision will ensure protection from unjust harm for future providers that are similarly situated to Family Rehab. Further, the court's decision underscores the inadequacy of payment recoupment as a method for remedying the Medicare appeals backlog.

1. Medicare is a driving force of the American health care industry, and providers similarly situated as Family Rehab must be protected from unjust harm.

In 2017, the federal government spent almost $600 billion on Medicare, roughly 3.1% of the nation's gross domestic product.[124] Further, in 2017, the number of beneficiaries expected to be covered by Medicare was "projected to cover nearly 57.7 million elderly and disabled beneficiaries, nearly one in six Americans."[125] These numbers illustrate the massive portion of both the overall economy and the United States' population that Medicare directly affects, and

120. *See* Family Rehab, Inc., 2018 WL 3155911, at *5 (N.D. Tex. June 28, 2018) (stating that while Congress allows CMS to begin recoupment before an ALJ issues a decision, they likely did not anticipate the delays in the process taking so long).

121. *Id.*

122. *Id.*

123. The court issued another Order in October of 2018 to clarify their prior order for preliminary injunction in favor of Family Rehab. *See* Family Rehabilitation, Inc. v. Azar, 2018 WL 10419829 (N.D.Tex., 2018).

124. CONG. BUDGET OFFICE, THE FEDERAL BUDGET IN 2017: AN INFOGRAPHIC (March 5, 2018), https://www.cbo.gov/publication/53624.

125. BARRY R. FURROW, ET. AL., HEALTH LAW – CASES, MATERIALS, AND PROBLEMS (West 2013).

demonstrates the aggregate effect that judicial decisions regarding Medicare can have on the country overall.

Medicare reimbursements were crucial to Family Rehab,[126] specifically in light of their status as a home health agency. Providers such as Family Rehab frequently serve a high percentage of elderly clientele, who are dependent on, or at least eligible for, Medicare and who prefer to stay in their homes as opposed to moving into assisted living centers.[127] Upholding the view that Medicare reimbursement payments are a vital property interest will protect the due process rights of providers like Family Rehab and thosesimilarly situated who are dependent on these payments to keep their businesses afloat.

The National Center for Health Statistics reported in 2014 that of the roughly 12,400 home health agencies operating in the country, 98% of the agencies were Medicare-certified.[128] These numbers illustrate a business scheme that heavily involves Medicare reimbursements, and relies on the ability to properly navigate the administrative appeals process that accompanies Medicare claims and beneficiaries. The decision in *Family Rehab* further protects the property interests in these payments that providers may depend upon. If further adopted by the Fifth Circuit, or on a more national scale, the holding in *Family Rehab* will ensure less burdensome claims appeals for providers like Family Rehab whose business models involve Medicare payments.

2. The recoupment of Medicare payments is an ineffective means of eliminating the Medicare appeals backlog

The Medicare appeals backlog is a widely known problem facing both HHS and the federal government, as well as the health care industry as a whole. Ongoing litigation focuses on different methods of eliminating the backlog, and recent filings may illustrate a problematic solution being proposed by the current administration.[129] In these most recent filings from *American Hospital Association v. Azar*, HHS cites the apportionment of funds from Congress geared towards increasing the staffing capabilities of OMHA as being a credible solution for the appeals backlog.[130] The funding proposals seek to increase the overall OMHA budget by, "a 70% increase over the amount appropriated for fiscal year

126. *See Family Rehab., Inc. v. Azar,* No. 3:17-CV-3008-K, 2018 WL 3155911, at *5 (N.D. Tex. June 28, 2018) ("Family Rehab is a small home health care provider, serving 289 patients until recently, and relies on Medicare reimbursements for services rendered for approximately 94% of Family Rehab's revenue stream.").

127. L. Harris-Kojetin et al., *Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014*, VITAL HEALTH STATS. 3(38) (2016).

128. *Id.*

129. *See supra* Section II.C.

130. Am. Hosp. Ass'n v. Azar, No. CV 14-851 (JEB), 2018 WL 5723141, Defendant's Status Report and Response to Plaintiff's Proposed Non-Deadline Remedies, https://www.aha.org/system/files/2018-08/180803-ahavazar-secy-remedy-brief.pdf.

2017."[131] The increased apportionment of funds is an encouraging sign that the different branches of government are attempting to fix the solution outside of a federal courtroom and shows promise that Congress is willing to seriously work towards eliminating the backlog. However, this massive budget apportionment to OMHA may be a shortsighted, inadequate strategy and, ultimately, a largely pyric victory.

OMHA is just the third stage in the Medicare appeals process, with a statutory right to appeal ALJ decisions issued by OMHA to the DAB.[132] While the figures are more staggering for the number of appeals awaiting to be adjudicated at the OMHA level, a considerable backlog at the DAB level remains.[133] If OMHA is able to use its new budgetary apportionment to increase the number of decisions it is able to produce, it may not be a surprise to some that the number of appeals of ALJ decisions could increase.[134] The increased productivity of OMHA will likely benefit providers such as Family Rehab who have their claims adjudicated through an evidentiary hearing before an ALJ. It may even prove contradictory to this court's holding, in that providers may no longer be harmed by escalating their appeals up through the system if they are actually able to sit for an evidentiary hearing.[135]

Nonetheless, this increase in adjudicatory efficiency at one level of the Medicare appeals chain must be met with increased efficiency at the requisite step in the appeals process. While the increased productivity of OMHA may allow more evidentiary hearings to take place, the court's holding that Congress did not intend for the escalation process to become mandatory is still relevant.[136] Lessening the damage rendered through an approach centered on escalation fails to address the root issues at play in the Medicare Act's language. If a health care provider has the opportunity for at least an evidentiary hearing before an ALJ prior to getting back in line to wait to appeal that same ALJ's ruling to the DAB, the provider still remains stuck in the administrative system.

The increased budgetary apportionment for OMHA may not achieve the overall goals that HHS is ultimately trying to accomplish in truly eliminating the

131. *Id.*

132. *See* 42 U.S.C. § 405.1395.

133. U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS PRIMER: THE MEDICARE APPEALS PROCESS 3 (2015), https://www.hhs.gov/dab/medicare-appeals-backlog.pdf ("As a result, as of the end of FY 2015, 884,017 appeals were waiting to be adjudicated by OMHA and 14,874 appeals were waiting to be reviewed at the Council. Under current resources (and without any additional appeals), it would take 11 years for OMHA and 6 years for the Council to process their respective backlogs.

134. Am. Hosp. Ass'n v. Azar, No. CV 14-851 (JEB), 2018 WL 5723141, Defendant's Status Report and Response to Plaintiff's Proposed Non-Deadline Remedies, https://www.aha.org/system/files/2018-08/180803-ahavazar-secy-remedy-brief.pdf (2018).

135. *See supra* Section III.

136. *See supra* Section III.

backlog. This conclusion may not be realized, and it is presently impossible to do anything more than speculate on the actual results of this budgetary increase. This does provide hope that the legislative and executive branches may look to further increase their pragmatic approach to solving this problem.

V. CONCLUSION

In *Family Rehabilitation, Inc. v. Azar*[137], the United States District Court for the Northern District of Texas addressed issues facing health care suppliers and the administration of Medicare payments. In the June 2018 opinion, the court concluded that the plaintiff, Family Rehabilitation Clinic, demonstrated both the required standards for a procedural due process claim and the threat of "irreparable harm", and thus granted their motion for a preliminary injunction.[138] The court's decision was correct and implicates policy concerns that may not be addressed by simply throwing more money at the problem through simply increasing funding to the Office of Medicare Hearings and Appeals.[139] The court correctly held that Medicare payments are a property interest in the context of due process proceedings, and thus ensured protections for health care providers who base their business models on these payments.[140] It remains important to see how the case unfolds, but this seemingly innocuous slip opinion may very well serve to protect health care providers mired in the Medicare appeals process and illustrate the means by which providers in other Federal districts may protect themselves from HHS's improper means of recoupment during post-payment reviews.[141]

137. No. 3:17-CV-3008-K, 2018 WL 3155911, (N.D. Tex. June 28, 2018).

138. *Family Rehab., Inc.*, 2018 WL 3155911.

139. S*ee supra* Section IV.C.

140. *See supra* Section IV.A.

141. *See supra* Section IV.B.