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CLIENT ALERT

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Clearing the Logjam: District Court Issues Deadlines for HHS to Eliminate the Medicare Payment Appeals Backlog

By Trevor Presler, William Stewart, and PJ Puryear

In a highly anticipated decision, the U.S. District Court for the District of Columbia has granted mandamus and ordered that the Department of Health and Human Services ("HHS") must eliminate the substantial backlog of Medicare payment appeals awaiting review by an administrative law judge ("ALJ") over the next four years. *Am. Hosp. Ass'n v. Burwell*, No. 14-851 (D.D.C. Dec. 5, 2016). If allowed to stand, this decision will likely result in leverage—if not relief—for health care providers facing Medicare reimbursement claims.

The mandamus action sought to compel HHS to meet the statutory deadlines for administrative review of denied Medicare reimbursement claims. Although the Medicare statute directs ALJs to "conduct and conclude a hearing . . . and render a decision within 90 days", HHS' increased efforts since 2010 to recoup overpayments through the Medicare Recovery Audit Program ("RAC Program") has resulted in a significant and growing logjam of cases pending review by an ALJ. Indeed, the D.C. Circuit Court of Appeals noted that, at the "current rates, some already-filed claims could take a decade or more to resolve." *Burwell*, 812 F.3d 183 at 187.

The District Court largely adopted the Plaintiffs' proposed timetable for relief, determining that HHS must reduce the number of old cases pending ALJ review by 30 percent by the end of 2017, 60 percent by the end of 2018, 90 percent by the end of 2019, and 100 percent by the end of 2020. Beginning on January 1, 2021, claimants whose appeals have been pending ALJ review without hearing for more than one calendar year may file for default judgment or for mandamus. The District Court's determination places the onus on HHS to determine how best to reduce the appeal backlog, and is likely to increase the government's incentive to settle cases pending appeal.

The Medicare Administrative Appeals Process and Appeals Backlog

Medicare providers submit claims to Medicare Administrative Contractors ("MACs"), which determine whether to reimburse or deny the claim. If the MAC determines that the claim should be denied, or if a claim is identified as an overpayment through the RAC Program, the Medicare statute and related regulations provide a four-level administrative appeal process, and place time constraints for each level of appeal. Level one appeals consist of a request for redetermination by

the MAC, and must be concluded within 60 days. Level two appeals consist of a request for reconsideration by a Qualified Independent Contractor, and must be concluded within 60 days unless an exception applies. Both level one and level two appeals are overseen by the Centers for Medicare and Medicaid Services. Level three appeals, which are overseen by the Office of Medicare Hearings and Appeals, are limited to claims greater than $150 and require a *de novo* review by an ALJ. The Medicare statute requires that ALJ hearings must be conducted and concluded within 90 days unless the provider waives this deadline. Finally, level four appeals involve *de novo* review by the Medicare Appeals Council, and must be conducted and concluded within 90 days. After exhausting these administrative remedies, providers with claims greater than $1,500 may request review in district court.

Absent delays, an appeal should be able to work through the four stages of administrative review in under a year; and for many years, this was the case. However, as result of increased efforts to identify waste, fraud, and abuse through the RAC Program, as well as increased utilization of Medicare services overall, the number of administrative appeals increased by nearly 936 percent between 2010 and 2014. Despite considerable efforts by HHS to reduce delays, including a ten percent increase in staffing, ALJs have been unable keep pace with the burgeoning caseload. By July 2014, a bottleneck of over 800,000 cases had formed. By February 2015, the typical case took over 18 months to be resolved by an ALJ once it was appealed from an adverse Reconsideration decision. Because HHS recoups funds following the Reconsideration phase, providers are denied access to funds during the pendency of appeal at the ALJ stage.

The District Court Decision

Plaintiffs filed a request for mandamus with the U.S. District Court for the District of Columbia in May of 2014 to compel HHS to meet the statutory deadlines for administrative review of overpayment recoupments and denied claims. The complaint alleged that all of the plaintiff-hospitals had substantial revenues entangled in the administrative appeal process, and that delays at the ALJ phase had stymied hospital operations and jeopardized services. While the District Court initially dismissed the complaint for lack of jurisdiction, the D.C. Circuit Court of Appeals reversed the decision and remanded the case with an instruction for the District Court to determine whether "compelling equitable grounds" exist to issue a writ of mandamus, including whether delays in processing appeals are "so egregious as to warrant mandamus." *Burwell*, 812 F.3d 183 at 192.

On remand, HHS moved to stay the proceedings until September 30, 2017, the end of the appropriations cycle, to allow the agency to implement various legislative and administrative remedies aimed at reducing the backlog of appeals. The District Court rejected this approach, however, finding that adequate equitable grounds existed to grant mandamus. In its December 5th ruling, the District Court largely adopted a strategy proposed by the Plaintiffs, which imposes targeted numeric reductions in the appeals backlog through 2020 but grants HHS latitude in determining how best to meet these goals. Under the timetable, HHS must achieve the following reductions in cases currently pending appeal at the ALJ level:

- 30 percent by the December 31, 2017;

- 60 percent by the December 31, 2018;
- 90 percent by the December 31, 2019; and
- 100 percent by the December 31, 2020.

The District Court rejected the Plaintiff's request to automatically grant a default judgement to claimants whose appeals have been pending ALJ review without hearing for more than one calendar year as of January 1, 2021. It held, however, that such claimants may file for default judgement at that time. While HHS may appeal the decision, both the recent District Court ruling and the D.C. Circuit opinion make clear that the courts will not grant HHS unlimited time to resolve Medicare appeals, particularly following recoupment. The ruling is likely to give providers more leverage to reach settlements with HHS in Medicare payment appeals, particularly those pending review before an ALJ.

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