[ORAL ARGUMENT NOT SCHEDULED]

No. 15-5015

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

AMERICAN HOSPITAL ASSOCIATION, BAXTER REGIONAL MEDICAL CENTER, RUTLAND REGIONAL MEDICAL CENTER, AND COVENANT HEALTH

Plaintiffs-Appellants,

v.

SYLVIA MATHEWS BURWELL, in her official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellee.

On Appeal from the United States District Court
for the District of Columbia

BRIEF FOR THE APPELLEE

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CERTIFICATE AS TO PARTIES, RULINGS, AND RELATED CASES

A. *Parties and Amici*. All parties, intervenors, and amici appearing before the district court and in this Court are listed in the Brief for Appellants.

B. *Rulings Under Review*. All rulings under review are listed in the Brief for Appellants.

C. *Related Cases.* The Secretary is aware of the following cases raising issues substantially similar to the ones at issue here: *Cumberland County Hospital v. Burwell*, No. 15-1393 (4th Cir.); *Exley v. Burwell*, No. 3:14-cv-1230 (D. Conn.); *Triple A Home Care Agency v Burwell*, No. 4:15-cv-00668 (E.D. Mo.); *Casa Colina Hosp. v. Burwell*, 2:15-cv-03990-DSF-AS (C.D. Cal.).

/s/ *Joshua M. Salzman*
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GLOSSARY

ALJ	Administrative Law Judge
CMS	Center for Medicare & Medicaid Services
HHS	Department of Health and Human Services
OMHA	Office of Medicare Hearings and Appeals

INTRODUCTION

Medicare providers have a statutory right to multiple layers of administrative review of decisions denying claims for reimbursement. The pertinent statute contemplates that components within the Department of Health and Human Services (HHS) will provide this review within specified timetables. In recent years, however, the number of appeals reaching the third level of administrative review has skyrocketed tenfold, while funding of the HHS component that administers this level of appeal has remained relatively flat. Due to this massive influx of appeals, HHS adjudicators have been unable to resolve appeals within the timeframes contemplated by the Medicare statute, even though the agency doubled the efficiency of its administrative law judges. Subcommittees of both houses of Congress have held hearings regarding the backlog, during which, members recognized that HHS currently lacks the resources to resolve the existing backlog and expressed their intent to devise a legislative solution.

Plaintiffs seek a writ of mandamus that would require HHS to meet the statutory timetables. Plaintiffs do not seriously contest that it is currently impossible for the Secretary to adjudicate claims on the timeline they demand, but they insist that the "Secretary could consider any number of partial interim solutions to help eliminate the backlog." Br. 35. Plaintiffs and their amici also

specifically criticize the current operations of the statutorily-mandated recovery audit program, and ask that the Secretary be required to change it.

But demands of these sorts are not cognizable through a writ of mandamus. A writ of mandamus, like an order to compel agency action improperly delayed pursuant to 5 U.S.C. § 706(1), is available only to compel clearly defined, ministerial acts, where the claimant has a clear entitlement to relief and where the federal officer has clear duty to act. *See Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55, 64 (2004). This case, by contrast, implicates discretionary policy judgments of a sort uniquely reserved for the political branches. *See Mashpee Wampanoag Tribal Council, Inc. v. Norton*, 336 F.3d 1094, 1101 (D.C. Cir. 2003). As this Court has recognized, when a "problem stem[s] from a lack of resources," it is "'a problem for the political branches to work out.'" *Id.* (quoting *In re Barr Labs.*, 930 F.2d 72, 75 (D.C. Cir. 1991)). The district court correctly denied plaintiffs' request for a writ of mandamus, and this Court should affirm that judgment.

STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction pursuant to 28 U.S.C. § 1361. JA6 (Complaint). The district court granted the Secretary's motion to dismiss for lack of jurisdiction and entered final judgment on December 18, 2014. JA165 (Final Judgment). Plaintiffs filed a timely notice of appeal on January 16,

2015. JA187-JA188. This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291.

STATUTES AND REGULATIONS

The relevant statutes and regulations are reprinted in the Brief of the Appellants.

STATEMENT OF THE ISSUE

Whether plaintiffs are entitled to a writ of mandamus that would compel HHS to adjudicate Medicare appeals on a particular timetable, particularly where the agency lacks the resources to meet that timetable.

STATEMENT OF THE CASE

A. Medicare And The Administrative Appeals Process For Part A And Part B Claims

The Medicare statute, 42 U.S.C. § 1395 *et seq.*, establishes a federal program of health insurance for the elderly and disabled. In general, Part A covers inpatient hospital stays and other institutional care, as well as home health care, *see* 42 U.S.C. § 1395d; Part B covers physician and other medical services, *see* 42 U.S.C. § 1395k. The Secretary administers the Medicare program and has authority to promulgate implementing regulations, 42 U.S.C. § 1395hh(a)(1). Within HHS, the Medicare reimbursement program is administered by the Center for Medicare & Medicaid Services (CMS).

As relevant here, when a health-care provider furnishes services the provider believes to be covered under Medicare Part A or B, the provider submits a claim for payment to a Medicare Administrative Contractor, a private contractor responsible for making an "initial determination" as to what payment (if any) should be made on the claim. *See* 42 U.S.C. § 1395kk-1(a); 42 U.S.C. § 1395ff(a)(1)-(2); 42 C.F.R. §§ 405.904(a)(2), 405.920-405.928. When a provider is dissatisfied with this initial determination, it can bring a challenge through a four-level administrative appeals process. *See* 42 U.S.C. § 1395ff. After administrative appeals are exhausted, if the provider is still dissatisfied, it may bring suit in federal court.

At the first level of administrative review, a party dissatisfied with an initial determination may seek a "redetermination" by the private contractor. 42 U.S.C. § 1395ff(a)(3); 42 C.F.R. §§ 405.904(a)(2), 405.940-405.958. Such determinations should generally issue 60 days after the filing of the redetermination request. *See* 42 U.S.C. § 1395ff(a)(3)(C)(ii); 42 C.F.R. § 405.950.

At the second level of administrative review, a party dissatisfied with the redetermination may seek "reconsideration" by a Qualified Independent Contractor, another independent entity under contract with CMS. 42 U.S.C. § 1395ff(b)-(c), (g); 42 C.F.R. §§ 405.902, 405.904(a)(2), 405.960-405.978. The Qualified Independent Contractor is required to conduct an "independent, on-the-

record review of an initial determination, including the redetermination and all issues related to payment of the claim," and in doing so, to "review[] the evidence and findings upon which the [previous determinations were] based, and any additional evidence the parties submit or that the [Qualified Independent Contractor] obtains on its own." 42 C.F.R. § 405.968(a). Reconsideration decisions should generally issue within 60 days of the timely filing of the reconsideration request. *See* 42 U.S.C. § 1395ff(c)(3)(C)(i); 42 C.F.R. § 405.970.

If the provider is still dissatisfied or if no decision is made within 60 days, the provider may appeal to the third level of administrative review, a hearing before an administrative law judge (ALJ). 42 U.S.C. § 1395ff(b), (d)(1); 42 C.F.R. §§ 405.904(a)(2), 405.1000-405.1054. The Medicare statute provides that ALJs "shall conduct and conclude a hearing on a decision of a [Qualified Independent Contractor] and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed." 42 U.S.C. §1395ff(d)(1)(A); *accord* 42 C.F.R. § 405.1016 (reiterating 90-day time frame unless extended). The statute further specifies the "[c]onsequences of failure to meet [this] deadline[]"; if the ALJ fails to provide a timely determination, the party is excused from having to exhaust ALJ review and may "escalate" the appeal—without an ALJ hearing decision—to the fourth level of administrative review. 42 U.S.C. § 1395ff(d)(3)(A); 42 C.F.R. § 405.1104.

The fourth and final level of administrative review is provided by the Medicare Appeals Council ("Appeals Council"), a component within HHS's Departmental Appeals Board. 42 U.S.C. § 1395ff(d)(2); 42 C.F.R. §§ 405.904(a)(2), 405.1100-405.1140; JA115 (Declaration of Appeals Board Chair Constance Tobias). The Appeals Council generally conducts de novo review of the ALJ's determination, 42 C.F.R. § 405.1100(c), and its decisions are subject to judicial review, 42 C.F.R. § 405.1130. The Medicare statute directs the Appeal Council to make a decision or remand the case to the ALJ within 90 days of the date a request for review is received. 42 U.S.C. § 1395ff(d)(2); *see also* 42 C.F.R. § 405.1100(c).[1] The statute further specifies the "[c]onsequences of failure to meet [this] deadline[]"; if the Appeals Council fails to act in a timely manner, the party may "escalate" the appeal by seeking review directly in federal court. 42 U.S.C. § 1395ff(d)(3)(B); 42 C.F.R. § 405.1132.[2]

The ALJ hearing program that provides the third level of administrative review is administered by HHS's Office of Medicare Hearings and Appeals

[1] For cases "escalated" from the ALJ level to this level, the Appeals Council is either to issue a final decision or dismissal order or to remand the case to the ALJ within 180 days from receipt of the appellant's request for escalation. 42 C.F.R. § 405.1100(d).

[2] A party has 60 days from the date it receives the Appeals Council's notice that it is not able to issue a final decision in which to file an action in district court. 42 C.F.R. § 405.1132(b).

(OMHA), a division within the Office of the Secretary that is independent of CMS. *See* JA50 (2014 Testimony of Chief ALJ Nancy Griswold); *see also* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 931, 117 Stat. 2066, 2396 (2003); 76 Fed. Reg. 19,995 (Apr. 11, 2011); 70 Fed. Reg. 36,386 (June 23, 2005). To help maintain its independence, OMHA is funded through a separate appropriation. JA50 (2014 Griswold Testimony); Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, 128 Stat. 2130, 2483 (2014).

B. The Recovery Audit Contractor Program

The Medicare program processes more than one billion claims each year, submitted by more than one million healthcare providers.[3] Due to the large volume of claims submitted, most claims submitted to Medicare are generally paid without requesting and reviewing the medical records to support the services billed, and as a result, claims may be paid inappropriately.[4] In 2003, Congress directed the Secretary to "conduct a demonstration project . . . to demonstrate the use of recovery audit contractors" to identify and recoup overpayments under Medicare

[3] CMS, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2013*, at iv, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf (last visited June 30, 2015) (*2013 RAC Report*).

[4] *2013 RAC Report* at 1-2.

parts A and B. Pub. L. No. 108–173, § 306, 117 Stat. at 2256. Congress instructed the Secretary to hire independent contractors to identify duplicative payments, inaccurate coding, and other breaches of payment policies in which inaccurate payments arise. *Id.*

"In light of the demonstration project's success, Congress made the [recovery audit] program a permanent part of the Medicare Integrity Program and expanded its coverage to all states." *Palomar Med. Ctr. v. Sebelius*, 693 F.3d 1151, 1157 (9th Cir. 2012); *see* Pub. L. No. 109–432, div. B, § 302, 120 Stat. 2922, 2991 (2006) (codified at 42 U.S.C. § 1395ddd(h)). In so doing, Congress directed that payments to recovery audit contractors be made "on a contingent basis for collecting overpayments." 42 U.S.C. § 1395ddd(h)(1)(B). The recovery audit program took nationwide effect in 2010. *Id.* § 1395ddd(h)(1).

The recovery audit program has successfully returned billions of dollars of improper payments to the Medicare Trust Fund. In 2012, the program identified $2.3 billion in overpayments,[5] and in fiscal year 2013, the recovery auditors

[5] See CMS, *Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012*, at iv-v, 11, *available at* http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Report-To-Congress-Recovery-Auditing-in-Medicare-and-Medicaid-for-Fiscal-Year-2012_013114.pdf (last visited June 30, 2015) (*2012 RAC Report*).

identified and corrected $3.65 billion in overpayments.[6] In 2012, only 7% of claims identified by audit contractors as overpayments were challenged and overturned on appeal.[7] For 2013, the figure was 9.3%.[8]

C. The Present Backlog Of Provider Medicare Appeals

The 90-day time frame for the third and fourth level of coverage appeals took effect in 2005. In general, the agency successfully met that time frame from its 2005 inception through fiscal year 2010. JA50 (2014 Griswold Testimony). Between fiscal years 2011 and 2013, however, the upward trend in ALJ hearing requests "took an unexpectedly sharp turn": appeals filed with the agency increased by 545%. JA50. Overall, between fiscal year 2010 through fiscal year 2014, OMHA experienced a 1,222% surge in appeals.[9] A combination of factors contributed to this dramatic workload increase: increased utilization of Medicare-covered services, the additional appeals from audits conducted under the recovery audit program, as well as an increases in Medicaid State Agency appeals of

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[6] *2013 RAC Report* at iv, 11.

[7] *2012 RAC Report* at 11; *see also* JA50 (2014 Griswold Testimony).

[8] *2013 RAC Report* at 13.

[9] Judge Nancy J. Griswold, *Appellant Forum–Update from OMHA*, at 8 (June 25, 2015), http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/ presentation_of_judge_nancy_j._griswold.pdf (last visited June 30, 2015).

Medicare coverage denials for beneficiaries enrolled in both Medicare and Medicaid. JA50 (2014 Griswold Testimony).

Despite the massive increase in its workload, OMHA, which is funded through a specific line-item appropriation, has received only a modest increase in funding since the surge in appeals. JA51 (2014 Griswold Testimony). The agency has sought to maximize the efficiency of the existing process by supporting each ALJ with a processing team of attorneys and support staff so that the ALJs can focus on hearing and deciding appeals. JA50-JA51. The ALJs have responded to the additional workload by increasing their productivity—the average number of dispositions per ALJ more than doubled between fiscal year 2009 and fiscal 2013. JA50.

Despite these efforts, because appropriations have remained relatively flat, there is currently a backlog of 800,000 appeals before the agency, roughly ten times the number of claims that it can adjudicate annually at current funding levels. JA51 (2014 Griswold Testimony). As of February 28, 2015, OMHA was taking an average of 572 days to adjudicate appeals.[10]

[10] *See Statement of Nancy J. Griswold Before the United States Senate Finance Committee* (Apr. 28, 2015), http://www.finance.senate.gov/imo/media/doc/SFC%20GriswoldOMHA%20updated%20testimony%20%204%2028% 2015.pdf (last visited June 30, 2015) (*2015 Griswold Testimony*).

The Departmental Appeals Board, which provides the fourth level of review through the Appeals Council, has likewise seen a surge in the number of appeals. Between fiscal years 2010 and 2013, the Appeals Council's pertinent caseload doubled. JA117 (Tobias Decl.). Accordingly, the Appeals Council has developed a corresponding (though smaller) backlog of 9,850 cases.[11] Like OMHA, the Appeals Council has not received corresponding resources to handle this spike in appeals. As a result of the lack of resources to address the current volume of appeals, the Appeals Council cannot meet the 90-day timeframe for issuing decisions in most appeals. JA117 (Tobias Decl.), JA127 (Presentation).

In order to address the backlog, the President's fiscal year 2016 Budget (FY 2016 Budget) proposes more than tripling OMHA's funding from $87.3 million to $270 million.[12] The FY 2016 Budget also includes a package of seven legislative proposals aimed both at helping OMHA process a greater number of appeals and facilitating the appropriate resolution of appeals at earlier levels of the process. *2015 Griswold Testimony* at 7-9. HHS projects that if the legislative and funding

[11] Judge Constance Tobias, *Departmental Appeals Board Update, Medicare Appeals Council*, at 5, http://www.hhs.gov/omha/OMHA%20Medicare%20Appellant%20Forum/presentation_of_judge_constance_b._tobias.pdf (June 25, 2015) (last visited June 30, 2015).

[12] *2015 Griswold Testimony* at 7; Office of the Sec'y, OMHA, *HHS FY 2016 Budget in Brief*, http://www.hhs.gov/about/budget/budget-in-brief/omha/index.html (last visited June 30, 2015).

requests made in the President's budget are granted in full, OMHA will increase its adjudication capacity by 261%, from 77,000 appeals per year to approximately 278,000 appeals per year.[13]

Since well before the FY 2016 Budget, Congress has been aware of the existing backlog and has recognized the need for a legislative solution. In July 2014, a congressional subcommittee conducted a hearing devoted to the problem and took testimony from Chief Administrative Law Judge Nancy Griswold. *See Medicare Mismanagement Part II: Exploring Medicare Appeals Reform: Hearing Before the H. Oversight and Government Reform Subcomm. on Energy Policy, Health Care, and Entitlements*, 113th Cong. (July 10, 2014).[14] At that hearing, Congress recognized that HHS has been tasked with conflicting responsibilities and has been provided with inadequate resources. Representative Jackie Speier

[13] *2015 Griswold Testimony* at 7. The FY 2016 Budget also includes a request by CMS for $36.2 million to enable "CMS to engage in discussions with providers to resolve disputes at the earliest stage in the appeals process and additional funding for greater CMS participation in Administrative Law Judge hearings" which will "improve the efficiency of the Medicare appeals process at the third and fourth level, enabling OMHA to more quickly and efficiently adjudicate its current backlog by reducing the number of claims appealed beyond the CMS levels." CMS, HHS, *Justification of Estimates for Appropriations Committees Fiscal Year 2016*, at 48, http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf (last visited June 30, 2015).

[14] Hearing video available at http://oversight.house.gov/hearing/ medicare-mismanagement-part-ii-exploring-medicare-appeals-reform/ (last visited June 30, 2015) (*House Hrg. Video*).

described the backlog as "a problem that Congress created" by directing CMS to implement the recovery audit program so to as limit "waste, fraud, and abuse," while not providing "additional funds to address the influx of claims and appeals that have resulted." *House Hrg. Video* at 6:14-6:54 ; *see id.* at 7:59 (noting when "we wring our hands" about the existing delays we should "look directly at ourselves"). Representative Mark Meadows likewise recognized that OMHA lacks the resources to resolve the caseload it is facing. *Id.* at 22:9 ("This is not a problem of an administrative law judge just sitting back eating bonbons.").

In April 2015, the Senate Finance Committee similarly devoted a hearing to the backlog and took testimony from Judge Griswold and others. *See Creating a More Efficient and Level Playing Field: Audit and Appeals Issues in Medicare: Hearing Before Sen. Comm. on Finance* (Apr. 28, 2015).[15] Senator Wyden recognized that "with a 10-fold increase in the number of cases, it's clear that additional resources are needed."[16] And Chairman Hatch noted that "The Office of Medicare Hearings and Appeals has . . . taken steps to address its backlog, but

[15] Hearing video available at http://www.finance.senate.gov/hearings/hearing/?id=d29af43d-5056-a032-526a-1de427f91aeb (last visited June 30, 2015); *see also 2015 Griswold Testimony*.

[16] *Wyden Statement at Finance Hearing on the Medicare Appeals Process* (Apr. 28, 2015), http://www.finance.senate.gov/imo/media/doc/042815%20Wyden%20Statement%20at%20Finance%20Hearing%20on%20the%20Medicare%20Appeals%20Process1.pdf (last visited June 30, 2015).

there is only so much the agency can do with their current authorities and staffing."[17] He made clear that Congress is focused on addressing the problem, concluding, "Senator Wyden and I, and the other members of this committee, are committed to finding ways to make the appeals process work more efficiently and effectively in order to ease the burden on beneficiaries and providers and to protect the Medicare Trust Fund."[18]

On June 3, 2015, the Senate Finance Committee reported out a bipartisan bill, the Audit and Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015, to address existing problems in the Medicare appeals process, including the existing backlog.[19] This proposed legislation would provide $125 million in new funding to OMHA (over and above existing funding levels), would modify the audit recovery program in certain respects, and would incorporate other measures designed to improve efficiency and promote alternative dispute resolution. The

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[17] *Hatch Statement at Finance Hearing on Medicare Audit and Appeals* (Apr. 28, 2015), http://www.finance.senate.gov/imo/media/doc/4.14.15%20RELEASE%20Hatch%20Statement%20at%20Finance%20Hearing%20on%20Creating%20a%20More%20Efficient%20and%20Level%20Playing%20Field%20Audit%20and%20Appeals%20Issues%20in%20Medicare1.pdf (last visited June 30, 2015) (*Hatch Statement*).

[18] *Id.*

[19] *See* Sen. Comm. on Finance, *Open Executive Session to Consider an Original Bill Entitled Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015* (June 3, 2015), http://www.finance.senate.gov/hearings/hearing/?id=d84a2bef-5056-a032-522c-8a3c9badb3ac (last visited June 30, 2015).

legislation also proposes additional resources for the Departmental Appeals Board.[20]

D. Facts And Prior Proceedings

Plaintiffs are the American Hospital Association and three individual hospitals or health systems that state that they have appeals that have been pending before OMHA and/or the Appeals Council for more than 90 days. JA18-JA19 (Complaint). They filed this suit pursuant to 28 U.S.C. § 1361, seeking a mandamus order to compel the Secretary to "forthwith . . . provide" the individual plaintiffs with decisions in each of their claim appeals that have been pending for more than 90 days. JA21-JA22. They also sought a declaration that HHS's delay in adjudication violates federal law and an order "requiring HHS to otherwise comply with its statutory obligations in administering the appeals process for all hospitals." JA21-JA22.

Plaintiffs moved for summary judgment and the Secretary moved to dismiss. The district court then granted the motion to dismiss, denied summary judgment to the plaintiffs, and entered final judgment in favor of the Secretary. *See* JA165 (Final Judgement).

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[20] Sen. Comm. on Finance, *Description of the Chairman's Mark Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015* (2015), http://www.finance.senate.gov/imo/media/doc/FINAL%20Mark%20language%20060115.pdf (last visited June 30, 2015).

Drawing on this Court's decision in *In re Barr Laboratories, Inc.*, 930 F.2d 72 (D.C. Cir. 1991), which the court noted "resembles the present [case] in several key respects," the court recognized this case to present "precisely the kind of conundrum" this Court "has cautioned courts against trying to solve." JA179, JA181 (District Court Op.). Applying the factors described in *Telecommunications Research & Action Center v. FCC*, 750 F.2d 70 (D.C. Cir. 1984) (*TRAC*), the court concluded that plaintiffs had failed to show equitable entitlement to relief.[21] The court recognized that "mandamus jurisdiction is not a license to intermeddle" and potentially interfere with "the problem-solving efforts of the other two branches of government." JA182-JA183. It concluded that the case is "fraught with policy considerations best left to the judgment of the Secretary and Congress." JA184. Because this case involves an agency that is "underfunded" and "processing Plaintiffs' appeals on a first-come first-served basis," the court concluded that judicial intervention would be inappropriate. JA184. This timely appeal followed.

[21] The *TRAC* factors are: (1) the time agencies take to make decisions must be governed by a rule of reason; (2) where Congress has provided a timetable or other indication of the speed with which it expects the agency to proceed in the enabling statute, that statutory scheme may supply content for this rule of reason; (3) delays that might be reasonable in the sphere of economic regulation are less tolerable when human health and welfare are at stake; (4) the court should consider the effect of expediting delayed action on agency activities of a higher or competing priority; (5) the court should also take into account the nature and extent of the interests prejudiced by delay; and (6) the court need not find any impropriety lurking behind agency lassitude in order to hold that agency action is unreasonably delayed. 750 F.2d at 80.

SUMMARY OF ARGUMENT

Plaintiffs seek to compel HHS to resolve a substantial backlog of administrative appeals by Medicare providers who are challenging reimbursement determinations and to adjudicate appeals at the ALJ and Appeals Council levels within the 90-day timeframes contemplated by the statute.

As an initial matter, mandamus relief is inappropriate because the same statute that prescribes the 90-day time frames also specifies the consequences for failure to meet those time-frames: in the absence of a timely ALJ decision, a claimant may seek review before the Appeals Council and, if the Appeals Council fails to render a timely decision, the claimant may then seek review directly in district court. Plaintiffs would prefer an order accelerating the administrative process, but they cannot demand a mandamus order to effectuate their preferred path of review.

In any event, plaintiffs do not dispute that the Secretary currently lacks resources to eliminate the backlog or meet the 90-day time frames. Although the agency has doubled the efficiency of its ALJs since 2009, Congress has not provided the resources needed to adjudicate claims within the timetable contemplated by the Medicare statute. Several members of Congress have explicitly recognized that this is the case, and plaintiffs do not seriously contend otherwise. When, as here, a "problem stem[s] from a lack of resources," it is "'a

problem for the political branches to work out.'" *Mashpee Wampanoag Tribal Council, Inc. v. Norton*, 336 F.3d 1094, 1101 (D.C. Cir. 2003) (quoting *In re Barr Labs.*, 930 F.2d 72, 75 (D.C. Cir. 1991)).

Plaintiffs propose "partial interim solutions" (Br. 35), but these are ill-defined and intrude on the Secretary's quintessentially discretionary policymaking authority. As the Supreme Court has emphasized, a court may compel agency action only when an agency has "failed to take a *discrete* agency action that it is *required to take*," and may require only actions that are "ministerial or non-discretionary." *Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55, 64 (2004).

Plaintiffs likewise offer no basis for an order compelling the Secretary to scale back or suspend the recovery audit program, a demand that disregards the fact that the program "was created by Congress and should be addressed by the Secretary and Congress together." JA184 (District Court Op.).

In sum, the problem at issue is one to be addressed by the political branches and which cannot be solved by a writ of mandamus directed to discrete, statutorily required agency actions.

STANDARD OF REVIEW

This Court reviews de novo a decision denying mandamus relief under 28 U.S.C. § 1361. *See Baptist Mem'l Hosp. v. Sebelius*, 603 F.3d 57, 62 (D.C. Cir. 2010).

ARGUMENT

PLAINTIFFS HAVE NOT MADE THE EXTRAORDINARY SHOWING NEEDED TO DEMONSTRATE ENTITLEMENT TO MANDAMUS RELIEF

A. The Medicare Statute Does Not Confer On Plaintiffs A Right To A Hearing Within 90 Days That Is Enforceable Through Mandamus

To establish mandamus jurisdiction, plaintiffs must demonstrate that (1) they have "a clear right to relief," (2) the Secretary has a "clear duty to act," and (3) "there is no other adequate remedy available to [them]." *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002). Plaintiffs cannot satisfy these threshold criteria.

The Medicare statute provides that both ALJ and Appeals Council determinations shall generally issue within 90 days, *see* 42 U.S.C. § 1395ff(d)(1)-(2), but also specifies—within the same subsection—the "[c]onsequences of failure to meet deadlines," *id.* § 1395ff(d)(3). The statute states that if an ALJ fails to meet a deadline, the "consequence[]" is that the claimant may escalate its claim to the next administrative appeal level, *i.e.*, the Appeals Council, without waiting for an ALJ determination. *See id.* § 1395ff(d)(3)(A). Likewise, when the Appeals

Council fails to meet the deadline, the claimant may immediately seek review in district court. *See id.* § 1395ff(d)(3)(B).

Thus, while the statute establishes a time frame for decisions, it also recognizes that the time frame may not be satisfied and provides persons seeking review with a specific avenue of relief. Although plaintiffs would prefer to accelerate the agency process rather than to pursue the route of review made available by Congress, they have no basis for obtaining a writ to effectuate that preference. *See Cumberland Cnty. Hosp. Sys., Inc. v. Burwell*, No. 5:14-CV-508-BR, 2015 WL 1249959, at *6 (E.D.N.C. Mar. 18, 2015) (rejecting indistinguishable mandamus petition because "Congress . . . expressly anticipated delays in Medicare adjudications and prescribed escalation as the remedy").

Plaintiffs claim that escalation to the Appeals Council or to district court is inadequate because they must forgo a hearing, which they mistakenly claim allows the hospitals "their first opportunity to present testimony based on clinical factors." Br. 40 (internal quotation marks omitted). But, as previously discussed, at the earlier second level of review, the Qualified Independent Contractor performs an "independent, on-the-record review of an initial determination, including the redetermination and all issues related to payment of the claim," and in doing so, "reviews the evidence and findings upon which the [previous determination] was based, *and any additional evidence the parties submit or that the [Qualified*

Independent Contractor] obtains on its own." 42 C.F.R. § 405.968(a) (emphasis added); *see also id.* § 405.966 (detailing evidence to be submitted when a party files a reconsideration request, including "evidence and allegations of fact or law related to the issue in dispute" and an "expla[nation] why it disagrees with the initial determination, including the redetermination").[22]

B. Plaintiffs Have Not Identified A Failure To Take A Ministerial Action Required By Law And Instead Urge The Court To Require Programmatic Changes And Otherwise Resolve Questions Reserved For The Political Branches

1. An agency's failure to meet a statutory deadline "does not, alone, justify judicial intervention." *In re Barr Labs.*, 930 F.2d 72, 75 (D.C. Cir. 1991) (citing *In re Ctr. for Auto Safety*, 793 F.2d 1346, 1354 (D.C. Cir. 1986)); *accord, e.g.*, *In re United Mine Workers of Am. Int'l*, 190 F.3d 545, 551 (D.C. Cir. 1999). Two central principles emphasized by the Supreme Court and this Court underscore the unavailability of mandamus relief in this case.

First, mandamus is only available to compel acts that are ministerial and non-discretionary. *See Stern v. South Chester Tube Co.*, 390 U.S. 606, 608 (1968)

[22] Plaintiffs also assert (Br. 40) that HHS conceded before the district court that providers are more likely to prevail before an ALJ, but the cite they provide only references plaintiffs' assertion that a provider may be more likely to prevail before an ALJ than at lower levels of review. Dkt. 12, at 30 ("Plaintiffs' assertion that hospitals are most likely to succeed in their appeals at the ALJ level . . . does not undercut the quality of lower-level review."). Whether or not that assertion is correct has no bearing on whether plaintiffs have an adequate alternative remedy because they have the right to escalate to a *higher* level of review.

(describing mandamus as traditionally "a suit against a public officer to compel performance of some 'ministerial' duty"); *U.S. ex rel. Roughton v. Ickes*, 101 F.2d 248, 252 (D.C. Cir. 1938) ("[I]t is only when the duty of the officer to do the act is clear-cut, well-defined, and positive that it is considered ministerial and compellable by mandamus. If discretion exists, the duty is never ministerial."); 12 Charles Alan Wright et al., *Federal Practice & Procedure* § 3134 (3d ed. 2014) (noting "relief in the nature of mandamus is available only to compel performance of a duty that is essentially ministerial"). As applied to petitions seeking to compel agency action alleged to have been wrongfully withheld or delayed, the Supreme Court has recognized in the closely related context of cases applying 5 U.S.C. § 706(1) that courts may only order relief when an agency has "failed to take a *discrete* agency action that it is *required to take*." *Norton v. Southern Utah Wilderness Alliance*, 542 U.S. 55, 64 (2004) (*Southern Utah*); *see also id.* at 64, 66 (noting that this limitation on judicial review is derived from "the traditional limitations upon mandamus," which confines the mandamus power to requiring actions that are "ministerial or non-discretionary").

Second, when a "problem stem[s] from a lack of resources," it is "'a problem for the political branches to work out.'" *Mashpee Wampanoag Tribal Council, Inc. v. Norton*, 336 F.3d 1094, 1101 (D.C. Cir. 2003) (quoting *Barr Labs.*, 930 F.2d at 75); *cf. In re Aiken Cnty.*, 725 F.3d 255, 259 (D.C. Cir. 2013) (noting

"the President must follow statutory mandates *so long as there is appropriated money available*") (emphasis altered).

Even when an agency could, at least in theory, shift resources from other programs to cure a statutory violation, this Court has "hesitate[d] to require" an agency to do so where "such a command would seriously disrupt" other agency activities "of higher or competing priority." *United Mine Workers of Am.*, 190 F.3d at 553 (internal quotation marks omitted); *see also Telecommunications Research & Action Ctr. v. FCC*, 750 F.2d 70, 80 (D.C. Cir. 1984) (*TRAC*) (in considering whether to compel agency action "the court should consider the effect of expediting delayed action on agency activities of a higher or competing priority"); *Barr Labs.*, 930 F.2d at 76 (noting that the Court had "no basis for reordering agency priorities" and refusing to order compliance with a 180-day deadline for processing applications when the agency had chosen to deploy its resources elsewhere).

2. In this case, the agency lacks even the theoretical ability to effect a significant reallocation of resources. OMHA is funded through a separate appropriation. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, 128 Stat. 2130, 2483 (2014) (*2015 Appropriations Act*); JA50 (2014 Griswold Testimony) (noting that the office "operates under a separate appropriation and is both functionally and fiscally

separate from CMS"). The decision to provide additional resources must be made by Congress, consistent with basic separation-of-powers principles, which vest control over appropriations in Congress and which require the agency to perform its duties using the resources provided by Congress. *See OPM v. Richmond*, 496 U.S. 414, 424 (1990); *see also* U.S. Const., art. I, § 9, cl. 7.

Plaintiffs argue (Br. 37) that the Secretary should utilize her limited authority to transfer funds from other HHS appropriations to OMHA. But as plaintiffs themselves acknowledge, the Secretary's authority to transfer funds is "capped." Br. 37. In fact, the Secretary cannot augment the size of any particular appropriation by more than 3%. JA181 (District Court Op.) (citing Department of Health & Human Services Appropriations Act, 2014, Pub. L. No. 113-76, § 206, 128 Stat. 363, 382).[23] As the district court found, and plaintiffs do not dispute, this means that the Secretary could transfer no more than $2.5 million to OMHA, a "meager bump in funding" that would "do little to stanch the tide of appeals." JA182. In any event, the question of whether resources devoted to other projects would be better spent on supplementing the appropriation Congress chose to provide is a discretionary policy judgment. *Barr Labs.*, 930 F.2d at 76 (any

[23] The same rule applies under the *2015 Appropriations Act*. *See* Pub. L. No. 113-235, div. G, tit. II, § 206, 128 Stat. at 2485.

"budget flexibility as Congress has allowed the agency is not for [the Court] to hijack").

3. Tacitly recognizing that Congress has not appropriated the resources necessary to eliminate the appeals backlog, plaintiffs urge that "the Secretary could consider any number of partial interim solutions to help eliminate the backlog" or "mitigate the financial strain" it allegedly has caused. Br. 35.[24] In describing their proposed partial interim solutions as acts that the Secretary might "consider" undertaking, plaintiffs do not suggest that any of their proposals is an act that the Secretary is required to take. On the contrary, each of plaintiffs' proposals relates to quintessentially discretionary judgments on fundamental matters of policy. Plaintiffs ask this Court to order the Secretary to allocate resources in a particular manner and to strike a particular balance between identifying fraud and minimizing burdens on providers. But this Court has recognized that mandamus is not an appropriate means of resolving discretionary policy judgments of these kinds. *See, e.g.*, *Barr Labs.*, 930 F.2d at 76 ("The agency is in a unique—and authoritative—

[24] Although plaintiffs' complaint demanded immediate processing of their own pending claims, JA21-JA22, plaintiffs have since made clear that they "do not seek to jump the line—they seek HHS's compliance with the Medicare Act's deadlines broadly." Dkt. 14, at 14; *see also* Br. 31 n.24 (plaintiffs are not asking to be put at the head of the queue at the expense of those claims currently ahead of theirs). Any other position would be foreclosed by *Barr Laboratories*, which rejected the suggestion that mandamus should issue where an agency is facing a backlog and "a judicial order putting [plaintiff] at the head of the queue simply moves all others back one space and produces no net gain." 930 F.2d at 75.

position to view its projects as a whole, estimate the prospects for each, and allocate its resources in the optimal way.").

For example, plaintiffs suggest (Br. 35) that the Secretary could resolve the existing backlog by offering more widespread settlement of claims. But deciding whether and how to seek settlement of billions of dollars of claims by thousands of different claimants is entirely discretionary and the antithesis of the sort of ministerial act that mandamus might be used to compel. While the Secretary has offered settlement terms for a particular class of claims, *see* CMS, HHS, *Hospital Participant—Settlement Instructions*, http://goo.gl/LLkRwW (last visited June 30, 2015), and is actively exploring whether additional settlements can be offered, mandamus cannot be used to compel the Secretary to seek further settlements.

Plaintiffs also suggest (Br. 35-36) that CMS should change the timeframe for when interest on dollar amounts of denied claims begins to accumulate and the step in the appeals process at which CMS begins to recoup the funds associated with denied claims. But plaintiffs do not allege that the Secretary has any duty to do so. In fact, the Medicare statute sets forth when recoupment can be delayed. See 42 U.S.C. §1395ddd(f)(2). Moreover, changing interest-payment and recoupment policies would not cause plaintiffs' claims to be adjudicated any faster, and thus would not cure the purported statutory violation that their mandamus action seeks to rectify.

Plaintiffs' proposals amount to "the kind of broad programmatic attack" that is precluded by "[t]he limitation [of the mandamus power] to discrete agency action," *Southern Utah*, 542 U.S. at 64. A plaintiff "cannot seek *wholesale* improvement of [a] program by court decree, rather than in the offices of the Department or the halls of Congress, where programmatic improvements are normally made." *Id.* No case cited by plaintiffs involved a wholesale reordering of resources, much less the expenditure of resources that have not been appropriated by Congress. *See, e.g.*, *In re People's Mojahedin Org. of Iran*, 680 F.3d 832 (D.C. Cir. 2012) (ordering agency to reconsider designation of a single organization as a foreign terrorist organization); *Public Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1159 (D.C. Cir. 1983) (action to compel agency to issue notice of proposed rulemaking regulating exposure to a single toxin); *In re Core Commc'ns, Inc.*, 531 F.3d 849, 859 (D.C. Cir. 2008) (ordering agency to state legal basis for a single rule, while stressing that the required act was "neither technical nor intrusive" and would not "second-guess the [agency's] policy judgment"); *In re Am. Rivers & Idaho Rivers United*, 372 F.3d 413, 414 (D.C. Cir. 2004) (ordering agency to respond to a single petition); *United Mine Workers of Am.*, 190 F.3d at 546 (mandamus action to compel agency to issue a particular final rule); *TRAC*, 750 F.2d at 72 (action to compel agency to resolve whether regulated entity had overcharged ratepayers in two specific instances); *MCI Telecomms.*

Corp. v. FCC, 627 F.2d 322, 345 (D.C. Cir. 1980) (proceeding to compel agency to set a single tariff); *Midwest Gas Users Ass'n v. FERC*, 833 F.2d 341, 360 (D.C. Cir. 1987) (agency decision to defer adjudicating a single issue in a single case).

In district court, plaintiffs also asked that the Secretary be required to seek greater appropriations for the appeal process. JA182 (District Court Op.). But even if this were proper relief to request through mandamus—and is it not, for the reasons found by the district court (JA182-JA183)— the President's fiscal year 2016 budget requests that the OMHA budget be more than tripled from $87.3 million to $270 million. *See supra* p.11. The President's budget also proposes seven legislative reforms to address the existing backlog. *See id.* Congress has responded by proposing bipartisan legislation that would substantially increase funding for OMHA. *See supra* p. 14. Thus, the agency is already working with Congress to address the backlog through additional resources.

4. Citing *TRAC*, plaintiffs emphasize (Br. 27-31) that a decision to compel agency action can in some circumstances be based, in part, on the consideration of the interests prejudiced by the delay and granted greater weight when human health and welfare are at stake (the third and fifth *TRAC* factors). But this Court has "noted before the importance of 'competing priorities' [the fourth *TRAC* factor] in assessing the reasonableness of an administrative delay" and has "refused to grant relief" on that basis alone "even though all the other factors considered in

TRAC favored it." *Mashpee Wampanoag Tribal Council*, 336 F.3d at 1100 (describing *Barr Labs*).

In any case, the district court found that that while plaintiffs have demonstrated "*economic* consequences" from the backlog, plaintiffs have failed to demonstrate the sort of "immediate and undisputed dangers that have weighed heavily in the *TRAC* analysis in other cases." JA178.[25] Plaintiffs counter that the district court "failed to appreciate the close (indeed, inexorable) tie between economic harm to hospitals and the attendant risk of harm to health and welfare." Br. 30. But under this logic, which equates economic harm to an entity that protects human health with harm to human health and welfare itself, an order requiring HHS to radically reorder its priorities would also harm human health and welfare. Nearly all of HHS's activities implicate human health and welfare. *See HHS Strategic Plan, FY2014-2018: Overview*, http://www.hhs.gov/about/strategic-plan/introduction/index.html (last visited June 30, 2015) ("[HHS] is the U.S. government's principal agency for protecting the health of all Americans and

[25] Plaintiffs accuse the district court of inventing an "immediate and undisputed danger" requirement. Br. 28-29. But the court was merely noting that the harms to human health and welfare alleged by plaintiffs here were far more attenuated than the harms established in other cases where this Court has granted relief. The district court never suggested that a plaintiff could only prevail by showing an immediate and undisputed danger to human health and welfare. Rather, the court was explaining why, on the facts of this case, the third and fifth *TRAC* factors deserved only slight weight relative to the fourth factor.

providing essential human services, especially for those who are least able to help themselves."). Thus, even if the Secretary could restructure agency operations to resolve the backlog (though as noted at *supra* p. 23-24, she lacks the statutory authority to do so), the backlog could only be resolved at the expense of other programs that protect human health and welfare. Accordingly, the human health and welfare impact factor thus "can hardly be considered dispositive" because "virtually the entire docket of the agency involves issues of this type" and "acceleration here may come at the expense of delay" elsewhere. *Sierra Club v. Thomas*, 828 F.2d 783, 798 (D.C. Cir. 1987). For this reason, the district court correctly found that the third and fifth *TRAC* factors "weigh, if at all, only very lightly in favor of granting relief." JA179.

Moreover, the sixth *TRAC* factor—the agency's good faith—does not support relief. Even in the absence of increased funding, the agency has undertaken significant efforts to mitigate the backlog. As noted, ALJs are adjudicating cases at twice their previous rate. JA50 (2014 Griswold Testimony); *see also Hatch Statement*, *supra* n.17 ("The Office of Medicare Hearings and Appeals has . . . taken steps to address its backlog, but there is only so much the agency can do with their current authorities and staffing."). New initiatives are also being developed to resolve claims, including through alternative dispute resolution and statistical sampling and extrapolation. JA52 (2014 Griswold

Testimony). Thus, as in *Barr Laboratories*, this is not a case where the relevant agency officials have been "twiddl[ing] their thumbs." 930 F.2d at 75 (alteration in original) (internal quotation marks omitted); *see also House Hrg. Video*, *supra* n.14, at 22:9 (statement of Rep. Meadows) ("This is not a problem of an administrative law judge just sitting back eating bonbons."). The agency is aggressively working within existing constraints to alleviate the backlog.

C. Plaintiffs Are Not Entitled To An Order Suspending Or Modifying The Recovery Audit Program

Plaintiffs assert (Br. 33) that the Secretary should be required to modify the recovery audit program so as to "rein in the-out-of-control" auditors. Indeed, the district court noted that forcing a modification of the recovery audit program "appears to be [plaintiffs'] true aim in bringing suit." JA183 (District Court Op.). Plaintiffs' amici are even more transparent in this regard, calling on the Secretary to "suspend or severely limit [recovery] audits until the backlog has cleared." FAIR Amicus Br. 21.

The district court correctly recognized that it had no authority to order the suspension or alteration of the recovery audit program. The recovery audit program is statutorily required. *See* 42 U.S.C. § 1395ddd(h)*; see also Palomar Med. Ctr. v. Sebelius*, 693 F.3d 1151, 1165 (9th Cir. 2012) ("Concerned about the millions of dollars of Medicare Trust Funds being lost to improper payments, Congress directed the Secretary to use [recovery audit contractors] to identify and

correct past overpayments and underpayments."). Plaintiffs would thus have the Secretary achieve one Congressional aim—timely adjudications—by disregarding the statutory requirement to operate the recovery audit program. And, while plaintiffs and their amici object to the fact that auditors are paid on a contingency basis (Pls. Br. 32 n.25, 36; FAIR Amicus Br. 17), the statute itself mandates contingency payments, 42 U.S.C. § 1395ddd(h)(1)(B) (payments to recovery audit contractors "shall be made on a contingent basis for collecting overpayments"). As the district court correctly recognized, "[t]o the extent that the [recovery audit] program is the cause of the delays, it was created by Congress and should be addressed by the Secretary and Congress together." JA184 (District Court Op.).

In any event, the Secretary's decision as to how best to operate the recovery audit program is precisely the sort of discretionary agency decision that cannot be attacked through mandamus. Indeed, in district court, plaintiffs disclaimed that they were seeking an order requiring the Secretary to revise the recovery audit program in any particular respect. Dkt. 14, at 24 ("Plaintiffs do not purport to ask this Court to tell HHS that it must fix the [recovery audit] program[.]").

Moreover, modification of the recovery audit program would not necessarily redress plaintiffs' asserted injury. Even if the Secretary were to suspend the program tomorrow, the existing backlog would remain, and plaintiffs would still need to wait their turns for adjudication of their currently pending appeals of

overpayments that have already been assessed. There is thus a mismatch between plaintiffs' objective and their purported basis for entitlement to relief.

Finally, and most fundamentally, legislation recently reported out of the Senate Finance Committee would do what plaintiffs seek, implementing reforms to the recovery audit program to minimize the number of new appeals. *See supra* p. 14.

In sum, plaintiffs fail to show entitlement to any specific form of relief with regard to the recovery audit program or otherwise. Accordingly, they have not demonstrated entitlement to mandamus.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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CERTIFICATION OF COMPLIANCE

I hereby certify this brief complies with the requirements of Fed. R. App. P. 32(a)(5) and (6) because it has been prepared in 14-point Times New Roman, a proportionally spaced font, and that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B), because it contains 7,546 words, excluding the parts of the brief exempted under Rule 32(a)(7)(B)(iii), according to the count of Microsoft Word.

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CERTIFICATE OF SERVICE

I hereby certify that on July 1, 2015, I electronically filed the foregoing brief with the Clerk of this Court by using the appellate CM/ECF. The participants in the case are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

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