ORAL ARGUMENT SCHEDULED ON MAY 15, 2017

No. 17-5018

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-Appellees,

v.

THOMAS E. PRICE, in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,

Defendant-Appellant.

On Appeal from the
United States District Court for the District of Columbia
Case No. 1:14-cv-851 (Hon. James E. Boasberg)

BRIEF FOR APPELLEES AMERICAN HOSPITAL ASSOCIATION, *ET AL.*

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March 23, 2017

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CERTIFICATE OF PARTIES, RULINGS, AND RELATED CASES

Pursuant to Circuit Rule 28.1(a)(1), the undersigned counsel for Appellees submits this Certificate of Parties, Rulings, and Related Cases.

(A) Parties and Amici. Except for the following, all parties, intervenors, and amici appearing before the district court and in this court are listed in the Brief for Appellant:

1. The American Hospital Association has no parent companies, and no publicly held company has a 10% or greater ownership interest (such as stock or partnership shares) in the entity.

2. Baxter Regional Medical Center has no parent companies, and no publicly held company has a 10% or greater ownership interest (such as stock or partnership shares) in the entity.

3. Covenant Health has no parent companies, and no publicly held company has a 10% or greater ownership interest (such as stock or partnership shares) in the entity.

4. Rutland Regional Medical Center has no parent companies, and no publicly held company has a 10% or greater ownership interest (such as stock or partnership shares) in the entity.

(B) Rulings Under Review. References to the rulings at issue appear in the Brief for Appellant.

(C) Related Cases. References to any related cases appear in the Brief for Appellant.

/s/ Catherine E. Stetson
Catherine E. Stetson

Counsel for Appellees

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GLOSSARY

ALJ: Administrative Law Judge

CMS: Centers for Medicare & Medicaid Services

HHS: Department of Health and Human Services

OMHA: Office of Medicare Hearings and Appeals

RAC: Medicare Recovery Audit Contractor

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INTRODUCTION

This case—a challenge to serious delays in the Medicare appeals process—has been here once before. Just over a year ago, the Court determined that the Plaintiffs' suit met the jurisdictional threshold for mandamus relief. *See Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183 (D.C. Cir. 2016) (*AHA I*). The Court explained that the statute required Medicare providers' and suppliers' appeals to be decided within 90 days, but those appeals were languishing in a queue and "could take a

decade or more to resolve." *Id.* at 187. Although the Secretary had argued that the Department of Health and Human Services (HHS) "lack[ed] the resources to render decisions within the statutory time frames," the Court was not persuaded. *Id.* at 191. It held that "the statute imposes a clear duty on the Secretary to comply with the statutory deadlines" and that the Plaintiffs have "a corresponding right to demand that compliance." *Id.* at 192.

On remand, the District Court balanced the equities and determined that the time had come for a writ of mandamus. It ordered the Secretary to attain compliance with the Medicare appeals deadlines over the next four years, by meeting certain reduction targets each year. The District Court did not purport to instruct the Secretary *how* those targets should be met—only that the backlog must be reduced by a specified percentage by a date certain.

The Secretary now protests that mandamus is generally inappropriate here, and that this particular mandamus order is so flawed as to warrant reversal. The first assertion gives too little weight to this Court's prior review. After all, the point of the remand was that mandamus was appropriate; the question was merely whether it was appropriate *yet*. The Secretary's second assertion, meanwhile, gives too little weight to the standard of review. The District Court did not abuse its discretion in crafting an order that required eventual compliance with the statute, while phasing in such compliance to accommodate practical limitations.

The Secretary, for his part, attacks an order that bears no resemblance to the one that the District Court actually issued. His preferred narrative is that the District Court ordered the agency to settle certain claims, and that the Medicare statute prohibits such settlements. Neither part of that story is accurate. The District Court, like this Court in *AHA I*, disclaimed placing any constraints on the Secretary's options for reform. And even assuming that settlement is the only viable option, there is no statutory bar to that solution: The Secretary has settled groups of cases before—something it touted earlier in this very litigation. He can adopt the same strategy again, if that is what he deems necessary to comply with the District Court's mandamus order.

ISSUE PRESENTED FOR REVIEW

Whether the District Court abused its discretion in granting a writ of mandamus requiring HHS to attain compliance with mandatory statutory deadlines by the end of 2020.

PERTINENT STATUTES & REGULATIONS

Pertinent statutes and regulations are reproduced in the separate addendum to this brief.

STATEMENT OF THE CASE

I. FACTUAL BACKGROUND

The Medicare Appeals Process. The Plaintiff Hospitals provide inpatient hospital services. The federal government pays for some of those services—

primarily services involving individuals over age 65—under Title XVIII of the Social Security Act, more commonly called the Medicare Act. *See* Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. §§ 1395-1396v).

When a hospital treats a Medicare beneficiary, it submits a claim for reimbursement to a Medicare administrative contractor. 42 U.S.C. § 1395ff(a)(2)(A). Within 45 days, that contractor makes an initial determination to pay the claim or to deny it. *Id.* Some paid claims, however, are subject to an additional level of review by Medicare Recovery Audit Contractors (RACs). RACs audit initial payment decisions, theoretically in order to "identify[] underpayments and overpayments and recoup[] overpayments." *Id.* § 1395ddd(h)(1). But RACs work on a contingent-fee basis and have strong financial incentives to deny high-value claims. *See id.*; JA48.

If a hospital's claim is denied, whether after an initial determination or after a post-payment RAC audit, the hospital may file an administrative appeal. The Medicare Act sets out a four-step appeals process and prescribes deadlines at each step. 42 U.S.C. § 1395ff.

First, the hospital may request a "redetermination" from the Medicare administrative contractor. *Id.* § 1395ff(a)(3)(A). The contractor must issue a redetermination decision within 60 days. *Id.* § 1395ff(a)(3)(C)(ii).

Second, the hospital may appeal the redetermination decision to a Qualified Independent Contractor for "reconsideration." *Id.* § 1395ff(c). The Qualified Independent Contractor must issue a decision within 60 days. *Id.* § 1395ff(c)(3)(C)(i).

Third, the hospital may request a hearing before an administrative law judge (ALJ) within the Office of Medicare Hearings and Appeals (OMHA). *Id.* § 1395ff(b)(1), (d)(1). The ALJ must "conduct and conclude a hearing" and "render a decision on such hearing" within 90 days. *Id.* § 1395ff(d)(1); 42 C.F.R. § 405.1016(a). The ALJ stage is unique among the steps in the appeals process; hospitals have the ability to present oral testimony, respond to questions posed by the ALJ, and explain written materials in the record. 42 C.F.R. §§ 405.1018(d), 405.1036(a). It is also the first stage at which the hospital obtains an *independent* review of its claims. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 931(b)(2), 117 Stat. 2066, 2398 (requiring HHS to "assure the independence of administrative law judges" and to keep the office "organizationally and functionally separate").

Fourth, the hospital may appeal an adverse ALJ ruling to the Departmental Appeals Board within HHS. 42 U.S.C. § 1395ff(d)(2). The Departmental Appeals Board must issue a decision, or remand the case to the ALJ for further proceedings, within 90 days. *Id.*; 42 C.F.R. § 405.1108(a). If the Board itself issues a decision,

then such decision "constitutes final agency action and is subject to judicial review" in federal court—if it meets the statute's amount-in-controversy requirement. 42 U.S.C. § 1395ff(b)(1)(E), (f)(1)(A)(v).

The Medicare Act also provides a process called "escalation," under which the second, third, and fourth levels of review may be bypassed if the reviewing body is unable to comply with the statutory deadlines. So, if a Qualified Independent Contractor does not complete its review within 60 days, the hospital has the opportunity to "escalate" the appeal to an ALJ. 42 C.F.R. § 405.970. That escalation can also occur from the ALJ to the Departmental Appeals Board, and from the Board to federal court. *Id.* §§ 405.1106, 405.1132. If the hospital elects to escalate its claim, however, it forfeits the critical ALJ step, which entails the right to a hearing and the opportunity to supplement the administrative record. Moreover, the cost of "escalating" to, and then litigating in, federal court can often outstrip the value of the claim appealed—assuming the amount of the claim even meets the jurisdictional threshold. *See, e.g.*, JA38, JA43, JA52.

The Current Appeals Backlog. If a hospital or other provider promptly pursues the four steps in the administrative appeals process, the entire process should be completed in around a year. *See AHA I*, 812 F.3d at 186. That, at least, is what the Medicare Act requires. And the process indeed functioned for years as

Congress had intended, with appeals completed roughly within the statutory time frames. But in recent years, it does not happen that way.

In particular, there is a growing backlog at the ALJ level. Starting in 2010, OMHA began seeing a significant growth in appeals at the ALJ level—in part as a consequence of "the nationwide implementation of the Recovery Audit Program." JA84. Appeals to the ALJ level then *quintupled* between 2011 and 2013. *Id.* And HHS stopped meeting its statutory deadlines. *Id.*

This year, the delays hit record levels: The ALJ hearings that, under the Medicare Act, must be completed within 90 days are now taking an average of 1041.5 days. HHS, *Office of Medicare Hearings and Appeals (OMHA): Workload Information and Statistics—Average Processing Time by Fiscal Year* (Jan. 27, 2017), https://goo.gl/FEStmd. Put differently, a hospital must wait almost *three full years*—more than eleven times the period provided for by Congress—for an ALJ hearing and for the chance to recoup desperately needed funds.

Although HHS has made some small programmatic changes, it has not taken significant steps toward eliminating this massive backlog. Its latest projections reveal an even bleaker future. As of March 5, 2017, there were 667,326 appeals awaiting review at the ALJ level. *See* Status Report at 2, No. 14-cv-851 (Mar. 6, 2017), ECF No. 55. Accounting for every one of its current administrative actions, HHS predicts that the backlog will grow to over *one million appeals* by the end of

2021. *Id.* As this Court previously noted, "at current rates, some already-filed claims could take a decade or more to resolve." *AHA I*, 812 F.3d at 187.

Hospitals lodging appeals from the first two administrative appeal stages to the third ALJ stage can thus realistically expect to wait several years for an independent review of their claims for reimbursement. And many of them will ultimately have success at that third stage of independent review: Between 2010 and 2014, a full 54% of Part A claim denials were partially or fully reversed at the ALJ level. U.S. Gov't Accountability Office, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process* 69 (May 2016) (*GAO Report*). For RAC-related appeals, that number jumped to 58%. *Id.* at 69-70. One of the Plaintiffs reports success rates at the ALJ stage as high as 81%. JA43. And for certain types of providers, such as rehabilitation hospitals, that high success rate is fairly standard. *See* Fund for Access to Inpatient Rehabilitation Amicus Br. at 5, No. 14-cv-851 (June 20, 2016), ECF No. 32-1.

In short, many—and, for some types of providers, *most*—of these appeals have merit. *See AHA I*, 812 F.3d at 188. That means that for at least three years, Medicare providers that deliver services to elderly Americans will have to make do without the prompt reimbursement that Congress promised them.

The Plaintiff Hospitals' Pending Appeals. Some hospitals cannot so easily make do without timely access to the funds to which they are statutorily

entitled. Plaintiff American Hospital Association, which represents more than 5,000 hospitals, estimates that even in 2014—when long delays were a more recent phenomenon—93% of its member hospitals had waited longer than the 90-day statutory period to receive an ALJ determination. JA46-47. The Plaintiff Hospitals are among the providers that have suffered the most from lengthy delays in the appeals process.

Baxter Regional Medical Center is a regional hospital in Mountain Home, Arkansas. JA36. It is one of the most Medicare-dependent hospitals in the nation; in 2013, Medicare receipts accounted for 65% of its gross revenue. JA37. And with an aging population in the counties it serves, that number is apt to rise. *Id.* As of 2014, Baxter was pursuing Medicare appeals to recover about $4 million in reimbursement. *Id.* Many of those appeals had been pending at the ALJ stage for more than the statutorily mandated 90 days. *Id.* The long delays had crippled Baxter's cash flow and had prevented it from, for example, purchasing basic replacement equipment in its intensive-care unit, replacing a failing roof over its surgery department, and replacing an outdated catheterization laboratory. JA38. The delays of its rehabilitation-related appeals became so prohibitive that Baxter considered closing its rehabilitation center. JA39.

Covenant Health is a community-owned health system of nine hospitals in East Tennessee. JA40. Medicare receipts account for over half of the gross

revenue across those nine hospitals. JA41. As of 2014, Covenant had more than $7 million in reimbursement claims tied up at the ALJ level, almost all of which had been pending for more than 90 days. The delays significantly impaired Covenant's cash flow, leading to a negative operating margin when it joined this suit. JA44.

Rutland Regional Medical Center is a community-owned rural hospital in Rutland, Vermont. JA50. It has been classified as a "sole community hospital" that provides services to Medicare beneficiaries in a geographically isolated area. JA50-51; *see* 42 U.S.C. § 1395ww(d)(5)(D)(iii). Medicare receipts account for about half of its gross revenues. JA51. As of 2014, Rutland had over half a million dollars stuck in the appeals process—almost all of it at the ALJ level. *Id.* It responded by implementing various cost-cutting measures, including eliminating 32 jobs, which negatively affected the hospital's ability to serve the community. JA53.

II. PROCEDURAL BACKGROUND

In 2014, the three Plaintiff Hospitals, joined by the American Hospital Association, filed a complaint in federal district court. JA11. They sought a writ of mandamus requiring HHS to provide timely hearings on their pending ALJ appeals and to otherwise comply with its statutory obligations in administering the appeals process. JA31-32; *see* 28 U.S.C. § 1361.

This Court's Jurisdictional Decision. The District Court initially dismissed the complaint for lack of jurisdiction. *Am. Hosp. Ass'n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014). It acknowledged that HHS was failing to adjudicate appeals "in accord with the statutory guidelines laid out by Congress," but it concluded that the agency's "budgetary constraints, its competing priorities, and its incipient efforts to resolve the issue together dictate that mandamus is not warranted." *Id.* at 56.

This Court reversed. It held that the Plaintiffs' complaint satisfied the threshold requirements for mandamus jurisdiction because the Secretary had a "clear duty" to comply with statutory deadlines yet was flagrantly violating that duty. *AHA I*, 812 F.3d at 190-192. The Court rejected the Secretary's argument that this suit "constitutes a programmatic attack on the way [his] department manages its resources." *Id.* at 191 (internal quotation marks omitted). To the contrary, it explained, "the failure to take some decision by a statutory deadline" is an appropriate basis for mandamus relief. *Id.* (alterations and internal quotation marks omitted).

The Court then remanded for the District Court to consider in the first instance whether equitable considerations warranted the issuance of mandamus. *Id.* at 192. On the one hand, the Court identified "several significant factors" that favor immediate relief, including the delays' "real impact on human health and

welfare" and the Secretary's substantial discretion to make changes to the RAC program. *Id.* at 193 (internal quotation marks omitted). On the other hand, the Court pointed to the potential for disruption in asking "the agency to make major changes to its operations and priorities," and to the desirability of a political solution. *Id.* at 192-193.

The Court concluded by "reiterat[ing] that the district court has broad discretion in weighing the equities." *Id.* at 193. It noted that there might be a legislative fix forthcoming. *Id.* But if not, "the district court . . . might find it appropriate to issue a writ of mandamus." *Id.* Indeed, if the political branches "failed to make meaningful progress within a reasonable period of time," then "the clarity of the statutory duty likely will *require* issuance of the writ." *Id.* (emphasis added).

The District Court's Mandamus Grant. On remand, the Secretary promptly moved for a 15-month stay. JA115. The agency contended that it was pursuing several administrative and legislative solutions to alleviate the backlog. *Id.* In that context, the parties argued at length about the propriety of mandamus, and the District Court evaluated the equitable considerations this Court had outlined. JA120-123. The District Court concluded that HHS's various administrative actions to that point would not "result in meaningful progress to reduce the backlog and comply with the statutory deadlines." JA130. As a result,

the court denied the stay motion and determined that the balance of interests favored mandamus. *Id.* But the court cautioned that it could not wave "a magic wand" and order HHS to eliminate the entire backlog immediately. *Id.* Instead, following a status hearing to discuss the matter, it ordered the parties to brief the question of remedy.

The parties next filed cross-motions for summary judgment, which focused on the contours of a mandamus order. JA131-134. The Plaintiffs suggested three categories of reforms that could be ordered: (1) broad settlements, (2) deferral of repayment and tolling of interest, and (3) RAC reform. JA163. In the alternative, they proposed a schedule of tiered reductions of the backlog, culminating in elimination of the backlog by the end of 2020—or, as the District Court described it, "a thoughtful and reasonable four-year plan for this complex problem." JA165. The Secretary opposed each of those remedies. *Id.* In particular, HHS protested that it would be forced to settle claims regardless of their merit, in contravention of the Medicare Act. *Id.* The District Court countered that "the timetable does not so require. It simply demands that the Secretary figure out how to undertake proper claim substantiation within a reasonable timeframe." *Id.* (internal quotation marks omitted). As for the timeframe itself, the District Court observed that the Secretary had not proposed any alternate dates or percentages. JA166. It thus adopted the Plaintiffs' proposed timetable: a 30% reduction from the current backlog of cases

pending at the ALJ level by the end of 2017, a 60% reduction by the end of 2018, a 90% reduction by the end of 2019, and elimination of the backlog by the end of 2020. *Id.*

The Secretary moved for reconsideration, which the District Court denied, concluding that he had not raised any new arguments warranting yet another round of review. JA173; *see Firestone v. Firestone*, 76 F.3d 1205, 1208 (D.C. Cir. 1996) (per curiam). This appeal followed.

STANDARD OF REVIEW

"[T]he exercise of the power of mandamus is a matter committed to the sound discretion of the trial court." *13th Reg'l Corp. v. U.S. Dep't of Interior*, 654 F.2d 758, 760 (D.C. Cir. 1980) (internal quotation marks omitted). Once the threshold requirements for mandamus jurisdiction have been satisfied, this Court reviews a district court's balancing of the equities for abuse of discretion. *AHA I*, 812 F.3d at 190; *see also In re Medicare Reimbursement Litig.*, 414 F.3d 7, 10 (D.C. Cir. 2005).

SUMMARY OF ARGUMENT

The District Court did not abuse its discretion in granting mandamus and ordering the Secretary to comply with the Medicare Act appeal deadlines by the end of 2020. Indeed, given this Court's prior decision, the persistent

administrative delays, and the Secretary's litigating position, it is difficult to see what else the District Court *could* have done.

The Secretary first argues that mandamus was inappropriate altogether because the agency lacks the resources to comply with the Medicare Act's deadlines. But this Court already rejected that argument at the jurisdictional stage, explaining that HHS's limited resources could not shield the agency from mandamus forever. The law-of-the-case doctrine thus bars relitigation of that point. Moreover, the Secretary cannot meet the "heavy burden" of demonstrating impossibility. *Ala. Power Co. v. Costle*, 636 F.2d 323, 359 (D.C. Cir. 1979). Contrary to the Secretary's assertions, the RAC program remains a key contributor to the burgeoning backlog—and the Secretary has never disputed that there remain significant opportunities for curbing the excesses of that program. Settlements are another viable option for reducing the backlog. And both the agency's regulations and its prior willingness to offer group settlements make clear that this is a legal option, too.

The Secretary next argues that the District Court abused its discretion in shaping its mandamus order. That argument, though, is mostly a repackaging of the first argument that mandamus is improper. It fails for the same reasons. And to the extent the Secretary now quibbles with the specific timetable that the District Court ordered, it is too late. The Secretary never offered his own proposal—aside

from requesting a stamp of approval for the agency's current, inadequate efforts. If the agency believed that the schedule the Plaintiffs proposed was too stringent, then it should have offered a reasonable alternative. It did not.

For all of the complications of Medicare's administrative scheme, this case has become clear over three years and multiple rounds of briefing: The backlog is poised to grow to a million appeals by the end of 2021. The Plaintiff Hospitals have waited for years to collect the money that the federal government owes them. This Court has acknowledged the severity of the problem and the propriety of judicial intervention. And the agency has offered increasingly dire predictions since that time. In light of those inputs, the District Court reasonably balanced the equities and ordered mandamus relief. This Court should affirm.

ARGUMENT

I. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN GRANTING MANDAMUS.

The Secretary begins by arguing that mandamus was inappropriate because HHS has no power to reduce the backlog of administrative appeals. HHS Br. 16-24. There are several problems with that argument—not least that this Court has already rejected it. The District Court thus did not abuse its discretion in ordering the agency to take additional actions of its choosing.

A. The Law-Of-The-Case Doctrine Bars The Secretary's Argument.

"The law-of-the-case doctrine rests on a simple premise: 'the *same* issue presented a second time in the *same case* in the *same court* should lead to the *same result*.'" *Kimberlin v. Quinlan*, 199 F.3d 496, 500 (D.C. Cir. 1999) (emphases in original) (quoting *LaShawn A. v. Barry*, 87 F.3d 1389, 1393 (D.C. Cir. 1996) (en banc)). The parties already litigated whether mandamus was categorically out-of-bounds in cases like this one; this Court held that it was not. In fact, it observed that at some point mandamus might be "require[d]." *AHA I*, 812 F.3d at 193. The Court remanded to the District Court to perform a balancing of the equities only. *Id.* at 192-193.

The Secretary does not really argue that the District Court abused its discretion in balancing the equities.[1] Rather, he contends that mandamus is not available as a matter of law because HHS lacks the necessary resources. But this Court has already rejected the argument "that the department lacks the resources to render decisions within the statutory time frames." *Id.* at 191; *see also id.*

[1] The Secretary has, for example, dropped his reliance on a legislative solution—the critical unanswered question in this Court's remand to the District Court. *See AHA I*, 812 F.3d at 193 (remanding for consideration of legislative action and, in particular, the progress of the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, S. 2368, 114th Cong. (2015)); *see also id.* at 187-188. He had good reason to abandon that line of argument: There is no pending legislative fix. The 114th Congress adjourned without taking action on the relevant reforms and the 115th Congress has taken no action to remedy the appeal backlog.

(explaining that, "'however many priorities the agency may have, and however modest its personnel and budgetary resources may be, there is a limit to how long it may use these justifications to excuse inaction in the face of' a statutory deadline") (quoting *In re United Mine Workers of Am. Int'l Union*, 190 F.3d 545, 554 (D.C. Cir. 1999)). This Court has also already distinguished several of the same cases the Secretary recycles for this round of briefing. *Compare AHA I*, 812 F.3d at 192, *with* HHS Br. 22-23 (citing *In re Barr Labs., Inc.*, 930 F.2d 72 (D.C. Cir. 1991), and *Mashpee Wampanoag Tribal Council, Inc. v. Norton*, 336 F.3d 1094 (D.C. Cir. 2003)). As it explained, those cases stand for the proposition that mandamus claims cannot be used "to jump the line, functionally solving [a plaintiff's] delay problem at the expense of other similarly situated applicants." *AHA I*, 812 F.3d at 192. Those "line-jumping cases," *id.*, do not control here.

B. The Administrative-Necessity Doctrine Does Not Apply.

To the extent there is anything new to it, the Secretary's overarching "impossibility" argument is both legally and factually flawed in any event. As a legal matter, the doctrine of administrative necessity is a narrow one. In *Alabama Power*, this Court recognized that an agency might be permitted to adopt "streamlined . . . procedures where the conventional course, typically case-by-case determinations, would, as a practical matter," be impossible. 636 F.2d at 358. Or, where Congress has not provided sufficient funds for an agency to act in a

comprehensive fashion, the agency may direct those funds to achieve the most pressing statutory objectives. *See id.* at 359; *see also Morton v. Ruiz*, 415 U.S. 199, 231 (1974). Those two strands of the administrative-necessity doctrine allow an agency to do more with less; they do not permanently exempt an agency from compliance with a statutory deadline.

As a factual matter, too, an agency bears "a heavy burden" to claim impossibility. *Ala. Power*, 636 F.2d at 359; *see also Sierra Club v. EPA*, 719 F.2d 436, 469 (D.C. Cir. 1983) (rejecting the agency's "conclusory statement" of impossibility). HHS cannot meet that burden here. This Court earlier observed that certain policymaking choices within HHS's discretion have a significant effect on the backlog. *See AHA I*, 812 F.3d at 191, 193. That factual premise remains correct today. So long as the agency has some discretion, "[n]othing in the statute authorizes the Secretary to adopt a position of impossibility." *Ganem v. Heckler*, 746 F.2d 844, 854 (D.C. Cir. 1984).

1. RAC Reform. This Court previously determined that the Secretary has "broad discretion to determine" the details of the RAC program. *AHA I*, 812 F.3d at 186; *see also id.* at 193. The District Court likewise observed that the limited "scope of the initiatives involving the RAC Program give the Court particular pause." JA127; *see also id.* ("The Secretary's failure to offer a more robust

response to the high volume of appeals generated by the RAC Program . . . is concerning."). There is, in short, far more to be done on this front.

The Secretary objects that the RAC program is no longer a significant contributor to the backlog. HHS Br. 18-19. That is not true. At the end of fiscal year 2016, there were about 150,000 RAC-related appeals pending at OMHA. JA140. That number is significant on its own, to be sure. But it is also misleading: It reflects the fact that the RAC program was placed on hold for the last two years while new contracts were negotiated. The suspension was lifted in October 2016, when new RAC contracts took effect. JA144. Now that the RACs' contracts have been renewed, RAC-related appeals will no doubt contribute significantly to the massive growth of the backlog that the Secretary predicts. This is not just our speculation; HHS has already said as much, reporting to the Government Accountability Office that "it expects the number of incoming appeals to increase again when . . . the [RAC] program resumes full operation." *GAO Report* 38. When the RAC program was last in full force, RAC-related appeals ballooned to more than half of OMHA's total receipts, accounting for hundreds of thousands of appeals a year. JA140; *see GAO Report* 61. The agency's small tweaks to the new RAC program, by contrast, are estimated to cut only 26,000 appeals over six years. JA156. That number is the wrong order of magnitude.

Notably, the Secretary never claims that he *cannot* further limit the RACs' abusive practices and thus the number of RAC-related appeals. The most effective solution, which the Plaintiffs proposed below, would be to penalize RACs for poor performance. The Medicare Payment Advisory Commission, Congress's independent Medicare advisory body, has explained that "RACs currently face no penalties when claim denials are overturned on appeal." Medicare Payment Advisory Comm'n, *Report to Congress: Medicare and the Health Care Delivery System* 195 (June 2015). The Commission accordingly recommended that the Secretary "modify each RAC's contingency fees to be based, in part, on its claim denial overturn rate." *Id.* at 194. So, for example, RACs might agree to a tiered fee schedule under which they receive a diminishing contingency-fee percentage when their overall error rate at the ALJ level increases. The key is that any penalty be significant and be keyed to the ALJ level—the primary site of the backlog, the only stage at which live testimony is offered, and the first stage at which there is an independent decisionmaker. Not coincidentally, the ALJ level is also the stage at which RACs' reversal rates are the highest. *Compare GAO Report* 64 (11% reversal rate in RAC-related Part A appeals at the initial Medicare administrative contractor stage), *with id.* at 69 (57% reversal rate in RAC-related Part A appeals at the ALJ stage). The existing financial incentives for affirmances at earlier

stages of the appeal process simply do not have the same bite, given those contractors' tendency to rubber-stamp RAC decisions.

The Plaintiffs suggested multiple other possibilities for RAC reform as well. In order to increase financial predictability for providers, HHS might shorten the RAC look-back period from three years to one. *See* 42 U.S.C. § 1395ddd(h)(4). It also might bar denials for isolated failures to satisfy documentation deadlines or comparable technical errors, or suspend all medical-necessity audits unless there is evidence of fraud. It might even suspend the RAC program altogether while the backlog persists; statutory violations are at least as strong a justification for doing so as contract negotiations. The Secretary has discretion to adopt any of these approaches, or others of his own, to limit the type or number of claims that RACs may audit. Yet HHS has only tinkered at the margins. *See* JA141 (describing minor modifications to RAC program).

2. Settlement. The simplest and broadest-sweeping solution remains settlement. The Secretary could conduct broad settlements of claims based on the type of claim or the type of provider, or both. That could remove hundreds of thousands of claims from the backlog in short order. And HHS is no stranger to this solution: It has offered broad settlements previously. In 2014, the Centers for Medicare & Medicaid Services (CMS), a division of HHS, offered 68 cents on the dollar to hospitals appealing certain patient-status claims. *Id.* It came to that

number by "examin[ing] the denied amounts, the tendency of hospitals to appeal decisions, and the vulnerability that hospitals and CMS face throughout the appeals process"—that is, the typical inputs for settlement. JA142. It made a similar offer again in 2016, at 66 cents on the dollar. JA141.

The Secretary claims that there are several legal barriers to pursuing such settlements more broadly. Those claims do not withstand scrutiny.

First, the Secretary repeatedly cites his "statutory obligation to ensure that non-meritorious claims are not paid." HHS Br. 20 (citing, among other things, 42 U.S.C. § 1395y(a)). He cannot, he contends, offer settlements without regard to "the underlying merits of the claims involved." *Id.* at 25; *see also id.* at 26 (arguing against "settlements that are not tied to the merits of the underlying claims"). But that is not how settlements work. The merits of the underlying claims—whether a particular provider's claims or a particular type of claim, or a combination of the two—are obviously relevant. They are merely evaluated at a higher level of generality instead of at a case-by-case level. HHS has adopted that approach on multiple occasions. The patient-status settlements were based on a general estimate of how often hospitals correctly offered treatment on an inpatient patient basis versus an outpatient basis; HHS did not separately evaluate each of

the 380,000 claims that it settled. *See id.* at 9, 26.[2] So too for its "statistical sampling and extrapolation" initiatives, *id.* at 10, 26, which by their very nature involve an overarching analysis of success rates rather than a case-by-case settlement decision. The suggestion that HHS is bound by statute to litigate the merits of each individual claim may be convenient for this appeal, but it is at odds with HHS's established practices, policies, and regulations. *See generally* 42 C.F.R. §§ 401.613, 405.376 (describing relevant considerations for the "[c]ompromise of claims").

Because the Secretary has the legal authority to settle pending appeals, his reliance on *OPM v. Richmond*, 496 U.S. 414 (1990), is misplaced. *See* HHS Br. 23-24. In *OPM*, the question was whether equitable estoppel applied to the federal government, such that an individual could be entitled "to a monetary payment not otherwise permitted by law." 496 U.S. at 416. Estoppel did not apply, the Supreme Court held, because the judiciary must "observe the conditions

[2] In a list of Frequently Asked Questions for providers considering the patient-status settlement, the agency asked and answered the question at issue here: "**What authority does CMS have to do this type of settlement?** CMS is offering this settlement pursuant to the Social Security Act and CMS's regulations regarding claims collection and compromise at 42 C.F.R. 401.601 and 401.613, and regarding compromise of overpayments at 42 C.F.R. 405.376." CMS, *Frequently Asked Questions—Hospital Appeals Settlement for Fee-For-Service Denials Based on Patient Status Reviews for Admissions Prior to October 1, 2013*, at 1, https://goo.gl/YH5cC6 (*CMS Settlement FAQs*) (last visited Mar. 21, 2017). Those regulations authorize CMS to agree to settlements that "[b]ear a reasonable relation to the amount of the claim" and reflect the agency's assessment of "[l]itigative probabilities." 42 C.F.R. § 401.613(a)(1), (c)(2); *see also id.* § 405.376(h).

defined by Congress for charging the public treasury." *Id.* at 420 (quoting *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385-386 (1947)). As already discussed, however, a settlement is not "a monetary payment not otherwise permitted by law"; it is an authorized method of compromising potentially meritorious claims prior to full adjudication. Thus, *OPM* has never stood for the sweeping proposition that the federal government cannot settle any monetary claims against it. *See Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2193 n.9 (2012) (explaining that *OPM* held only "that the Appropriations Clause does not permit plaintiffs to recover money for Government-caused injuries for which Congress appropriated no money") (internal quotation marks omitted).

Second, the Secretary suggests that the patient-status settlement represented a uniquely "homogenous" set of claims, and that no other claims can be similarly bundled together. HHS Br. 26. That sort of blanket statement is not sufficient to meet the Secretary's "heavy burden." *Envtl. Def. Fund, Inc. v. EPA*, 636 F.2d 1267, 1283 (D.C. Cir. 1980). There are a number of suggestions in the record of sufficiently homogenous groups that could be targeted for settlements. For example, HHS reports that "a small number of appellants are responsible for a substantial portion of the appeals filed" and that, in 2015, "three appellants filed nearly 40 percent of the appeals." JA92-93. Indeed, a single durable medical equipment supplier is responsible for almost a quarter of all pending appeals.

JA138. And HHS already has calculated that provider's accuracy rate. *Id.* It does not seem like a drastic step to offer a settlement that reflects that rate; HHS might even be able to offer a *lower* rate on the assumption that the provider would prefer a timely resolution to waiting in line for a decade. As another example, groups of rehabilitation hospitals affirmatively approached the Secretary with statistics about rehabilitation hospitals' rates of success and proposed a global settlement. *See* Fund for Access to Inpatient Rehabilitation Amicus Br. 9-10. They were rebuffed without a counteroffer. *Id.* at 10-11.

Third, the Secretary raises a variety of practical concerns. He notes, for instance, that there are large amounts of money at stake and that ALJs, across all appeals, rule for the claimant less than a third of the time. HHS Br. 27. Those generic numbers illustrate the size of the backlog and the crippling consequences of inaction. But they do not preclude settlement; a settlement offer to a particular group will no doubt account for that group's rate of meritorious claims.

The Secretary also worries about adverse selection. *Id.* at 27-28. As he has done before, though, he can mitigate those concerns by requiring a provider to settle all eligible appeals and by extending an offer only to those claims pending at a particular date. *See CMS Settlement FAQs* 3. Finally, the Secretary speculates that this litigation might have a negative impact on his bargaining position. HHS Br. 27-28. Such unsupported speculation should not weigh into this Court's

decision. And in any event, any loss of negotiating power is a consequence of the Secretary's choice to litigate this case to the bitter end, rather than take the necessary affirmative steps immediately after this Court's remand.

3. Other Reforms. RAC reforms and broad settlements were the two main programmatic changes that the *Plaintiffs* suggested. At the end of the day, though, it is *HHS*'s burden to comply with the mandatory statutory deadlines. And contrary to the Secretary's suggestions, he is not limited to the menu that the Plaintiffs offered. The Plaintiffs have never "agreed that settlements . . . were the *only* conceivable means for meeting the court's schedule." HHS Br. 28 (emphasis added). Rather, they repeatedly urged that group settlements represented the "most efficient, concrete way for the Secretary to cut down on the existing backlog." Pls.' Mot. for Summ. J. at 4, No. 14-cv-851 (Oct. 14, 2016), ECF No. 39. Nor did this Court believe that modifications to the RAC program were the *only* change that might alleviate the backlog. HHS Br. 17-18. It instead explained that the statutory "deadlines dictate that the Secretary will have to curtail the RAC program *or find some other way to meet them*." *AHA I*, 812 F.3d at 193 (emphasis added). The District Court likewise declined to mandate certain settlements or modifications to the RAC program, "leaving to [the Secretary's] discretion the means by which such targets are to be achieved." JA163. That is precisely what a court is supposed to do. *See Norton v. S. Utah Wilderness All.*, 542 U.S. 55, 65

(2004) (explaining that, "when an agency is compelled by law to act within a certain time period, . . . a court can compel the agency to act, but has no power to specify what the action must be").

The Secretary, in sum, has options—perhaps including options that the Plaintiffs have never proposed. This Court acknowledged that a year ago, and the District Court did not abuse its discretion in coming to the same conclusion ten months later. A writ of mandamus was, and is, an appropriate way to resolve HHS's persistent statutory violations.

II. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN ADOPTING A SET OF DEADLINES FOR COMPLIANCE.

District courts have enormous flexibility in shaping their mandamus orders. That is because the "liberalizing purpose" of the mandamus statute "was intended to permit District Courts generally to issue appropriate corrective orders where Federal officials are not acting within the zone of their permissible discretion." *Peoples v. U.S. Dep't of Agric.*, 427 F.2d 561, 565 (D.C. Cir. 1970) (per curiam). The Secretary offers a few criticisms of the particular mandamus order entered here, but most are reiterations of earlier points and none can surmount the high standard of review.

First, the Secretary spends pages attacking the legality of settlements. HHS Br. 25-29. As already explained, however, CMS can—and, indeed, *does*—settle

cases without scrutiny of individual claims. *See supra* pp. 22-27. More to the point, the Secretary has not been ordered to settle anything. JA163.

Second, the Secretary falls back on the possibility of escalation. HHS Br. 29. But this Court has flatly rejected that argument: "[N]othing suggests that Congress intended escalation to serve as an adequate or exclusive remedy where, as here, a systemic failure causes virtually all appeals to be decided well after the statutory deadlines." *AHA I*, 812 F.3d at 191.

Third, the Secretary suggests in a footnote that he may be entitled to some sort of deference if there is a "conflict" between the statutory deadlines and the Medicare Act's substantive provisions. HHS Br. 30 n.14. Again, though, this Court has made clear that the Secretary must make any "discretionary decisions" necessary to comply with its "clear statutory deadlines." *AHA I*, 812 F.3d at 193. Because there is no conflict between two discrete agency commands, as in *Scialabba v. Cuellar de Osorio*, 134 S. Ct. 2191 (2014), there is no question of one provision "supersed[ing]" another, HHS Br. 29.

Fourth, the Secretary argues that an appropriate mandamus order would have required HHS to "continue to submit status reports" and to otherwise "maintain" its current programs. *Id.* at 30. Yet he never explains how that would bring the agency into compliance with the statute. Mandamus "is not to be granted in order

to command a gesture." *Weber v. United States*, 209 F.3d 756, 760 (D.C. Cir. 2000).

More fundamentally, the Secretary has waived any challenge to the specific form of the District Court's mandamus order. Throughout this litigation, HHS has argued that it cannot be ordered to eliminate the backlog. As a consequence of staking out that categorical position, it has never offered a schedule for reductions that it believes *would* be possible. At summary judgment, the Plaintiffs requested that the Secretary be ordered to take several specific actions, including RAC reform and broad settlements. Pls.' Mot. for Summ. J. at 4, 9-10. The Plaintiffs even proposed an alternative whereby the Secretary would not eliminate the backlog but would mitigate its harmful effects by deferring the repayment of disputed claims and tolling the accrual of interest for those periods of time when an appeal is pending beyond the statutory deadlines. *Id.* at 5-9.[3] Or, as a different way of tackling the problem, the Plaintiffs outlined a set of aggressive-yet-

[3] Coincidentally, the Secretary has found flexibility in the statute for such tolling when the roles are reversed. *See* 42 U.S.C. § 1395ddd(f)(2)(B) (requiring Secretary to pay the same interest rate as providers); 42 C.F.R. § 405.378(j)(3)(iv)-(v) (providing for tolling during certain claimant-induced delays); *see also Medicare Program: Limitation on Recoupment of Provider and Supplier Overpayments*, 74 Fed. Reg. 47,458, 47,462 (Sept. 16, 2009) (stating that "CMS should not be required to pay interest on days that the appellant is in control of"). Although the statute requires that interest accrue from the date of the notice of overpayment, 42 U.S.C. § 1395ddd(f)(2)(B), claimants should be entitled to the same equitable exception that CMS has afforded itself. That change would not formally eliminate the backlog, *see* HHS Br. 25 n.12, but would approximate that outcome for providers to the greatest extent possible.

attainable deadlines to bring HHS into compliance with the statute by the start of 2021. *Id.* at 12.

To all of that, the Secretary responded, "no." He criticized each of the Plaintiffs' proposed solutions—with the exception of status reports. *See* Def.'s Mot. for Summ. J. & Opp'n to Pls.' Mot. for Summ. J. at 11-23, No. 14-cv-851 (Nov. 7, 2016), ECF No. 42. The Secretary rejected settlements, arguing that he had already proposed the only aggregate settlement offers consistent with his statutory duties. *Id.* at 12. He rejected RAC reform, arguing that penalties might constitute improper liquidated damages. *Id.* at 20-21. He rejected delayed repayment and interest tolling, arguing that they would increase the backlog and violate statutory duties (even though HHS could take advantage of such tolling). *Id.* at 13-17. And he rejected the notion that the agency might be subject to "calendar deadlines." *Id.* at 22.

The District Court thus had only one real proposal in front of it: the Plaintiffs'. As it explained, "the Secretary does not otherwise dispute the specific dates and reduction percentages in Plaintiffs' proposed timetable." JA166. The District Court therefore adopted the only proposal that it had. *Id.* Having failed to suggest an alternate timetable for statutory compliance, the Secretary cannot now contend that the court's selection was flawed. And to the extent he contends that the District Court should not have ordered *any* timetable at all, that is just a way of

repackaging his (flawed) argument that the District Court lacked discretion to grant mandamus relief.

The District Court's approach fell well within its discretion. It made clear to the parties that it "does not possess a magic wand" and would not order immediate compliance with every deadline. JA130. It then adopted a schedule that gave HHS four years to come into compliance with statutory deadlines. JA166. And it declined to impose the Plaintiffs' preferred remedy of automatic default judgments, opting instead for consideration of all the circumstances in the event that HHS failed to meet a deadline. *Id.* The District Court also carefully considered this Court's earlier decision, *see* JA120, and received multiple rounds of briefing from the parties. It did not abuse its discretion.

CONCLUSION

For the foregoing reasons, the District Court's decision should be affirmed.

Respectfully submitted,

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March 23, 2017

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), I hereby certify that this Brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because the brief contains 7,408 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) and Circuit Rule 32(e)(1).

I further certify that this brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because the brief has been prepared in Times New Roman 14-point font using Microsoft Word 2010.

/s/ Catherine E. Stetson
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CERTIFICATE OF SERVICE

I hereby certify that on March 23, 2017, the foregoing was electronically filed through this Court's CM/ECF system, which will send a notice of filing to all registered users.

/s/ Catherine E. Stetson
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