ORAL ARGUMENT SCHEDULED FOR MAY 15, 2017

No. 17-5018

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

AMERICAN HOSPITAL ASSOCIATION; BAXTER REGIONAL HOSPITAL, INC., d/b/a BAXTER REGIONAL MEDICAL CENTER; RUTLAND HOSPITAL, INC., d/b/a RUTLAND REGIONAL MEDICAL CENTER; COVENANT HEALTH,

Plaintiffs-Appellees,

v.

THOMAS E. PRICE, M.D., 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

REPLY BRIEF FOR THE APPELLANT

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GLOSSARY

ALJ	Administrative Law Judge
HHS	U.S. Department of Health and Human Services
OMHA	Office of Medicare Hearings and Appeals
RAC	Recovery Audit Contractor

INTRODUCTION AND SUMMARY OF ARGUMENT

In its decision in the prior appeal, this Court held that the Medicare statute's deadline for the completion of administrative law judge (ALJ) review of Medicare appeals is mandatory and may be enforced through mandamus if and when it is equitable to do so. The Court remanded to the district court to determine whether mandamus should issue, and if so, what form it might take. As discussed in our opening brief, the Court's "critical[]" assumption in the prior appeal was that the appeals backlog could be rectified through discretionary changes to the recovery audit contractor (RAC) program. *American Hosp. Ass'n v. Burwell*, 812 F.3d 183, 193 (D.C. Cir. 2016). The record on remand makes clear that this is not the case. Nor has Congress increased the line-item appropriation that funds the Office of Medicare Hearings and Appeals (OMHA), which administers the ALJ review program. It is not controverted that Congress's appropriations will allow OMHA to adjudicate, at most, about 90,000 appeals this year. JA156.

The district court nevertheless ordered OMHA to reduce the backlog of Medicare appeals pending before ALJs by 30% by the end of 2017, and to completely eliminate the entire backlog—which exceeded 657,000 appeals in December 2016 (JA170)—by the end of 2020. The immediate practical effect of the district court's order is to require the agency to resolve some 350,000 appeals by the end of 2017 (*i.e.*,

over the next eight months).[1] The record makes clear that the Department of Health and Human Services (HHS) could not possibly comply with the district court's order without abdicating its duty to pay claims only in accordance with the statute's requirements for reimbursement, requirements that apply "[n]otwithstanding any other provision" of the Medicare statute. 42 U.S.C. § 1395y(a). To meet the deadlines established by the district court, the agency would be required to settle claims en masse without regard to their merits, negotiating with parties who have absolutely no incentive to reduce their demands. Indeed, under these circumstances, providers will have every incentive to seek ALJ review of additional claims. The magnitude of the resulting impact on the taxpayer is extraordinary. The potential amounts in controversy already total approximately $6.6 billion. JA170. Each claim has already been rejected three separate times, and, based on the rate at which ALJs upheld claim denials in 2016, the vast majority of these claims—in excess of 70%—do not meet payment criteria or will otherwise ultimately be rejected by an ALJ. JA170.

Plaintiffs provide no plausible basis for sustaining a court order that would in effect require the agency to make payments never authorized by Congress. Instead, they devote much of their brief to defending hypothetical mandamus remedies, such as mandated changes to the RAC program, not ordered by the district court. The

[1] Thirty percent of 657,000 is nearly 200,000. The agency must also offset the more than 150,000 new appeals expected to be filed in 2017. JA91.

record at this juncture demonstrates that no mandamus order can properly issue. But, at a minimum, the order that the district court actually issued should be vacated.

ARGUMENT

THE COURT SHOULD REVERSE THE MANDAMUS ORDER AND DIRECT ENTRY OF JUDGMENT IN FAVOR OF THE SECRETARY

A. The District Court Improperly Imposed A Timetable That Requires Mass Settlements Of Claims Without Proper Regard For Whether The Claims Satisfy The Requirements Established By Congress

1. Mandamus is an equitable remedy, and any mandamus order must conform to equitable principles. *See Weber v. United States*, 209 F.3d 756, 760 (D.C. Cir. 2000). Courts do not have equitable discretion to order something that is impossible or contrary to law. *See, e.g., INS v. Pangilinan*, 486 U.S. 875, 883 (1988); *Natural Res. Def. Council, Inc. v. Train*, 510 F.2d 692, 713 (D.C. Cir. 1974); *see also Environmental Def. Ctr. v. Babbitt*, 73 F.3d 867, 871-72 (9th Cir. 1995) (holding that the district court erred in requiring agency to comply with a nondiscretionary duty where the lack of appropriated funds precluded the agency from complying with the order). The district court's order cannot stand unless the agency has some lawful means of compliance.

The only conceivable means through which the agency might comply with the court's order is through mass settlements untethered from the merits of the underlying claims. Plaintiffs insist that this is not what the order requires. Pls. Br. 3. But there is no dispute that OMHA's adjudication capacity is a "far cry" from that

required to adjudicate the backlogged claims. *See American Hosp. Ass'n v. Burwell*, 812 F.3d 183, 187 (D.C. Cir. 2016) (*AHA*); *see also* U.S. Gov't Accountability Office, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process* 41 (May 2016) ("[T]he number of incoming appeals continue to surpass [OMHA's] adjudication capacity."); *see also* JA85, JA156, JA168-JA170.

Plaintiffs have never suggested any way that HHS could comply with the mandamus order except through broad settlements. While plaintiffs argue at length that the Secretary should be required to make certain changes to the RAC program (Pls. Br. 19-22), there is no dispute that even the complete suspension of the RAC program would not enable the Secretary to comply with the mandamus order. Opening Br. 18; JA140. Any changes to the RAC program will impact how RACs review claims in the future (and thus may affect the future inflow of appeals to OMHA), but would not have any retroactive effect on the claims in the backlog, which have already been denied.[2]

Plaintiffs also offer unsupported speculation that HHS may have additional, unidentified backlog-reduction options. Pls. Br. 28. But HHS has been under significant pressure from both Congress and the judiciary to resolve the backlog.

[2] Plaintiffs note that 150,000 of the backlogged appeals originated in claim denials by RACs. Pls. Br. 20; *see* JA140. But those claims were generally denied years ago, and those denials have already been upheld at the first two levels of administrative review. There were only 16,000 new RAC appeals in 2016. JA140.

Doing so is a priority now and has been a priority since at least 2013. JA86, JA89.[3] Indeed, the district court recognized that "the Secretary appears to have devoted considerable effort to designing and implementing various administrative initiatives to target the backlog." JA121; *see generally* JA95-JA105; JA141-JA147. As the district court itself earlier recognized, there is simply no "magic wand" that can be waved to eliminate the backlog. JA130.

Before issuing a writ of mandamus, it was incumbent on the district court to determine whether the agency could comply with the writ's terms in a manner consistent with the statute that Congress entrusted the agency to implement. Instead, the court declared that it "need not dive into the parties' debate" over plaintiffs' specific proposals, which included mass settlement. JA165. But a court cannot decline to consider whether the consequence of its order will be payment of claims unauthorized by Congress. *See OPM v. Richmond*, 496 U.S. 414, 424 (1990) (an agency may not pay claims except as authorized by statute). It is axiomatic that the Medicare statute defines the terms on which payments may be made and that the Secretary cannot pay claims that fail to meet these criteria, "[n]otwithstanding any other provision" of the Medicare statute. 42 U.S.C. § 1395y(a); *see also id.* §§ 1395f, 1395n,

[3] The last administration offered a number of legislative proposals for fixing the backlog. Opening Br. 10. The new administration has not yet had the opportunity to formulate its own proposals, but is equally committed to working with Congress to address the backlog. Decl. of Norris Cochran 4 (Mar. 6, 2017) (Dkt. No. 55-1).

1395g(a), 1395*l*(e). Judging by the most recent rates at which challengers prevail before ALJs, the vast majority of the backlogged claims—in excess of 70%—likely do not meet payment criteria. JA170.[4]

To provide even a partial justification for the district court's order, it would thus be necessary to conclude that in enacting the ninety-day period for ALJ determinations, Congress implicitly appropriated funds for payment of claims in the event of a backlog. But nothing in the provision of the Medicare statute establishing the ALJ adjudication timetable, 42 U.S.C. § 1395ff(d)(1), remotely suggests such congressional intent. On the contrary, in the same subsection of the Medicare statute that includes the ALJ adjudication timetable, Congress anticipated that the consequence of delay would be that the provider would be eligible to escalate its challenge to a higher level of review. *See id.* § 1395ff(d)(2). In its decision in the previous appeal, this Court held that escalation is not the exclusive remedy when ALJ review is overdue. *AHA*, 812 F.3d at 191. The escalation provision certainly indicates, however, that Congress did not enact the timetable as an independent basis

[4] Plaintiffs' amicus speculates (FAIR Amicus Br. 27-29) that this number may be skewed by the inclusion of appeals by beneficiaries. This argument was first raised in this Court, so the record does not address this issue. However, HHS informs us that the agency has reconsidered the issue and determined that the overturn rate in appeals by providers is in line with the overall 2016 overturn rate quoted in the cited declaration. HHS thus stands by the conclusion that it is reasonable to assume that "at least 72% of [the backlogged] claims lack merit or are procedurally flawed and should not be paid." JA170; *see also* JA102 (explaining decrease in ALJ reversal rate).

for funding claims, or that a consequence of delay should be default judgments against HHS. This Court did not suggest otherwise.

It is not the government's position—as plaintiffs mistakenly suggest (Pls. Br. 24)—that HHS is bound by statute to determine each claim by each provider in a separate proceeding and that it is barred from settling multiple claims simultaneously when it can do so responsibly. On the contrary, HHS has actively pursued aggregate settlements, based on factors such as historic success rates of particular types of claims, where it has been feasible to do so. JA98-JA99, JA141-JA143, JA151-JA152. And the agency continues to design and negotiate settlements to reduce the existing backlog that incorporate merits-based factors and considerations. But it would be improper for HHS to settle claims in a manner that would vastly increase the overall exposure of the Medicare trust funds beyond the amounts authorized by Congress.

Nevertheless, that is precisely what the district court's order requires the agency to do. The backlog currently consists of approximately 650,000 claims by more than 700 providers, totaling approximately $6.6 billion. JA138, JA170. Most of these claims lack commonalities that would make them amenable to resolution under a set of generally-applicable terms. JA142. Resolving these dissimilar claims on the scale necessary to comply with the mandamus order would require HHS to make available settlements far broader than past settlements. *See* Pls.' Summ. J. Reply 5 (Nov. 15, 2016) (Dkt. No. 43) (insisting that "settlements must be offered on a large enough scale to materially decrease the backlog in the short term"). HHS has

determined that "[t]he only way for the Department to potentially meet such reduction targets without legislative action would be to settle claims for the full value or nearly the full value of each appeal without regard to its merit." JA169.

An example offered by plaintiffs illustrates the contrast between past settlements and those that would be needed to comply with the district court's order. As plaintiffs note, HHS entered into a targeted settlement with providers that asserted a very specific kind of claim. Pls. Br. 22-23. That settlement, which involved a "unique set of circumstances," was based on HHS's "knowledge of the specific types of claims at issue and the associated value of the services performed." JA141-JA142. It was undisputed in that instance that the providers had performed the services; the question was whether they should be reimbursed at the rates for inpatient services or outpatient services. JA141-JA142.[5]

Settling other claims that do not share these characteristics on terms set at a "higher level of generality" (Pls. Br. 23), means settling claims on terms far more attenuated from their underlying merits. If HHS were to agree to settle with any

[5] Plaintiffs argue that there are indications in the record that there are other providers with whom HHS should have been able to settle. Pls. Br. 25-26. Without commenting on any specific provider or groups of providers, HHS notes that settlement requires a willing counterparty, and that it has expressed willingness to compromise with interested providers based on individualized factors including their properly-computed historic success rates (JA151-JA152), though exclusions have to be made for providers that are the subject of program integrity or law enforcement scrutiny (JA152).

interested hospital based on the overall average success rate of such providers, the predictable consequence would be that hospitals with below-average success rates would accept at disproportionately high rates and settle all of their claims. Hospitals with higher average success rates would tend to hold out for more.

Knowing the agency's imperative to settle, providers with pending claims would lack any inducement to lower their demands. This is not "unsupported speculation" (Pls. Br. 26), but the inevitable consequence of a "negotiation" where one party has no power to say "no." It should thus be unsurprising that HHS reported in a recent sworn affidavit that, since the mandamus order, "HHS has seen reduced participation in settlement conference facilitations" and that "it appears, based on the Department's interactions with providers, that some of them are choosing to wait in the anticipation that relief mandated by the Court will yield a higher payout than a settlement" tied to the merits of their claims. Decl. of Norris Cochran 4 (Mar. 6, 2017) (Dkt. No. 55-1). Plaintiffs fault HHS for not taking affirmative steps to enter into mass settlements immediately after this Court's remand (Pls. Br. 27), but this Court's opinion in the prior appeal contemplated that Congress should be given an opportunity to address the backlog through legislation. *AHA*, 812 F.3d at 193-94.

Worse still, because there are no meaningful barriers to filing new appeals, providers also have every incentive to file new claims—regardless of merit—in the hope of receiving unduly high settlements. JA151. Plaintiffs suggest that the mass-

settlement requirement might be limited to claims pending as of a particular date. Pls. Br. 26. But the district court's order requires *all* backlogged claims to be resolved by the end of 2020, and the logic of its order does not distinguish between claims based on the year in which they were filed. The court's requirement is that the agency must dispose of all claims—at any cost—until it strictly complies with the ninety-day provision.

For all these reasons, the type and scale of settlements required by the district court's order would expose the Medicare trust funds to claims far in excess of the amounts authorized by Congress. This order is contrary to law and must be set aside.

2. Plaintiffs mistakenly urge that HHS has "waived any challenge to the specific form of the District Court's mandamus order" (Pls. Br. 30), because the agency did not offer its own timetable for eliminating the backlog. Plaintiffs miss the point. The agency recognized that, absent new appropriations and authorities, any timetable would involve mass settlements without appropriate regard for the merits of the claims at issue; that the timetable would remove providers' incentives to settle at reasonable levels; and that it would encourage the filing of additional claims by providers eager to take advantage of the settlement requirement. As the agency explained, "imposing such a timetable would require [the Secretary] to 'make payment on Medicare claims regardless of the merit of those claims,' which 'would squarely conflict with the Medicare statute.'" JA165 (quoting HHS brief). The agency explained that it could not commit to any specific timetable because "absent

Congressional intervention [the agency] will not be able to eliminate the backlog." HHS Reply Br. 11 (Nov. 23, 2016) (Dkt. No. 45-1).

Plaintiffs incorrectly assert that HHS thereby left the district court with no alternative to plaintiffs' proposal, in the event that the court determined that mandamus relief was appropriate. Pls. Br. 31. While HHS opposed mandamus, it also offered several suggestions as to the form of remedy that should be imposed if mandamus were to issue. *See* JA146, JA152-JA154; Opening Br. 30-31. Plaintiffs now suggest that any proposal that did not include a timetable for resolving the backlog was tantamount to no proposal at all. Pls. Br. 31-32. That is self-evidently not the case, and, indeed, plaintiffs themselves proposed mandamus remedies that did not include a timetable for backlog reduction and would not have eliminated the backlog. *See* Pls. Br. 30 (noting that one of their primary proposals in district court "would not eliminate the backlog").

B. Judgment Should Be Entered In Favor Of The Secretary

For the reasons described above, the district court's order must be vacated even if this Court concludes that the agency has not met the requirements for summary judgment. The record demonstrates, however, that judgment should have been entered in favor of the Secretary.

Remand proceedings have confirmed that the backlog inescapably "stem[s] from a lack of resources," and is therefore "'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., Inc.*, 930 F.2d 72, 75 (D.C. Cir. 1991)); *see also Cumberland Cty. Hosp. Sys., Inc. v. Burwell*, 816 F.3d 48, 56 (4th Cir. 2016) (concluding that if the backlog at issue here is "attributable to Congress' failure to fund the program more fully or otherwise to provide a legislative solution, it . . . [is] a problem for Congress, not the courts, to address"). The lack of appropriated resources has made it impossible for the agency to comply with the Medicare statute's adjudication timetable. Under the circumstances, this suit should yield to "the substantive authority of the Secretary to take appropriate action to cope with the administrative impossibility of applying the commands of the substantive statute." *Alabama Power Co. v. Costle*, 636 F.2d 323, 359 (D.C. Cir. 1979).

Plaintiffs insist that this argument is foreclosed by this Court's decision in the last appeal, at least to the extent that it relies on *Barr Labs* and *Mashpee*. Pls. Br. 17-18. But as we explained in our opening brief (at 17-18), the decision in the prior appeal was predicated on the "critical[]" assumption that the backlog was attributable to the Secretary's discretionary programmatic decisions in operating the RAC program. *AHA*, 812 F.3d at 193; *see also id.* at 185 (assuming the agency could meet the adjudication timetable if it was willing to "drastically curtail" the RAC program); *id.* at 192 (similar). The record compiled on remand—which reflects a time period when the number of RAC-related appeals "decreased drastically" (JA140)—establishes that the backlog is, in fact, a product of resource limitations, and that absent new funding, it will persist regardless of how the agency operates the RAC program. *See* Opening

Br. 18-19.[6] Because HHS is not electing to allow a "discretionary decision[]" to "trump" a "congressionally imposed mandate[]," *AHA*, 812 F.3d at 193, the principle established in *Barr Labs* and *Mashpee* applies. *Cf. Yesudian ex rel. United States v. Howard Univ.*, 270 F.3d 969, 972 (D.C. Cir. 2001) (holding that law of the case doctrine does not apply to issues not decided in a prior appeal).

Plaintiffs also note that *AHA* observed that the plaintiffs in *Barr Labs* and *Mashpee* were seeking to engage in "line-jumping," moving forward at the expense of those ahead of them. Pls. Br. 18 (quoting *AHA*, 812 F.3d at 192). But *Barr Labs* was decided on much broader grounds. There, the Court discussed not only the trade-off between Barr and those ahead of it in line, but also the trade-off with "the FDA's disposition of its other projects," and emphasized that "[s]uch budget flexibility as Congress has allowed the agency"—*i.e.*, the agency's ability to transfer resources from other programs to the backlogged generic drug approval program at issue—"is not for us to hijack." *Barr Labs*, 930 F.2d at 76. In fact, a trade association that intervened in *Barr Labs* argued that FDA should be ordered to meet the timetable at issue for all applicants (not just Barr). *See* Cross Pet. for Writ of Cert., *National Ass'n of Pharm.*

[6] As we acknowledged in our opening brief (at 18 n.11), some of this reduction was attributable to a temporary decrease in RAC activity, but the reduction was also due in significant part to permanent changes to the RAC program. JA140-JA141. In any case, the relevant point is that the record on remand shows that even a drastic curtailment of the RAC program cannot cure the backlog. *See* FAIR Amicus Br. 11 ("As the number of RAC denials has declined, however, the ALJ backlog has not.").

Mfrs. v. Sullivan, No. 91-300, 1991 WL 11177272, at *11-*12 (U.S.) (describing how intervenor argued that "giving only one company such as Barr relief" was suboptimal and that the Court should instead "issue an Order directing the Agency to comply *generally* with the 180-day statutory deadline"). The principle that violations stemming from resource shortages must be left for the political branches to resolve is not limited to line-jumping cases.

In any event, plaintiffs do not argue that the prior appeal forecloses consideration of whether the administrative necessity doctrine recognized in *Alabama Power* applies here. That doctrine applies. Plaintiffs note that the circumstances here are not identical to those in cases where the doctrine has been applied previously, but the basic point remains that HHS cannot lawfully "apply[] the commands of the substantive statute." *Alabama Power*, 636 F.2d at 359. Accordingly, the agency is entitled to leeway in managing its operations in the face of the impossibility of statutory compliance.

Plaintiffs argue that as a factual matter, the agency has not met the burden needed to claim impossibility. Pls. Br. 19. But there is no dispute that the agency lacks the funds that would be necessary to adjudicate the backlogged claims. And no one has proposed any *lawful* mechanism through which HHS could come into compliance with the Medicare statute's timetable. The agency has not, as plaintiffs would have it, "adopt[ed] a position of impossibility." Pls. Br. 19 (quoting *Ganem v. Heckler*, 746 F.2d 844, 854 (D.C. Cir. 1984)). The agency simply cannot comply.

Plaintiffs insist that mandamus is appropriate as long as the agency "has some discretion" to make policy choices that can impact the backlog. Pls. Br. 19. But if, as here, the agency truly has no power to comply with a statutory requirement, mandamus is not an appropriate mechanism to compel an agency to make marginal improvements to a program. In *Barr Labs*, this Court rejected the argument that the agency should be required to make changes in order to make its operations more efficient, concluding "judges have neither the capacity nor the authority to require such measures." 930 F.2d at 76; *see Cumberland Cty. Hosp.*, 816 F.3d at 56 ("[W]e have no reason to believe that any judicial intervention into HHS's administrative process, as urged by the Hospital System, would improve anything" because "[t]he courts surely do not have greater competence to administer the Medicare reimbursement claims process than does HHS."). Likewise, in the last appeal, this Court recognized that "the agency is entitled to some leeway to resolve the tension between competing priorities." *AHA*, 812 F.3d at 193. A rule that would allow for mandamus any time a marginal improvement might be achieved—even where the ultimate statutory requirement is wholly unobtainable—would not provide "enough clarity to guide judicial intervention." *Barr Labs*, 930 F.2d at 76; *see Norton v. Southern Utah Wilderness All.*, 542 U.S. 55, 66-67 (2004) (discussing "the clarity necessary to support judicial action" and the need to avoid "injecting the judge into day-to-day agency management").

Plaintiffs' proposed changes to the RAC program exemplify these concerns. Pls. Br. 19-22. Plaintiffs would have the courts order HHS to negotiate a particular type of contingency-fee schedule with the RACs or modify the look-back period for RAC review. Pls. Br. 21-22. There is no warrant for requiring changes of these types, which are untethered from any statutory requirement that could guide judicial intervention, and whose potential to meaningfully affect the backlog is ambiguous at best. The number of RAC-related appeals has already decreased substantially. JA140-JA141, JA157. This Court should decline plaintiffs' suggestion to tinker with the mechanics of the RAC program (which is itself statutorily mandated, *see* 42 U.S.C. § 1395ddd(h)).

Plaintiffs' RAC proposals are particularly unsuitable because HHS only recently completed negotiation of new RAC contracts that implement three financial incentives for RACs to make accurate claim determinations, including a provision that allows RACs to earn increased contingency fees by maintaining higher accuracy rates. JA144-JA145.[7] And under existing policy, when a RAC determination is overturned on appeal, the RAC does not receive any contingency payment or other reimbursement for the time it spent reviewing the claim. Plaintiffs' supposition that these measures do not go far enough is based on the erroneous premise that the first

[7] The new contracts took effect in October 2016, after the district court's statement questioning the sufficiency of the agency's changes to the RAC program. *See* Pls. Br. 19-20 (quoting JA127).

two levels of administrative review are mere rubber stamps—in fact, the most recently available data show that providers prevail at these stages in a significant number of RAC cases. JA147 (showing that in 2015, providers prevailed at the first level of review in 57% of RAC cases). And contrary to plaintiffs' suggestion (Pls. Br. 20), HHS does not expect that the reviews performed under these new RAC agreements will result in a surge of hundreds of thousands of new appeals annually. JA156 (showing projected receipts). Plaintiffs' speculative concerns about the future operation of the RAC program cannot be an adequate basis for mandamus.

At bottom, the record on remand has shown that this is a case where the statutory mandate is wholly unobtainable for HHS unless and until Congress provides the necessary resources and authorities. This political problem requires a political solution. Mandamus should not issue.[8]

[8] Plaintiffs briefly argue that HHS should have changed its policies on recoupment of overpayments and accrual of interest. Pls. Br. 30. Plaintiffs concede, however, that these changes would not improve the backlog—and indeed, they would only worsen it. JA148. In essence, plaintiffs ask that the government be required to extend providers interest-free loans for the value of all appealed claims, which would incentivize the filing of more questionable or even fraudulent claims. JA148-JA149. Moreover, there are statutory rules that govern recoupment, accrual of interest, and the circumstances under which an agency may decline to collect money that it is statutorily owed. *See* 42 U.S.C. §§ 1395g(d), 1395*l*(j), 1395ddd(f)(2)(A), (B); 31 U.S.C. § 3711(a). And contrary to plaintiffs' suggestion (Pls Br. 30 n.3), while the statute clearly prescribes the date on which interest payable by the provider begins to accrue, it does not specifically state when interest payable by the government should accrue. *See* 42 U.S.C. § 1395ddd(f)(2)(B).

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed and judgment should be entered in favor of the Secretary.

Respectfully submitted,

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April 2017

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a). This brief contains 4,539 words.

/s/ Joshua Salzman
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CERTIFICATE OF SERVICE

I hereby certify that on April 6, 2017, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the District of Columbia Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Joshua Salzman
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