UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*,

Plaintiffs,

v.

ERIC D. HARGAN, in his official capacity as Acting Secretary of Health and Human Services,

Defendant.

Civil Action No. 14-cv-00851 (JEB)

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

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OVERVIEW

The U.S. Department of Health and Human Services (HHS) cannot comply with an order mandating that it eliminate the current backlog of 531,926 appeals at the Office of Medicare Hearings and Appeals (OMHA) by December 31, 2020, or with any order mandating the elimination of the backlog by a date certain, because OMHA annually receives significantly more appeals than it can hear and decide. HHS has asked and continues to ask Congress for resources to increase OMHA's capacity, but Congress has not given HHS these tools as of yet. HHS has undertaken targeted settlement initiatives, and is introducing two more today, but HHS cannot guarantee their success—that depends on willing counterparties. HHS also has implemented changes to the Recovery Audit Contractor (RAC) program that have led to significantly fewer appeals resulting from their reviews, such that RAC reviews are no longer a significant driver of the backlog. What HHS cannot do is engage in indiscriminate settlements to buy its way out of the backlog on pain of contempt for missing the Court's deadlines—doing so would violate the Medicare statute, would encourage meritless appeals, and ultimately would be unsuccessful. In short, it would be impossible.

OMHA is part of HHS. It administers the nationwide Administrative Law Judge (ALJ) hearing program for appeals arising from individual claims for Medicare coverage and payment under Medicare Parts A through D, as well as appeals arising from claims for entitlement to Medicare benefits. The majority of appeals adjudicated by OMHA are filed by the health care providers or suppliers that serve Medicare beneficiaries.

OMHA is funded by a line-item appropriation that effectively limits the number of appeals that OMHA can adjudicate annually. Beginning in 2010, ALJ hearing requests skyrocketed. Between fiscal year (FY) 2010 and FY 2014 alone, OMHA experienced a 1,222% surge in appeals.

Although the growth in appeals has slowed since FY 2014, it continues to outpace OMHA's adjudicatory capacity at current funding levels. The unfortunate result has been a backlog of appeals that OMHA is incapable of adjudicating within the 90-day period contemplated by statute. As of October 20, 2017, the number of appeals pending at OMHA was 531,926 but OMHA only had the capacity to dispose of approximately 76,000 appeals in FY 2017.

Congress is aware of the problem and has held hearings on it. Both the prior and current administrations have repeatedly asked Congress to increase OMHA's funding levels and enact reforms that would help OMHA reduce the backlog. Congress has yet to do so.

HHS understands the impact of the OMHA backlog on providers, and has made the elimination of the backlog a top priority. HHS previously implemented numerous administrative reforms and a hospital settlement program that reduced the backlog. The new HHS leadership—which began to join the agency earlier this year[1]—has developed and is now implementing another wave of programs to try to further reduce the backlog.

Notwithstanding these extraordinary measures, HHS cannot lawfully comply with this Court's prior Order, or with any order requiring HHS to reduce the backlog by fixed, annual amounts. This is partly because OMHA has maximized its adjudicatory capacity at current funding levels. OMHA has optimized the productivity of its ALJs, to the point where increasing adjudication capacity could undermine reasoned decision-making. HHS cannot get more blood from that stone. OMHA could do more if Congress answered the Department's many requests for better tools and more money. But that has not happened, and HHS cannot force Congress to act.

[1] HHS's current Acting Secretary, Eric D. Hargan, was confirmed by the Senate as Deputy Secretary on October 4, 2017 and then named Acting Secretary shortly thereafter.

The only way HHS could even theoretically meet the thresholds in this Court's prior Order would be to settle large volumes of appeals without regard to either the merits of those appeals or the Government's related obligation to protect the taxpayers' money. Based on historical overturn rates, the vast majority of the appeals in the backlog (nearly 70%) are ultimately without merit. But to prevent the backlog from growing again, ongoing settlements of these appeals would be necessary given the continuing gap between OMHA's adjudicatory capacity and the new appeals filed annually, likely encouraging providers to file still more appeals to take advantage of a near guaranteed payout. This is not a realistic or equitable solution to the backlog. Nor is it a lawful one. The Medicare statute, among other similar requirements, directs that HHS may 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). HHS may of course settle with particular providers and classes of providers based on reasonable judgments about the likely merits of their claims, costs to the agency, and other litigative considerations. But HHS cannot engage in mass and continuing settlements under duress to hit backlog reduction targets, as any such order would, as a practical matter, require the agency to do.

Moreover, mass settlements would not be a reasonable solution to the backlog, because a large percentage of the appeals were filed by appellants that are the subject of program integrity investigations. HHS cannot vindicate its obligation to protect the Medicare Trust funds by settling with such appellants indiscriminately.

The new HHS leadership has carefully studied the possibility of further settlements that would help reduce the backlog while vindicating the agency's obligation to protect the Medicare Trust Fund. As noted above, HHS has developed two new settlement programs through that process. The first is a low-volume appeals (LVA) option that will be offered by the Centers for

Medicare & Medicaid Services (CMS). The LVA option will provide efficient relief to smaller providers—indeed, potentially the vast majority of providers with appeals pending at OMHA—while generating net savings to the taxpayer through the avoidance of administrative costs. The second is an expansion by OMHA of its settlement conference facilitation (SCF) pilot program. The expanded SCF program will help many providers that are ineligible for the LVA program to negotiate prompt, cost-effective resolutions of appeals with CMS.

These new programs will help to reduce the backlog and will target relief to those providers that are most likely to have suffered adverse effects from the backlog. But these programs will not enable HHS to meet the thresholds in the Court's previous Order or any similar order. HHS would still need willing counterparties—without program integrity issues—to settle enough appeals to meet the thresholds. And the agency's experience with past settlement initiatives shows that many appellants are not willing counterparties seeking reasonable settlements. It is simply not fair or equitable to taxpayers to require HHS to hit backlog-reduction targets that would require the agency to negotiate under duress.

And Plaintiffs, for their part, have done little to promote reasonable settlements that protect the Medicare Trust funds. Their focus has always been on the RAC program, which Congress began as a demonstration project in 2003 and subsequently directed HHS to implement nationwide in 2010. *See* Pub. L. No. 108-173, § 931, 117 Stat. 2066, 2256 (2003); 42 U.S.C. § 1395ddd(h)(1). The RAC program, however, was never the exclusive cause of the backlog and its relative contribution to the problem has declined dramatically in recent years. HHS has disposed of the vast majority of preexisting RAC appeals. And since 2015, the RAC program has accounted for less than 15% of new appeals every year. Plaintiffs have also suggested that HHS should suspend recoupment and toll interest accrual for claims pending at OMHA. But HHS does not have the

statutory authority to implement those changes. And even if HHS did have such authority, suspending recoupment and tolling interest accrual would not remove a single appeal from the backlog, or slow the growth of new appeals.

In light of the foregoing, mandamus should not issue. Given HHS's new settlement initiatives that encompass the vast majority of providers, the equities simply do not support such a drastic remedy. And the record now makes abundantly clear that the central prior assumption of both Plaintiffs and the D.C. Circuit in the 2016 appeal in this case—that HHS can solve the backlog by changing the RAC program—is wrong and that there are simply no other discretionary measures that HHS can take to eliminate the backlog. The situation here stems primarily from Congress's failure to provide OMHA with better tools and more money. It is accordingly a problem for the political branches to resolve.

If the Court decides that further relief is warranted, HHS respectfully requests that any such relief direct specific measures, rather than impose timetables. The agency should not be ordered to make reductions to the backlog that are impossible, or inequitable to the taxpayers, and that, in any event, depend on factors (such as responses to settlement offers) that are largely outside the agency's control.

LEGAL STANDARDS

"'The remedy of mandamus is a drastic one, to be invoked only in extraordinary circumstances.'" *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 189 (D.C. Cir. 2016) *("AHA I")* (quoting *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002)). And even where the legal requirements for mandamus jurisdiction are satisfied, "a court may grant relief only when it finds compelling equitable grounds" for doing so. *In re Medicare Reimbursement Litig.*, 414 F.3d 7, 10 (D.C. Cir. 2005) (citation and internal punctuation omitted). Furthermore, when an agency

contends that lawful compliance with a mandamus order is impossible, it is an abuse of discretion to issue the order unless the court makes a finding that lawful compliance is possible. *Am. Hosp. Ass'n v. Price*, 867 F.3d 160, 166 (D.C. Cir. 2017) ("*AHA II*"). The D.C. Circuit accordingly remanded this case with instructions "to evaluate the merits of the Secretary's claim that lawful compliance [with the mandamus order] would be impossible." *Id.* at 170.

Moreover, it is well-established in this Circuit that violation of a statutory deadline "does not, alone, justify judicial intervention." *In re Barr Labs, Inc.*, 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)). Rather, a court applies the following six principles the D.C. Circuit identified in *Telecommunications Research & Action Center v. FCC* ("*TRAC*"), 750 F.2d 70, 74-79 (D.C. Cir. 1984), in determining whether an agency's delay warrants a mandamus order:

> (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.

TRAC, 750 F.2d at 80 (internal quotation marks and citations omitted). "Although these factors provide guidance by setting out 'the hexagonal contours of a standard," the D.C. Circuit has explained that "they are 'hardly ironclad, and that '[e]ach case must be analyzed according to its own unique circumstances.'" *AHA I*, 812 F.3d at 189 (quoting *Air Line Pilots Ass'n v. Civil Aeronautics Bd.*, 750 F.2d 81, 86 (D.C. Cir. 1984)) (internal citation omitted).

ARGUMENT

I. IT IS IMPOSSIBLE FOR HHS TO LAWFULLY COMPLY WITH THIS COURT'S PRIOR ORDER, OR ANY SIMILAR ORDER

The Court's previous Order mandated a 30% reduction of the backlog by the close of 2017, further reductions in subsequent years, and total elimination of the backlog by the end of 2020. HHS cannot lawfully comply with this Order or any similar order that requires the agency to reduce the backlog to zero. The agency has taken all reasonable steps to increase OMHA's disposition capacity within current funding restraints, and to reduce the number of incoming appeals. But OMHA continues to receive more appeals than it can handle—on top of an existing backlog of more than 530,000 appeals—and that gap will continue for the foreseeable future. Congress has been aware of the backlog for years, has conducted hearings concerning it, has considered legislation to address it, and has received proposed budgets from each of the last two administrations that would commit substantial additional funds to OMHA; but Congress has not acted. And HHS cannot lawfully resolve the backlog through mass, indiscriminate settlements with providers and suppliers. Plaintiffs have proposed changes to the RAC program but the RAC program is not the fundamental cause of the ongoing backlog, and Plaintiffs' other past proposals would not reduce the backlog. At bottom, the targets in the Court's prior Order are wholly unobtainable for HHS. The agency cannot hit those targets unless and until Congress provides the necessary resources and authorities.

A. OMHA Has Taken All Reasonable Efforts to Increase its Disposition of Appeals, but OMHA's Existing Adjudicatory Capacity Remains Limited

As the Court is aware, OMHA is funded through a separate line-item appropriation, and the Secretary has no meaningful authority to increase OMHA's funding.[2] Despite massive

[2] *See* Continuing Appropriations Act, 2017, Pub. L. No. 114–223, div. C, 130 Stat. 857, 909 (2016).

increases to OMHA's workload since 2010 (including a 1,222% increase from FY 2010 to 2014 alone[3]), Congress has not provided OMHA with significant increases in funding levels.[4] At current funding levels, OMHA only had the capacity to dispose of 76,000 appeals in fiscal year ("FY") 2017, and OMHA's estimated adjudication capacity for FY 2018 is projected to rise to no more than 93,500 appeals. Declaration of Nancy J. Griswold ("Griswold Decl.") ¶¶ 3-4.

OMHA's current funding levels support 92 ALJ teams, consisting of one ALJ and four support staff; collectively, these 92 teams will be able to dispose of approximately 88,000 appeals per year. Griswold Decl. ¶ 5. OMHA already has taken a number of steps to maximize the productivity of its ALJ teams. It has established judicial training and other continuing training initiatives for adjudicators and staff on various issues that may be presented on appeals, reducing research time. *Id.* ¶ 7(b). It has re-engineered its field office staffing structure to use more of its funding on direct case-support functions (a step which has allowed OMHA to increase ALJ support to include two legal assistants and two attorneys per ALJ). *Id.* ¶ 7(c). It has utilized strategic case assignments to assign appellants with a large number of filings to a single ALJ, facilitating potential consolidated proceedings and more efficient adjudication. *Id.* ¶ 7(d). And it has introduced a number of electronic tools to reduce staff time spent on other tasks and redirect their efforts to processing more appeals. *Id.* ¶ 7(e). The average annual dispositions per ALJ more than doubled between FY 2009 and FY 2013. *See* Appellant Forum: February 12, 2014—Presentation, slide 15, *available at* https://www.hhs.gov/about/agencies/omha/about/special-

[3] Judge Nancy J. Griswold, Appellant Forum–Update from OMHA, at 8 (June 25, 2015), https://www.hhs.gov/sites/default/files/omha/OMHA%20Medicare%20Appellant%20Forum/presentations_june_25_2015.pdf (last visited November 2, 2017).

[4] *See* OMHA, HHS, Fiscal Year 2017, *Justification of Estimates for Appropriations Committee* 13 (FY 2017 Budget Estimate) (showing essentially flat appropriations between 2010 and 2013 and limited increases since), https://www.hhs.gov/sites/default/files/fy2017-budget-justification-office-of-medicare-hearings-and-appeals_0.pdf (last visited November 2, 2017).

initiatives/appellant-forums/index.html.

Despite these efforts, there are legal and practical limits to OMHA's adjudicatory capacity. The Medicare statute requires that ALJs provide a "hearing," and then issue a written decision stating "the specific reasons for the determination." 42 U.S.C. § 1395ff(b)(1)(A), (d)(4)(A). To fairly adjudicate each claim and issue a reasoned decision, each appealed claim must be individually reviewed and analyzed. Griswold Decl. ¶ 8. That process requires: a review to confirm that the appeal meets statutory requirements for jurisdiction; record preparation; research of the issues the appeal presents; scheduling and conducting conferences and hearings; deciding any procedural issues or other matters the parties raise; reviewing and analyzing testimony as well as other evidence; and drafting and finalizing a decision. *Id*. At OMHA's current disposition capacity, each ALJ team decides approximately 1,000 appeals per year. *Id.*

OMHA has also sought to increase its adjudication capacity through non-traditional methods, but its ability to do so is limited. It has established a process to streamline on-the-record decisions when appellants waive their right to an oral hearing. Griswold Decl. ¶¶ 6-7(a). This process permits qualifying appeals to be resolved by OMHA senior attorneys with minimal ALJ involvement, freeing ALJs to devote more time to preparing for hearings; OMHA attorneys have resolved approximately 5,000 appeals under this program since it began in July 2015. *Id.* ¶ 7(a). OMHA now has regulatory authority to allow attorney-adjudicators to decide these appeals, which will allow ALJs to devote more time to hearings. *Id.* ¶ 6. As noted above, however, the appellant must waive its right to an oral hearing to use this process. OMHA has also made use of the Office of Personal Management's senior ALJ program, under which it may reemploy retired ALJs on a temporary and part-time basis. *Id.* This program is subject to resource constraints; in FY 2018, OMHA projects that this program will increase adjudication capacity by only 500 appeals. *Id.*

OMHA's other programs aimed at increasing productivity—such as settlement conference facilitations, and statistical sampling—are similarly at the discretion of appellants. *Id.* ¶¶ 10-18; *see also* pp. 21-22., *infra* (noting limited appellant participation in these initiatives).

OMHA is committed to maximizing its disposition capacity. *See* Griswold Decl. ¶ 5. But as a matter of math and common sense, increasing adjudication capacity further—and further reducing the amount of time ALJs can devote to each appeal—would be inconsistent with ALJs' legal obligation to engage in reasoned decisionmaking. OMHA has undertaken all reasonable efforts to increase the adjudicatory capacity of the ALJ teams under its current budget. *Id*. Indeed, to Defendant's knowledge, Plaintiffs have never suggested in this litigation any ways that OMHA could meaningfully increase its adjudication capacity at current funding levels. As discussed further below, annual incoming appeals continue to far exceed OMHA's adjudication capacity, even putting aside the preexisting backlog.

B. HHS Has Taken All Reasonable Efforts to Reduce the Number of Incoming Appeals, but New Appeals Still Exceed (and Will Continue to Exceed) OMHA's Limited Adjudicatory Capacity

OMHA continues to receive incoming appeals far in excess of its limited adjudication capacity. In FY 2018, HHS estimates that OMHA will receive 186,245 new appeals, approximately double the 93,500 OMHA may be able to dispose of that year. Griswold Decl. ¶ 4. HHS estimates that OMHA's new receipts will generally climb slightly over the next few years, reaching 223,412 in FY 2021. See Declaration of Michael Bagel (Bagel Decl.) ¶ 8 and Exhibit 1.

HHS and its components have undertaken numerous efforts to obviate the need to appeal to OMHA (or to any level of the Medicare administrative appeals process), and to correspondingly reduce the influx of new appeals. *See generally* Declaration of George G. Mills (Mills Decl.) ¶¶ 11-13. Specifically:

(1) CMS established and recently expanded the Targeted Probe and Educate Program,

which allows providers to discuss claim errors with Medicare Administrative Contactors (MACs); providers subsequently have an opportunity to correct errors or improve their claims submissions, with the goal of ultimately decreasing the numbers of denials and resulting appeals. Mills Decl. ¶ 11.

(2) Last year, CMS launched a demonstration for durable medical equipment (DME) suppliers that submit fee-for-service claims; the program encompasses 37 states and territories covering the two largest DME Medicare Administrative Contractor jurisdictions, and gives providers the opportunity to discuss their claims by telephone with the DME Qualified Independent Contractor (QIC) (the appeal level preceding ALJ review), submit additional documentation, receive education on Medicare policies, the root causes of claim denials, and the documents the provider needs to submit and, under certain circumstances, obtain reopening of claims pending at OMHA that the QIC may now resolve in favor of the provider. Bagel Decl. ¶ 10. HHS estimates that this program will reduce the number of OMHA appeals by approximately 103,000 by the end of FY 2020 (in addition to other improvements it cannot yet quantify). *Id.* ¶ 10(b).

(3) CMS has further instituted a series of initiatives requiring providers and suppliers to obtain prior authorization from MACs for certain items or services in certain jurisdictions before billing for or providing a service or item. Mills Decl. ¶ 12. HHS estimates that these initiatives will reduce the number of appeals that would otherwise have reached OMHA by nearly 323,000 by the end of FY 2021. Mills Decl. ¶ 12.

(4) To improve accuracy rates at the lower levels of appeal, CMS has established an accuracy review team to verify (through monthly review of contractors' decisions) that contractors make accurate medical review determinations and are applying Medicare policies consistently.

Mills Decl. ¶ 13.

(5) CMS similarly uses validation contractors to assess the accuracy of RAC determinations; the contractors establish accuracy ratings for each RAC that are set forth in an annual report to Congress. Mills Decl. ¶ 13.

(6) Though the statute imposes no such requirement and HHS's regulations permit the MACs (Level I) and the QICs (Level II) to identify new issues, CMS has directed the MACs and the QICs to limit their reviews of each claim to the original basis for denial of the claim. Bagel Decl. ¶ 4(d).

(7) All of these steps are in addition to significant changes to the RAC program which have dramatically reduced the number of RAC appeals, as well as HHS's substantial and ongoing settlement efforts. These topics are discussed further below. *See* pp. 18-21, 22-25, *infra*.

These and other measures have helped HHS to make significant progress in reducing the flow of incoming appeals, to approximately 113,000 in the most recently completed fiscal year, Griswold Decl. ¶ 3 (though HHS projects that annual incoming appeals will rise somewhat in upcoming years based on its analysis of appeals receipt trends and the continuing growth of the number of Medicare beneficiaries). Bagel Decl. ¶ 6 & Ex. 1. But OMHA's ability to reduce the flow of incoming appeals is limited, since appellants have a statutory right to appeal denied claims meeting amount-in-controversy requirements to an ALJ. 42 U.S.C. § 1395ff(b), (d)(1). From FY 2019 to FY 2021, HHS currently projects that it will receive new appeals more than double its maximum adjudication capacity each year. Bagel Decl. Ex. 1.

This gap, moreover, is of course exacerbated by the preexisting backlog which, as the Court knows, is substantial (though HHS has made substantial progress in reducing it). As of October 20, 2017, the number of pending appeals at OMHA was 531,926 (compared, again, to a maximum

sustainable adjudication capacity of up to 93,500 appeals for FY 2018). Griswold Decl. ¶¶ 3-4. In short, a significant gap between incoming appeals and adjudication capacity remains that will continue for the foreseeable future.

C. The Executive Branch Has Proposed Legislative Measures to Address the Backlog, but Congress Has Not Acted on those Measures

HHS has repeatedly asked Congress for significant increases to OMHA's budget, as well as congressional approval for new authorities that would allow OMHA to process a greater number of appeals and facilitate the appropriate resolution of appeals at earlier levels of the process. *See* FY 2017 Budget Estimate 7 (asking Congress to more than double OMHA's funding, and stating that doing so would allow an increase from 92 ALJ teams to 193). The President's most recent proposals would also introduce a number of procedural reforms that would be expected to reduce the influx of pending appeals further, such as increasing the minimum amount-in-controversy threshold for an ALJ hearing, establishing magistrate adjudication, expediting appeals where no material facts are in dispute, and remanding appeals when new evidence is introduced. Bagel Decl. ¶ 12.

Congress has not entirely ignored this issue. Both Houses of Congress have conducted hearings on it,[5] and members of Congress from both sides of the aisle have recognized that OMHA currently lacks the resources and authorities needed to resolve the backlog. *See, e.g., Wyden Statement at Finance Hearing on the Medicare Appeals Process* (Apr. 28, 2015) (stating that "with

[5] *See Medicare Mismanagement Part II: Exploring Medicare Appeals Reform: Hr'g Before the Subcomm. on Energy Policy, Health Care, & Entitlements, of the H. Comm. On Oversight & Gov't Reform*, 113th Cong. (2014), https://oversight.house.gov/hearing/medicare-mismanagement-part-ii-exploring-medicare-appeals-reform/; *see also Creating a More Efficient & Level Playing Field: Audit & Appeals Issues in Medicare: Hr'g Before Sen Comm. on Finance*, 114th Cong. (2015), https://www.finance.senate.gov/imo/media/doc/20035.pdf.

a 10-fold increase in the number of cases, it's clear that additional resources are needed")[6]; *Hatch Statement at Finance Hearing on Medicare Audit and Appeals* (Apr. 28, 2015) ("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.").[7] And the D.C. Circuit has expressly invited a political resolution, noting that its decision might prompt Congress to "'clarify' potentially conflicting signals." *AHA I*, 812 F.3d at 194; *see also id.* at 192-93 ("The backlog and delays have their origin in the political branches, and ideally the political branches should resolve them."); Oral Arg. Recording at 47:47 (Tatel, J.) ("Wouldn't it help the Secretary in terms of her effort to get more resources to have a little pressure from the courts" through an order "short of mandamus"?).[8]

But as the Court is by now well aware, none of this has worked. In June 2015, the Senate Finance Committee unanimously reported out a bipartisan bill, the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, to address existing issues in the Medicare appeals process, including the existing backlog, and to provide OMHA with a significant funding increase. *See* S. 2368, 114th Cong. (2015-16); *see also* S. Rep. No. 114–177 (2015). However, the legislation did not proceed further, and no companion legislation was introduced in the House of Representatives. *Id*. Nor has Congress meaningfully increased OMHA's funding level, despite repeated requests from the Executive Branch that it do so. Bagel Decl. ¶ 11. HHS has committed to working with Congress to address the pending backlog. *Id.* ¶ 13. But despite Congress's

[6] https://www.finance.senate.gov/ranking-members-news/wyden-statementat-finance-hearing-on-the-medicare-appeals-process.

[7]https://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.

[8]https://www.cadc.uscourts.gov/recordings/recordings.nsf/DocsByRDate?OpenView&count=100&SKey=201511.

recognition of OMHA's constraints and the Executive Branch's repeated pleas for additional resources—and notwithstanding what Judge Tatel accurately described (even before this Court's prior mandamus order) as "a little pressure from the courts"—Congress has not acted to solve the problem.

D. Mass Settlements Will Not Eliminate the Backlog

Given the foregoing, the only way HHS could even theoretically approach the reductions in the Court's prior Order would be mass, indiscriminate settlements of appeals without regard to the merits or the agency's obligation to protect the Medicare Trust funds. Plaintiffs' Complaint does not mention settlements at all, and does not suggest any solution to the backlog besides RAC-related reforms. *See* ECF No. 1. The D.C. Circuit's decision in *AHA I* likewise does not mention settlements (and discusses only the RAC program in its analysis of the Secretary's possible options for reducing the backlog). 812 F.3d at 193. Plaintiffs' recent emphasis on mass settlements underscores that it is indeed impossible for HHS to do what Plaintiffs contend the Medicare statute ***actually requires*** the agency to do (adjudicate all pending appeals within 90 days). HHS cannot lawfully comply with the Court's prior Order (or any similar order) through mass, indiscriminate settlements.

1. At the outset, there are three reasons why an order directing HHS to enter into mass, indiscriminate settlements—or an order flatly instructing HHS to eliminate the backlog, leaving the agency no means to comply other than through such settlements—would be an inappropriate use of the mandamus power.

a. First, HHS has no control over whether (or how many) claimants ***accept*** any settlement proposals it makes. Indeed, Plaintiffs recognize as much. *See* ECF No. 39 at 9 (stating that, if the Secretary expanded a settlement program, "providers could choose whether to accept

or to soldier on"). It would simply be untenable to issue a mandamus order the compliance with which is dependent on a factor outside the agency's control. This is also one reason why, if the Court does issue a mandamus order, that order should direct specific measures rather than impose timetables. *See* pp. 30-31, *infra*.

b. Second, given the ongoing adjudication gap, to eliminate the backlog HHS would have to ***continually*** settle masses of claims as they reached OMHA. Again, Plaintiffs have implicitly acknowledged this. *See* ECF No. 15 at 27 (criticizing prior HHS settlement offer because "as a one-time retroactive lookback, [it would] not reduce the continuing growth in appeals"). The logical effect of such an indefinite appeal-then-settle regime is that providers would seek ALJ review of still more claims, seeking to take advantage of a payout that would be virtually guaranteed without regard to the merits of those claims.

c. And third, knowing the agency's imperative to settle, providers with pending claims would lack a meaningful incentive to reach a reasonable compromise. That is of course the inevitable consequence of a negotiation where one party is under duress. *See* pp. 21-22, *infra* (noting limited provider participation in HHS's settlement initiatives).

2. HHS can settle claims based on reasonable judgments that take into account the merits of those claims, costs to the taxpayer, and similar considerations. But a regime in which HHS is required to sharply reduce and ultimately eliminate the backlog through mass, ongoing, and indiscriminate settlements would be untenable because it would require HHS to break the law. *See AHA II*, 867 F.3d at 167 (noting Secretary's argument that prior Order required him to "either violate the Medicare statute by settling reimbursement claims *en masse* without regard for their merit, or violate the Court's mandamus order by missing the court-ordered deadlines" and stating that "equity courts, like any other, may not order parties to break the law").

a. HHS has a statutory obligation to ensure that non-meritorious claims are not paid. "Notwithstanding any other provision" of the Medicare statute—which includes the provision imposing the ninety-day timeline for ALJ hearings— "no payment may be made . . . for any expenses incurred for items or services" that do not meet statutory criteria. 42 U.S.C. § 1395y(a). Likewise, claims can only be paid where "[c]onditions of and limitations on payment for services" are satisfied, *id.* § 1395f (Medicare Part A); *see also id.* § 1395n (similar restrictions under Part B), and where the amounts due have been sufficiently verified, *id.* §§ 1395g(a) (Medicare Part A), 1395l(e) (Medicare Part B). The Medicare statute thus bars the agency from addressing the backlog through measures that would require payment of claims that do not meet statutory criteria for payment and without any consideration of the merits, litigation risk, costs to the taxpayer, or similar considerations.

b. HHS "regulations permit [HHS] to settle claims that are less than certain to prove meritorious on a case-by-case basis." *AHA II*, 867 F.3d at 176 (Henderson, J., dissenting). For example, CMS may compromise a claim based on a debtor's inability to pay the full amount of the claim, or if the cost of collection does not justify seeking the full amount. 42 C.F.R. § 401.613(c)(1), (3). And CMS may settle based on its reasonable judgment of "litigative possibilities," which involves consideration of CMS's likelihood of success on the legal issues involved, whether and to what extent CMS would have obtained a full or partial recovery, and the amount of court costs that would be assessed. *Id.* § 401.613(c)(2); *see also id.* § 405.376(d) (providing similar considerations for settlement of claims for overpayments against a provider or a supplier under the Medicare program). The amount of any such settlement must "bear a reasonable relation to the amount of the claim." *Id.* § 401.613(a)(1); *accord id.* § 405.376(h). But this measured approach is simply incompatible with a requirement that the agency settle masses

of claims to eliminate the backlog, on an ongoing and indefinite basis as more and more appeals come into OMHA, with counterparties who know that the agency has been put under duress and thus have no incentive to reach a compromise that is fair to the taxpayer.

c. HHS, moreover, is also charged with maintaining program integrity against waste, fraud, and abuse. 42 U.S.C. § 1395ddd. Providers responsible for a significant portion of the backlog present serious program integrity issues, including but not limited to active False Claims Act investigations encompassing a wide range of alleged improper practices, past and ongoing civil and criminal investigations by federal and state authorities, evidence of past program abuse, revocation of billing privileges, and Medicare payment suspensions.[9] Declaration of Sherri G. McQueen (McQueen Decl.) ¶ 6. These concerns have precluded or severely complicated efforts to negotiate comprehensive settlements or other resolutions to remove the large volume of appeals filed by these appellants.

3. Despite these significant constraints, HHS has engaged in a variety of settlement efforts that have resulted in substantial reductions to the backlog.

a. CMS has settled a large number of claims through the Hospital Appeals Settlement Process (HASP). McQueen Decl. ¶ 7. In 2014, CMS offered to resolve claims for the provision of medically necessary services in which contractors had denied the claim based solely on a determination that the underlying documentation supported payment at outpatient hospital rates, as opposed to the higher inpatient hospital rates sought by providers. *Id*. ¶ 7(a). At the time, such appeals represented a large portion of appeals pending at OMHA, but this settlement initiative allowed CMS to remove 323,492 appeals from the backlog. *Id*. In 2016, CMS announced that it

[9] HHS has compiled a declaration setting forth provider-specific program integrity considerations; due to the sensitivity of that information, HHS is separately seeking the Court's permission to submit that declaration for the Court's ex parte review. *See* ECF No. 65.

would allow eligible providers who failed to avail themselves of the original settlement initiative another opportunity to settle their inpatient status claims appeals. Doing so allowed CMS to eliminate an additional 56,720 appeals from the backlog. *Id.* ¶ 7(b).

b. CMS has also entered into settlement agreements with State Medicaid Agencies (SMAs) from Connecticut, Massachusetts, and New York, which were three of the highest volume appellants at OMHA. McQueen Decl. ¶ 9. Each SMA agreed to resolve their pending appeals at OMHA or at the Medicare Appeals Council in exchange for partial payment at a negotiated percentage of the net allowable amount. *Id*. They also agreed to additional measures to resolve or reduce the number of new appeals entering the system through the summer of 2018. *Id*. In total, these settlements will remove approximately 54,000 appeals from the backlog, and result in a reduction of approximately 9,000 new appeals being filed.

c. CMS is currently engaged in settlement discussions with representatives of a significant number of Inpatient Rehabilitation Facilities (IRFs) which, if successful, could remove up to 15,000 IRF appeals from the backlog. McQueen Decl. ¶ 10.

d. OMHA staff trained in mediation techniques also administer a settlement conference facilitation (SCF) program between CMS and individual appellants. Griswold Decl. ¶ 10. As of May 2016, providers could be eligible for the SCF program if they had at least 20 claims, or $10,000, at issue in most Part B appeals pending before OMHA, or had at least 50 claims and $20,000 at issue in most Part A appeals pending before OMHA. *Id*. The SCFs have thus far resulted in agreements to settle 15,500 appeals (in addition to the SMA settlements). *Id*. ¶ 11.

e. Under OMHA's voluntary statistical sampling program which has been in place since 2014, appellants with 250 or more claims pending at OMHA may choose to have OMHA adjudicate their claims using statistical sampling and extrapolation. Griswold Decl. ¶ 16.

This program has resolved 532 appeals; over 14,000 appeals are currently in the process of being resolved. *Id.*

4. Finally, since the administration change earlier this year, HHS's new leadership has continued to study the backlog and possible ways to reduce it. In particular, HHS has developed two new or expanded settlement initiatives to reduce the backlog.

a. First, HHS has developed a settlement initiative for appellants with low appeal volumes who may not have been eligible for other settlement initiatives (the LVA). McQueen Decl. ¶ 11(a). The LVA is available to appellants with fewer than 500 appeals pending at OMHA or the Appeals Council (where program integrity concerns are not apparent), and provides that appellants settle all of their eligible appeals filed on or before November 3, 2017 where the total billed amounts per appeal are $9,000 or less, in exchange for partial payment (62% of the net allowed amount of all of their eligible appeals). *Id.* The LVA is consistent with the Secretary's duty to safeguard the Medicare Trust funds. In developing it, CMS reviewed historic ALJ overturn rates in conjunction with costs of adjudication and set both the parameters of the program (the less-than-500-appeal and $9,000 limits) as well as the percentage payout at levels that will save the Trust Fund money because those parameters will enable HHS to avoid adjudication costs and mitigate HHS's litigation risk. *Id.* HHS has also set the appeal threshold, maximum billed amount, and payment percentage to maximize the projected cost avoidance of the initiative. *Id.* The LVA thus maximizes the expected cost savings to the agency after taking into account the provider's likelihood of success and the administrative costs of processing an appeal to its conclusion. This approach stands in contrast to the prospect of having the agency enter into mass settlements indiscriminately, which would create a perverse incentive for appellants to flood the system with appeals lacking in merit. Importantly, the LVA is not an ongoing program, and

involves carefully calibrated caps and limited amounts at issue that make it unlikely that appellants will respond by filing a flurry of new appeals that they would not otherwise file.

HHS estimates that approximately 80% of appellants with appeals pending at OMHA, with approximately 166,000 corresponding appeals (or approximately 30% of the backlog), would be eligible for this initiative (i.e., the provider has fewer than 500 pending appeals, and the appeals are for no more than $9,000). McQueen Decl. ¶ 11(a). This initiative would therefore direct relief to the large majority of providers who have not significantly contributed to the growth of the backlog yet claim to have been adversely impacted by it. *See AHA v. Burwell*, 209 F. Supp. 3d 221, 226 (D.D.C. 2016) (discussing providers' allegations regarding harm to patient care).

b. Second, HHS is expanding the SCF program. McQueen Decl. ¶ 11 (b). Specifically, many appellants not eligible for the LVA will be eligible for the expanded SCF program (other than providers with program integrity concerns). *Id*. The expanded SCF program will provide a vehicle for eligible providers to explore means to remove their cases from the backlog. Griswold Decl. ¶ 15.

5. But all of these settlement efforts—while substantial—also underscore that HHS cannot lawfully comply with this Court's prior order, or a similar order, through mass settlements. HHS has no control over provider response to its settlement initiatives. As to the HASP settlement, providers representing 40,000-50,000 potentially eligible appeals did not participate, and 7,000 of those appeals demonstrated program integrity concerns in any event. McQueen Decl. ¶ 7(c). With respect to the SCF program, OMHA reached out to 18 providers with a high number of appeals that CMS initially indicated did not present program integrity concerns, but only four of those overtures has resulted in a settlement (and nearly half of the 18 did not even ***respond*** to OMHA). Griswold Decl. ¶ 14. And as of October 27, 2017, only ***seven*** providers (out of an estimated 466

eligible) have chosen to participate in the voluntary statistical sampling initiative. *Id.* ¶ 17. Likewise, because HHS needs counterparties willing to settle on reasonable terms, HHS cannot guarantee the success of the IRF settlement talks. Similarly, HHS cannot control how many providers accept the LVA and cannot force eligible providers to participate in the SCF program (or guarantee that those who do participate will accept a reasonable settlement). The agency cannot settle with counter-parties that do not want a fair settlement, such as those who do not opt into the LVA, or those who do not qualify for the LVA and decline to participate in SCF. As the authorities cited above make clear, the agency may lawfully enter into settlements only if it determines that the settlement represents fair value for the public fisc. And again, against the backdrop of a mandamus order that would effectively require HHS to continually, indefinitely, and indiscriminately settle masses of claims, ***fair settlements*** are impossible.

E. The RAC Program is Not the Cause of—and Further Changes to the Program Will Not Solve—the Backlog

From the very beginning of this litigation, Plaintiffs have blamed RACs for the backlog and focused on the RAC program as a source of supposed solutions. Plaintiffs' Complaint contends that the backlog is caused "in significant part" by inappropriate RAC denials, ECF No. 1 ¶ 29, and dwells at length on what Plaintiffs see as overzealous RAC auditing activity, *id.* ¶¶ 21-24. And on remand after *AHA I*, Plaintiffs' only proposals for reducing the influx of new appeals—other than settlements—involved the RAC program (most prominently, imposing financial penalties on RACs for poor performance). ECF No. 39 at 9-11.

The record now makes clear that the RAC program is not the primary cause of the backlog. Further changes to the program—or even its outright cancellation, which would not be legally permissible under 42 U.S.C. § 1395ddd(h)(1)—will not enable the Secretary to comply with either the Court's prior Order or any similar order. In FY 2015, OMHA received only 31,624 new RAC-

related appeals, representing just 14.1 percent of total new receipts, Griswold Decl. ¶ 19. This means that OMHA received over 192,000 non-RAC related appeals, while its adjudicators were able to issue only 78,881 dispositions, *see* ECF No. 41-1 at 48. Similarly, in FY 2016, OMHA received only 15,761 new RAC-related appeals, representing just 9.5 percent of total new receipts, Griswold Decl. ¶ 19. This means that OMHA received over 150,000 non-RAC related appeals while its adjudicators were able to issue only 87,123 dispositions, ECF No. 41-1 at 48. Thus, as the D.C. Circuit observed in its most recent opinion, "even a complete suspension [of the RAC program] is likely to leave an annual disposition gap of over 100,000 appeals—appeals that will be piled onto the existing backlog, frustrating HHS's efforts to comply with the statute's timeframe and the Court's mandamus order." *AHA II*, 867 F.3d at 167.

To be sure, the D.C. Circuit also observed that the FY 2015 and 2016 decrease in RAC-related appeals "coincide[d] with a two-year suspension of most of the RAC program . . . while new contracts were being negotiated." 867 F.3d at 166. The renegotiated RAC contracts now include a number of measures, discussed in more detail below, that are designed to ensure that the RACs have the proper incentives to determine claims correctly. These measures are succeeding. The RACs have now been operational for almost a year under a new Statement of Work ("SOW"), which took effect on October 31, 2016. Mills Decl. ¶ 6. In FY 2017 (October 1, 2016-September 30, 2017), RAC-related appeals numbered just 13,782 (12.2 percent of total new appeals). Griswold Decl. ¶ 19. "This indicates that the changes to the RAC program are having the intended effect in reducing the number of appeals entering the administrative appeals process." Mills Decl. ¶ 6.

The measures undertaken to reduce the number of RAC appeals are many. First, the Hospital Appeals Settlement Process removed 380,212 appeals, and almost all of those (341,116)

were appeals of RAC overpayment determinations. Mills Decl. ¶ 5. As of September 30, 2017, the total RAC-related appeals pending at OMHA numbered 82,329, compared to 437,524 just two years ago. Griswold Decl. ¶ 19.

HHS has also taken significant steps aimed at reducing the number of incoming RAC-related appeals. Many of these steps relate to the RACs' financial incentives. The new RAC SOW includes three additional financial incentives for RACs to make accurate claim determinations:

- CMS requires RACs to maintain an accuracy rate of at least 95%, as determined by an independent contractor reviewing random monthly samples of improper payment decisions and provides a 0.2% contingency fee increase for each point above 95%;
- CMS requires RACs to maintain an overturn rate of less than 10% at the first level of appeal, providing a 0.1% contingency fee increase for each percentage point below 10%;
- RACs receive no contingency fee payment until after the second level of appeal.

Mills Decl. ¶ 7(a)-(d). These incentives are in addition to the basic structure of the RAC program, in which RACs are paid on a contingency fee basis: if a RAC determination is overturned at any level of appeal, the RAC loses any payment that it may have previously earned from the denial. *Id.* ¶ 8.

Beyond these financial incentives promoting accuracy, CMS has also placed a number of procedural constraints on the RACs' operations. Before a RAC may refer a claim for recoupment, it now must give the provider 30 days to discuss the basis of the claim with the RAC and submit additional information to substantiate payment. Mills Decl. ¶ 7(e). CMS also now restricts the number of reviews RACs may initially conduct under a topic CMS has approved for review, and it has imposed limits on how many additional document requests that a RAC can issue to a provider. *Id.* ¶ 9(a)-(b). And CMS has removed the RACs' authority to conduct patient status

reviews—previously accounting for a substantial portion of RAC appeals—which are now assigned to contractors under the Quality Improvement Organization program. *Id.* ¶ 9(c). Contractors under that program are paid on a flat-fee basis, not on a contingent fee basis like the RACs. *Id.*

Finally, CMS has temporarily reduced the permitted "look-back" review period, *i.e.*, the period from the date of service that RACs are permitted to review an initial determination to pay a claim, for patient status reviews in cases where the provider submits its claim within three months of the date of service. Mills Decl. ¶ 9(d). Although the Medicare statute and applicable regulations permit the RACs to look back up to three years from the date a claim was paid, CMS has reduced that period to six months for more intensive reviews and any patient status claim reviews. *Id.* Notably, as to these claims, this step goes beyond even what Plaintiff had previously suggested. *See* ECF No. 39 at 11 (suggesting "shortening the RAC lookback period from three years to one year").

The RAC program itself is statutorily required. *See* 42 U.S.C. § 1395ddd(h). HHS cannot terminate or suspend it. Moreover, there is also no evidence that Congress disapproves of the way HHS has implemented the program. *See AHA I*, 812 F.3d at 193 (acknowledging this point). And the substantial steps the Secretary has already taken with respect to the RAC program—along with the concomitant decrease in RAC-related appeals—have come at a substantial cost to the public fisc. In FY 2015, the amount of money returned to the Medicare Trust funds by the RAC program was $141 million, down 91% from the $1.6 billion returned in fiscal year 2014.[10] In any event, as

[10] *See* Centers for Medicare & Medicaid Services, HHS, Recovery Auditing in Medicare Fee-For-Service for Fiscal Year 2015, at v, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2015-Medicare-FFS-RAC-Report-to-Congress.pdf

the foregoing discussion makes clear, even a total suspension of the RAC program would leave HHS facing both an ongoing adjudication gap and a large preexisting backlog of appeals.

F. Plaintiffs' Previously Proposed Measures Would Not Resolve the Backlog and Further Demonstrate that Compliance is Impossible

Throughout this litigation, Plaintiffs have repeatedly suggested, focusing primarily on the RAC program, that HHS has tools available to solve the backlog but refuses to use them. But Plaintiffs' actual proposals—which are generally impermissible and would not significantly improve matters in any event—belie this wishful thinking.

During the parties' last round of summary judgment briefing, Plaintiffs asserted that the Secretary should defer repayment of disputed claims and toll the accrual of interest on those claims during any period beyond 90 days that those claims are awaiting ALJ review. ECF No. 39 at 5-9. As a threshold matter, 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), 1395l(j), 1395ddd(f)(2)(A), (B); 31 U.S.C. § 3711(a). And HHS has previously explained that suspending repayment and interest accrual would violate federal law: the Medicare statute requires the Secretary to charge interest on Medicare fee-for-service debts that remain outstanding for more than 30 days after the determination of overpayment or underpayment, while the Federal Claims Collection Act and Department of Treasury regulations require HHS to promptly collect debts owed to it. *See generally* ECF No. 41 at 21-23.

But more fundamentally for purposes of the Secretary's impossibility argument, these measures would do ***absolutely nothing*** to alleviate the backlog or facilitate compliance with this Court's prior Order. Tolling interest accrual or delaying repayment would obviously not remove a single appeal from the backlog.

Plaintiffs also previously argued that "[t]he Court should order the Secretary to implement

a more effective check on the RAC program by imposing financial penalties on RACs for high reversal rates." ECF No. 39 at 10. The Secretary has previously explained that penalty provisions in government contracts are generally unenforceable on grounds of public policy. ECF No. 41 at 27-28. In any event, as previously explained, HHS has built into the new RAC SOW a number of financial incentives for RACs to make accurate claim determinations, has eliminated the vast majority of preexisting RAC appeals from the backlog and has placed a number of additional constraints on the RACs. *See* pp. 23-26, *supra*. At this point, not even a complete suspension of the RAC program would solve the backlog. There is certainly no reason to suppose that this incremental step—substituting financial ***penalties*** for financial ***inducements***—would have any meaningful impact on the backlog, let alone enable HHS to comply with this Court's prior Order.

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It is thus impossible for HHS to lawfully comply with this Court's prior Order. In addition, the D.C. Circuit's most recent opinion contemplated that, even if this Court determines that compliance with its mandamus Order is legally possible, the Court should still reconsider the scope and terms of any mandamus order based on the parties' submissions. *See AHA II*, 867 F.3d at 168-69 ("[O]n remand, if the Court finds that the Secretary failed to carry his burden of demonstrating impossibility, it could ***potentially*** reissue the mandamus order without modification.") (emphasis added); *see also id.* at 170 n.4 (referring to the tools this Court possesses to "aid [in] the crafting of mandamus relief").

Indeed, it is a basic precept of mandamus that any mandamus order must be supported by compelling equitable grounds. *See In re Medicare Reimbursement Litig.*, 414 F.3d at 10. Even if lawful compliance were (barely) possible—which it is not—it is extraordinarily unfair and inequitable to mandate that HHS hit targets that would require it to: (1) continually settle claims

en masse; (2) the vast majority of which are likely to be without merit; (3) in negotiations in which the agency would be negotiating under duress; (4) with claimants that present serious program integrity concerns; and (5) when virtually all providers would be emboldened to file as many appeals as possible and to hold out for maximal settlements. The Court should not reissue its prior Order, or any similar timetable-based order.

II. MANDAMUS SHOULD NOT ISSUE

Given the foregoing considerations, mandamus should not issue. As an initial matter, the agency has not committed any statutory violation that could give rise to a mandamus order. 42 U.S.C. § 1395ff(d)(3) specifies that, if an ALJ fails to issue a decision within 90 days, the consequences is that the provider may escalate its appeal. Given the specification of this particular remedy, Congress did not intend that the 90-day deadline be enforced through an equitable order from this Court. *See Sandoz Inc. v. Amgen Inc.*, 137 S. Ct. 1664, 1675 (2017) (presence of a "textually specified remed[y]" "exclude[d] all other federal remedies," reaffirming that where "a statute expressly provides a remedy, courts must be especially reluctant to provide additional remedies"). The Secretary acknowledges, however, that the D.C. Circuit has held otherwise, and asserts here for preservation purposes only his argument that there is no statutory violation remediable through mandamus (because the statute confers no clear right to a hearing within 90 days and because escalation is an adequate and exclusive remedy in any event). But putting that point aside, the record now makes clear that no compelling equitable grounds exist that would justify mandamus.

To the extent that violating the 90-day statutory period for ALJ decisions could give rise to a mandamus order, the equities no longer weigh in favor of such an order. This Court previously evaluated the six *TRAC* factors, and determined that they weighed in favor of mandamus, relying

on its finding that agency delay is having a "real impact on 'human health and welfare,'" based on assertions from the plaintiff-hospitals that patient care was suffering due to their having a large amount of money tied up in appeals. *Am. Hosp. Ass'n v. Burwell*, 209 F. Supp. 3d at 226 (quoting *AHA I*, 812 F.3d at 193). This is no longer the case given the implementation of the LVA settlement option. Moreover, any provider that faces a genuine emergency may enter into an agreement with HHS to defer recoupment and enter into an extended repayment schedule (up to 60 months in cases of "extreme hardship"). 42 U.S.C. § 1395ddd(f)(1); 42 C.F.R. § 401.607 ("hardship" and "extreme hardship" defined). Thus, the *TRAC* factors now weigh decidedly against the issuance of a mandamus order.

In addition, Plaintiffs have contended since the beginning of this case that the backlog is primarily attributable to RAC-program abuses. *See* pp. 22, 26, *supra*. It was also "critical[]" to the *AHA I* panel's thinking about the case that Congress had given the agency substantial discretion to determine the RAC program's scope. 812 F.3d at 193; *see id.* at 185 (describing the "heart" of the case as a conflict between the ninety-day timetable and the RAC program); *id.* at 187; *id.* at 192; *id.* at 193. The record now makes clear, however, that further changes to the RAC program would not eliminate the backlog (and indeed, would not even significantly alleviate it). As described above, HHS has made significant changes to the program that have sharply reduced the number of incoming RAC appeals (less than 15% of total incoming appeals in each of the last three years), and eliminated the vast majority of preexisting RAC appeals from the backlog. *See* pp. 23-24, *supra*. The record further shows that HHS is doing all that it reasonably and lawfully can to reduce and ultimately eliminate the backlog, but that there are simply no discretionary and lawful measures that HHS could take to do so in the context of the RAC program.

At bottom, this is a case about resource restraints. The appropriations power belongs to

Congress, *see OPM v. Richmond*, 496 U.S. 414, 424 (1990), and if Congress does not appropriate the funding necessary "for a statutorily mandated program, the Executive obviously cannot move forward." *In re Aiken Cty.*, 725 F.3d 255, 259 (D.C. Cir. 2013).

And there are no ***constitutional*** rights at issue here. Plaintiffs' asserted right to an ALJ hearing is entirely a creation of Congress. Congress, however, has also repeatedly declined requests from two successive administrations for additional OMHA funding, has failed to pass legislative reforms that give HHS better tools to address the backlog, and has doubled down on inertia even as HHS faces the specter of mandamus. Whatever Congress's reason for failing to act, the problem here "stem[s] from a lack of resources," and 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). The Court should enter judgment in favor of the Secretary.

III. ANY FURTHER MANDAMUS RELIEF SHOULD INCORPORATE THE NEW INITIATIVES HHS HAS UNDERTAKEN AND, IN ANY EVENT, SHOULD DIRECT SPECIFIC MEASURES RATHER THAN TIMETABLES

In its prior decision in this case, this Court noted that Plaintiffs had proposed specific categories of discrete interventions but, in the alternative, had asked the Court to set an overall timetable by which the Secretary would be required to achieve reductions in the backlog. ECF No. 48 at 3. Choosing the latter course, the Court stated that it "continues to believe that it should intrude as little as possible on the Secretary's specific decisionmaking processes and operations, and it thus concludes that Plaintiffs' proposed timetable with deadlines for set backlog-reduction targets is the preferable approach." *Id.* at 5.

Defendant of course appreciates (and agrees with) the Court's desire to minimize its interference with HHS's operations. HHS also reiterates—and in no way retreats from—the arguments it has made to this point: HHS is working diligently within its current constraints to

address the backlog, there are no steps the agency can take to eliminate the backlog absent Congressional action, Plaintiffs have proposed no lawful measures that would reduce the backlog materially, and no mandamus order should issue.

Nonetheless, for reasons HHS has discussed at length above, court-ordered backlog-reduction targets place the agency—and, by extension, the taxpayer—in a uniquely inequitable and impossible situation. In this difficult and unusual context, Defendant thus requests that, if this Court does issue mandamus relief—which, respectfully, it should not—any such order should direct specific measures rather than impose backlog-reduction targets.

Specifically, the Court could instruct HHS to continue implementing the LVA and the other settlement initiatives described above. The Court could also retain jurisdiction and continue to require status reports to ensure that HHS continues to work diligently to address the backlog in a manner consistent with its legal obligations and OMHA's limited resources. But the Secretary should not be subjected to backlog reduction requirements he can only meet through mass, indiscriminate settlements with providers—many of whom present serious fraud and other program integrity concerns, and who would inevitably be incentivized to file still more claims—in negotiations where the agency would have little leverage, if any.

CONCLUSION

For the foregoing reasons, the Court should grant Defendant's motion for summary judgment. If the Court grants any mandamus relief, it should not order backlog-reduction targets but should instead direct specific measures that are consistent with the Secretary's statutory obligations and that protect the public fisc.

Date: November 3, 2017

Respectfully submitted,

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