UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. ALEX M. AZAR, in his official capacity as Secretary of Health and Human Services,[1] Defendant.	Civil Action No. 14-cv-00851 (JEB)

REPLY IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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[1] Pursuant to Fed. R. Civ. P. 25(d), Alex M. Azar is substituted as the defendant in his official capacity as Secretary of Health and Human Services.

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INTRODUCTION

AHA's own concessions and the undisputed facts make clear that it is impossible for the U.S. Department of Health and Human Services (HHS) to lawfully eliminate the backlog of over 500,000 pending appeals at the Department's Office of Medicare Hearings and Appeals (OMHA). *See* Mem. of Law in Opp. to Def's Mot. for Summ. J. and in Supp. of Pls' Cross-Mot. for Summ. J. Points (Pls.' MSJ), ECF No. 72-1. ***First***, there are many more appeals coming into OMHA each year than its total annual adjudication capacity, aside from the over 500,000 appeals already pending at OMHA. AHA effectively concedes that OMHA has increased its adjudication capacity to its maximum limits given the Department's current resource restraints. Although AHA continues to press for further changes to the Recovery Audit Contractor (RAC) program, AHA does not contend that these changes (or, indeed, even the outright elimination of the program) would eliminate the gap between the number of appeals that enter the system annually and OMHA's ability to adjudicate those appeals. Because of this adjudication gap, which is projected to persist despite gains to OMHA's adjudication capacity, new appeals will be added to the backlog each year, making it impossible to comply with this Court's mandamus order or any similar order requiring the Department to eliminate the backlog by a date certain.

Second, at least 41% of the backlog of pending appeals — amounting to approximately 219,000 appeals — are from providers with open Department of Justice (DOJ) investigations, including criminal investigations and investigations under the False Claims Act. This figure does not capture all providers with open DOJ investigations or other significant program-integrity flags. These pervasive program integrity concerns significantly constrain the Department's ability to reduce the backlog of pending appeals. Indeed, even if the Department were somehow able to reach reasonable settlements with respect to all appeals in the backlog

without serious program integrity concerns (but, as discussed below, an order requiring the Department to eliminate the backlog by a date certain will make it impossible to find enough willing counterparties to accomplish this feat), HHS would ***still*** not be able to come anywhere close to eliminating the backlog. AHA does not meaningfully dispute that program-integrity concerns, such as open DOJ investigations, limit the Department's ability to enter into comprehensive settlements with providers, thereby effectively conceding that it is impossible to eliminate the backlog by 2020 or any foreseeable date certain.

In short, the ongoing adjudication gap and the inability to enter into comprehensive settlements with providers with open DOJ investigations and other program-integrity concerns each independently demonstrates that it is quite literally impossible to lawfully comply with the Court's prior mandamus order.

Although it does not argue that doing so will make it possible for the Department to comply with the Court's prior mandamus order, AHA claims that the Department should be doing more to settle backlogged appeals, ignoring that the Department has ***already*** made reasonable settlement initiatives available to a wide array of providers, covering at least 90% of pending appeals that do not present known program integrity concerns. And AHA's proposed changes to the RAC program***, a program they concede must exist under the Medicare statute***, would not eliminate the ongoing adjudication gap or do anything to reduce the current backlog (and they fail to propose any other changes to reduce the influx of appeals). Similarly, its request for the Department to toll interest and suspend recoupment for appeals pending before ALJs for more than 90 days would also do nothing to reduce the backlog—and it is not permitted by statute. Rather than helping to reduce the backlog, it would create a powerful incentive for providers to appeal virtually all denied claims, which would make the backlog even worse.

Because it is impossible to lawfully comply with an order to eliminate the backlog by a date certain, the next question is whether the Court should order any mandamus relief. It should not because, to the extent the equities supported mandamus before (and the Secretary respectfully maintains that they did not), they have changed since the Court issued its prior order. As a threshold matter, the premise of the D.C. Circuit's first decision—that the RAC program was a significant driver of the backlog and that the Secretary can meaningfully reduce the backlog through changes to the RAC program—is not supported by current realities.

In addition, HHS has recently announced two new settlement initiatives that provide relief to providers, which was one of the key concerns informing the Court's prior mandamus order. And these initiatives follow in the wake of the Department's numerous initiatives to reduce both incoming and pending appeals, which have resulted in a reduction of about 172,000 appeals from the backlog from the beginning of FY 2017 to January 26, 2018.[2]

AHA ignores the comprehensive scope of these two new settlement initiatives, which work in tandem to provide potential relief to the vast majority of the providers with claims in the backlog that do not pose program integrity concerns. The first of these initiatives, the low-volume appeals (LVA) option, is targeted to low volume providers (defined as providers with fewer than 500 pending appeals) with each appeal having a total billed amount of $9,000 or less. These providers with fewer than 500 appeals, which make up approximately 80% of providers in the backlog and 30% of pending appeals, will be eligible for LVA's settlement offer of 62 percent of the net Medicare allowed amount for their qualifying appeals at OMHA as of November 3, 2017. This is a far better deal than what providers would normally receive given

[2] *See* Exhibit 1 to Bagel Decl., ECF No. 66-4 (explaining that there were 673,143 appeals in the OMHA backlog at the start of FY 2017); Supplemental Declaration of Nancy J. Griswold, February 1, 2018 ("Supp. Griswold Decl.") ¶ 4 (stating that, as of January 26, 2018, there are now 501,700 appeals in the backlog).

the average rate of success before OMHA in 2017, which was approximately 31% — although the offered amount is consistent with the Department's ability to settle cases where doing so saves the Medicare Trust Funds money by avoiding costs and mitigating litigation risk. [3]

Providers that do not meet the eligibility criteria for LVA will be eligible to enter into individually-tailored settlement negotiations using the Department's settlement conference facilitation (SCF) program. SCF considers a provider's historic success rate and a sampling of the provider's outstanding claims, among other factors, to generate settlement offers that take into account individual provider characteristics. As noted, however, providers with serious program-integrity concerns that preclude settlement will not be eligible for these initiatives.

The Department should have the opportunity to make LVA and SCF work as designed. However, if the Court issues a mandamus order that compels the Department to eliminate the backlog by a date certain, then neither LVA nor SCF will work as designed, because the mandamus order will encourage providers not to settle on reasonable terms. Such an order would force the Department to engage in mass settlements on unreasonable terms to the detriment of the Medicare Trust Funds and in contravention of statutory requirements. The Department's experience with prior settlement efforts, such as the successful settlement of approximately 380,000 short-stay appeals (also known as the Hospital Appeals Settlement Process, or HASP), corroborates this point. While the short-stay appeals settlement initiative was highly successful, providers still refused to settle tens of thousands of appeals, presumably hoping to improve on an already generous deal. And for most of that time the Department was

[3] As discussed below, saving the Medicare Trust Funds money is ***one*** lawful ground for the Department to settle an appeal, but contrary to AHA's arguments, the Department does not maintain that all settlements must save the Medicare Trust Funds money. Pls.' MSJ at 10. Rather, consistent with applicable statutes and HHS's regulations, lawful settlements must be reasonably tethered to the value of the claims at issue. *See infra*.

not operating under a coercive mandamus order requiring it to clear the backlog. If it had been, the short-stay appeal settlement would surely have been less successful, and there is every reason to believe the same dynamic would occur in the future.

For all these reasons, the Court should not order the Department to eliminate the backlog on a fixed timetable because doing so is literally impossible. In addition, it should reject AHA's misguided proposed alternatives because they are either unlawful, improperly constrain the Department or are likely to make the backlog worse than would otherwise be the case. Instead, the Court could order the Department to provide quarterly status reports about the status of the backlog.

The ultimate solution here is for Congress to fund the programs and operations it has ordered the Department to implement. Until that day comes, the Department will continue to work to reduce the backlog, but AHA's requested mandamus relief will make this task far less likely to succeed and should be rejected.

I. AHA EFFECTIVELY CONCEDES THAT IT IS IMPOSSIBLE FOR HHS TO LAWFULLY ELIMINATE THE BACKLOG.

It is impossible to lawfully comply either with this Court's prior order to eliminate the backlog by 2020 or any other similar order, and AHA has effectively acknowledged this reality. *See infra*.

A. OMHA Continues To Receive Thousands More Appeals Each Year Than It Is Funded To Adjudicate, Making It Impossible To Eliminate the Backlog.

OMHA has made a number of administrative changes that have significantly increased its adjudication capacity.[4] *See* Def's Mot. for Summ. J. (Def's MSJ) at 7-10, ECF No. 66-1;

[4] These changes include increased judicial training, field office reorganization, assigning providers with large numbers of appeals to a single ALJ and developing and further refining electronic tools to improve efficiency. Def's. MSJ at 7-10; Griswold Decl. ¶ 7. As a result, at

Griswold Decl. ¶¶ 3-4, ECF No. 66-3. But there are limits. OMHA is subject to a line-item appropriation from Congress that effectively limits the number of Administrative Law Judges (ALJs) that can be hired under the available funding. Def's MSJ at 7; Def's Statement of Undisputed Material Facts (Def's SMF) ¶ 1, ECF No. 66-2. In addition, ALJs have a legal obligation to engage in reasoned decision-making in individual cases. Def's SMF ¶ 8. Consistent with these constraints, OMHA has now taken all reasonably available steps to increase its adjudication capacity. Put simply, ALJs have become as efficient as reasonably possible. This point is not disputed by AHA. *Compare* Def's SMF ¶ 23 ("OMHA has undertaken all reasonable efforts to increase the number of disposition of appeals within OMHA's existing statutory and budget constraints") *with* Pls.' Resp. to Def's SMF (not disputing this point), ECF No. 73-3.

But despite the numerous changes made by OMHA to increase the efficiency of its ALJs, OMHA still faces a persistent gap between the number of appeals it receives each year and its annual funded adjudication capacity. Def's MSJ at 10-13. In FY 2017, OMHA's ALJs disposed of 77,121 appeals but received 112,933 new appeals, resulting in an adjudication "gap" of 35,812. *See* Updated Projections, attached as Ex. 2[5] This disparity is expected to continue in future years despite OMHA's projected increased capacity to dispose of appeals. *See id.* (projecting that OMHA will receive 119,488 new appeals in FY 2018 and have the adjudication capacity to adjudicate 88,000, leaving a gap of 31,488 appeals, and that this gap is projected to grow in future years).

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current funding levels, in FY 2018, OMHA will be able to staff 92 ALJ teams, consisting of one ALJ and four support staff, which are estimated to be able to dispose of 88,000 appeals. *Id.* ¶ 5.

[5] This chart was produced in discovery as AHA 915-19 and is Exhibit 11 to Michael Bagel's deposition. *See* Bagel Tr. 100-01.

While AHA does not dispute that OMHA has taken all reasonable steps to increase its adjudication capacity, *see supra*, or that the Department has undertaken numerous administrative changes that will reduce the influx of new appeals in future years,[6] it maintains that the Department can further reduce this influx by making additional changes to the RAC program. *See* Pls.' Resp. to Def's SMF ¶ 1 ("Plaintiffs disagree that OMHA's ability to reduce the flow of incoming appeals is limited (Sec'y SOF ¶ 26), insofar as that the Secretary may make additional modification to the Recovery Audit Contractor (or RAC) program."). But Plaintiffs' proposed changes to the RAC program, *see also infra*, would not resolve the adjudication gap. This is because RAC-related appeals make up a relatively small percentage of incoming appeals.

In FY 2017, a year ***after*** a new Statement of Work for the RACs went into effect, there were 13,782 RAC-related appeals, which represented only 12.2% of appeals that year and only 2.3% of the backlog.[7] Griswold Decl. ¶ 19. As noted, however, in 2017, OMHA received 35,812 more appeals than it could adjudicate. *See supra*. Therefore, even if there were no RAC-related appeals in 2017 at all — and there must be a RAC program by law, as Plaintiffs concede, *see* Def's MSJ at 22 and Pls.' MSJ at 6 — there still would have been an adjudication gap of approximately 22,030 appeals.

Because the number of incoming appeals is projected to rise over FY 2017 levels, this gap between incoming appeals and the adjudication capacity of ALJ teams will persist. *See* Updated Projections; Griswold Decl. ¶ 4; Ex. 1 to Bagel Decl.; SMF ¶¶ 5-6, 24-25, 40. As long as it does, new appeals will be added to the backlog each year, making it impossible to come into

[6] These initiatives were discussed in detail in the Government's opening brief. *See* Def's MSJ at 10-13.

[7] By way of comparison, there were 273,407 RAC-related appeals in FY 2014, constituting 53.8% of appeals. Griswold Decl. ¶ 19. In that same year, RAC-related appeals made up 52.4% of the pending backlog. *Id*. In contrast, at the end of FY 2017, RAC-related appeals made up only 14.2% of the backlog. *Id*.

compliance with the Court's order ***regardless*** of the Department's ability to settle pending appeals — which, as discussed below, is limited. In short, the ongoing adjudication gap alone makes it impossible to come into compliance with the Court's order.

B. It Is Impossible For HHS To Lawfully Settle Its Way Out of the Backlog.

The Department cannot lawfully settle its way into compliance with the Court's prior order to eliminate the backlog. The Secretary has explained that serious program integrity concerns preclude comprehensive, lawful settlements with respect to a significant portion of appeals in the backlog. A settlement regime in which the Government must settle all claims in the backlog is one in which HHS would inevitably be forced to engage in mass settlements completely untethered from the legal merits or the costs of adjudication; moreover, it would need to do so repeatedly given the ongoing adjudication gap discussed above. Finally, a settle-at-all-costs regime would likely have the perverse effect of encouraging an influx of new appeals, making the backlog worse. *See* Def's MSJ at 13-18**.**

Instead of such a counterproductive approach, the Court should allow the Department's newly minted LVA option and recently expanded SCF settlement initiative time to work. Def's MSJ at 20-21. The Department's prior experience makes clear that it is far more likely to find willing counterparties with which to settle if it can enter into negotiations without the coercion of a mandamus order that discourages appellants from settling at reasonable amounts by effectively making it impossible for the Government to say no.

1. Program Integrity Concerns Preclude Comprehensive Settlement of Over 219,000 Appeals.

As of October 20, 2017, there were 531,926 pending appeals before OMHA. *See* Griswold Decl. ¶ 3. The Secretary has explained that certain high-volume providers responsible for a significant portion of the backlog have serious program integrity issues that preclude or

severely limit the Department's ability to negotiate comprehensive settlements with these providers. *See* Def's MSJ at 18; Mills Program Integrity Decl. ¶¶ 6-12, ECF No. 71-1; *see also* McQueen Decl. ¶ 6, ECF No. 66-6 ("These program integrity issues have precluded or significantly constrained any efforts to reach settlement with such appellants to further reduce or eliminate the backlog.").

Specifically, based on the size of the backlog as of October 2017, at least 41% of the backlog, amounting to approximately 219,000 pending appeals at OMHA, were from providers with serious program-integrity concerns, ***all*** of whom are subject to ***active*** DOJ investigations encompassing a wide range of alleged improper practices, including criminal investigations and investigations under the False Claims Act. *See* Mills Program Integrity Decl. ¶¶ 5, 7. The Secretary has explained that, "[w]hile such investigations are pending, it is impossible for the Government to know the breadth and scope of any eventual enforcement actions, or if enforcement actions will even be pursued." *Id*. ¶ 11. As a result, the Government "cannot evaluate whether settlement is appropriate and, if so, what settlement range is reasonable. For these reasons, CMS generally does not settle with appellants that are subject to open investigations." *Id*.; *see also* Mills Dep. Tr. 159: 5-14 (explaining the difficulty of settling with providers with open investigations, given the Department's "fiduciary responsibility").

In addition to open DOJ investigations, many of the providers referred to above have ***other*** serious program-integrity issues that further limit the Department's ability to settle their appeals.[8] Moreover, because only high-volume providers with at least 3,000 appeals were

[8] *See* Mills Program Integrity Decl. ¶¶ 8-10 (noting that, with respect this same subset of high-volume providers that are all subject to active DOJ investigations and are responsible for 41% of appeals in the backlog, some of these providers ***also*** have appeals subject to open investigations by CMS program integrity contractors (these providers are responsible for at least 38.3% of pending appeals at OMHA; or have also settled a False Claims Act investigation in the past five

included in these statistics — and it is clear that many providers with fewer appeals also have serious program-integrity concerns — the 41% figure significantly ***understates*** the extent of the problem. *See* Mills Program Integrity Decl. ¶ 6.

AHA does not meaningfully dispute that the Department's ability to enter into settlements with providers with program-integrity concerns, including those subject to ***open*** DOJ investigations, is precluded or at least significantly constrained — thus rendering it impossible for the Department to lawfully settle its way out of the backlog. Instead, AHA merely contends that the Department ***might***, in ***some*** cases, be able to settle with individual providers who raise the more modest (but still significant) program integrity flag of having settled a False Claims Act investigation in the last five years. *Compare* Def's SMF ¶¶ 54-55 (explaining that 41.2% of the backlog are from providers, *inter alia*, who have "active False Claims Act investigations" and that such program-integrity concerns have "precluded or significantly constrained efforts to reach settlements with such appellants") (citing McQueen Decl. ¶ 6) *with* Pls.' Resp. to Def's SMF ¶ 3 ("Plaintiffs disagree that the Secretary cannot settle any claims with providers whose claims present program-integrity concerns, insofar as the Secretary has a 'never-say-never' approach to settling cases with providers ***who have settled a False Claims Act suit in the last five years***") (emphasis added); *see also* Pls.' MSJ at 12 (same).

In short, AHA does not appear to meaningfully dispute that the Department's ability to settle with providers with active DOJ investigations, constituting at least 41% of the backlog (or 219,000 appeals), is "precluded or significantly constrained." Def's SMF ¶ 55; McQueen Decl. ¶ 6; Pls.' Resp. to Def's SMF ¶ 3; Pls.' MSJ at 12. It could hardly do otherwise given the

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years (these providers are responsible for at least 33.% of appeals in the backlog at OMHA); or have also had their Medicare billing privileges revoked within the past five years (these providers are responsible for at least 6% of pending appeals).

Department's duty to protect the Medicare Trust Funds from waste, fraud and abuse. 42 U.S.C. § 1395ddd. Yet, once this simple point is conceded, it is clear that it is impossible for the Department to lawfully settle its way out of the backlog given that program integrity concerns preclude comprehensive settlements with providers responsible for at least 219,000 appeals in the backlog (i.e., the 41% figure referred to above). Put another way, even if the Government were somehow able to settle all remaining appeals in the OMHA backlog without program integrity concerns (which requires willing counterparties, *see infra*), the Department would still not come anywhere close to meeting the Court's requirement that it eliminate the backlog by the end of 2020. All the many pages of additional ink spilled in the back-and-forth of the parties' briefing cannot change this simple, incontrovertible reality. Because serious program integrity concerns pervade the backlog of appeals at OMHA, it is literally impossible to lawfully comply with this Court's prior order.

2. The Only Way The Department Could Ensure Compliance With An Order To Clear The Backlog By 2020 Would Be To Engage In Unlawful Mass Settlements.

In addition to the program integrity issues that pervade the backlog, the Government has explained that a mandamus order requiring the Department to clear the backlog of all pending appeals by the end of 2020 or other date certain would put it in the untenable position of either having to rely on the good-faith of thousands of providers to settle on reasonable terms; ***or*** force the Department to engage in en masse settlements that bear little relationship to the merits of the respective appeals or the costs of adjudication and thus violate the law. *See* 42 C.F.R. § 401.613(a)(1) (requiring that the amount of any settlement must "bear a reasonable relation to the amount of the claim"); *see also id.* §§ 401.613(c), 405.376 (d), (h).

In response, AHA misstates the Government's position on settlement and sets up various strawmen to attack. Contrary to AHA's suggestions, the Government does not maintain that it

must evaluate the merits of all individual appeals from a provider, or that it can only settle when doing so saves the Medicare Trust Funds money. *See* Pls.' MSJ at 9-11. Instead, the Department has explained that settlements must comply with Medicare requirements that preclude payment for items or services that do not meet statutory criteria. *See* Def's MSJ at 17. The Department also has a duty to protect the Trust Funds from waste, fraud and abuse. 42 U.S.C. § 1395ddd. In addition, the Federal Claims Collection Act and implementing regulations require that settlements "bear a reasonable relation to the amount of the claim." Def's MSJ at 17 (quoting 42 C.F.R. § 401.613(a)(1)). The Department's regulations also permit it to consider "litigative possibilities," which involve 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). But what the Government is not permitted to do is to engage in ***indiscriminate*** mass settlements ***untethered*** to the value of the claims at issue. *See supra*.

AHA does not appear to dispute that settlements must be tied to the merits of the underlying claims.[9] *See* Pls.' MSJ at 11 (not appearing to take issue with the Secretary's "more-modest claim" that settlements must bear a relationship to the merits of appeals). Instead, AHA

[9] AHA contends that the Government's understanding of its settlement authority ignores the requirements of the Fair Claims Collection Act (FCCA) and its implementing regulations. Pls.' MSJ at 9-10. That is not the case. The Government understands the requirements of the Medicare statute that preclude settling non-meritorious and fraudulent claims to be in harmony with the Fair Claims Collection Act and CMS's implementing regulations, which require that settlements "bear a reasonable relation to the amount of the claim" at issue. 42 C.F.R. § 401.613(a)(1). *See* Def's MSJ at 16-18. Regulations jointly issued by the Departments of Justice and the Treasury under the FCCA likewise contemplate that settlement should take into account the merits of a claim. *See* 31 C.F.R. § 902.2(d).

effectively argues that providers ***might*** be willing to accept reasonable settlements, and that the Department ***might*** be able to settle a large portion of the backlog without recourse to unlawful settlements.[10] *See id*. But what this argument ignores is that if providers are not willing to settle on fair terms, the Department must still settle all pending claims in the backlog if it is to comply with the Court's prior mandamus order. And the only way to ***ensure*** that outcome is to engage in settlements untethered to the value of the appeals (i.e., illegal settlements).

Such concerns are not baseless conjecture, as AHA suggests, but simple common sense that is well supported by the historical record in this case. For instance, the Hospital Appeals Settlement Process (HASP) offered to settle short-stay inpatient hospitalizations for 68 percent in 2014 and 66 percent of the net Medicare allowed amount in 2016. McQueen Decl. ¶ 7c. While this settlement effort proved highly successful and removed 380,212 appeals from the backlog, providers with between 40,000 to 50,000 short-stay appeals refused to settle on the same terms that the vast majority of other providers believed were reasonable. Def's MSJ at 21; McQueen Decl. ¶ 7a-c. And for most of this time, the Department was not under a Court order requiring it to eliminate the backlog via mass settlement. If it had been, it would assuredly have led to many more holdouts from the HASP settlement, rendering it far less effective. This shows that the best chance for the Department to meaningfully reduce the backlog through fair, lawful settlements is

[10] AHA cites the deposition testimony of George Mills, Deputy Director of CMS's Center for Program Integrity, who explained that it might be possible to eliminate the backlog ***if provider behavior radically changed***: that is, if providers voluntarily withdrew appeals, were willing to use the Department's voluntary sampling program and entered into reasonable settlements. Pls.' MSJ at 18 (citing Mills Dep. Tr. 32-33, 192-195). But it was clear Mr. Mills found this possibility exceedingly unlikely and none of these actions are within the Department's control. He also made clear that he does not believe there is anything more the Department (as opposed to providers) could reasonably do to eliminate the backlog. Mills Dep. Tr. 190-96.

for the Court ***not*** to enter its prior mandamus order, which would skew provider incentives away from settling on reasonable terms.[11]

In addition, the likely consequence of a settle-at-all-costs regime is that providers will appeal many more claims than they otherwise would have. *See, e.g.*, Def's MSJ at 16. In addition, because incoming annual appeals outpace the number of appeals that OMHA teams can resolve in a year, *see supra*; Def's MSJ at 10, the Department will be forced to engage in these illegal settlements on an ongoing basis.

In short, it is impossible for the Department to ensure compliance with the Court's order without violating the law: doing so would require it to settle with providers with serious program integrity issues, in violation of the Department's duty to the Medicare Trust Funds, *see* Def's MSJ at 10-12; as well as require it to settle claims for amounts that do not bear a reasonable relationship to the value of the appeals at issue, in violation of the Medicare statute.

[11] In its effort to suggest the Department has no basis to believe that providers will lack motivation to accept reasonable settlements — notwithstanding their knowledge that the Government ***must*** settle to comply with a mandamus order — AHA unfairly attacks Michael Bagel's testimony based on the fact that he does not consider himself an expert on mass settlements. Pls.' MSJ at 15. Mr. Bagel did not hold himself out as an expert on settlement, but is a senior program analyst who submitted a declaration discussing, among other things, the many administrative measures the Department has undertaken and their projected impact on reducing the backlog. *See* Bagel Decl. ¶ 1. The Department also submitted the declaration of Sherri G. McQueen, who conducts settlement negotiations on behalf of HHS. McQueen Decl.; *see also* Mills Tr. 196 (explaining that Ms. McQueen is the designated settlement official at the SCF), ECF No. 72-3. AHA had the opportunity to depose Ms. McQueen but chose not to do so. In her declaration, Ms. McQueen cited the example of the providers (responsible for between 40,000 to 50,000 appeals) holding out from the largely successful HASP settlements, despite their favorable terms. McQueen Decl. ¶ 7.a-c.; *see supra*. This prior experience indicates that there will be holdouts from even reasonable settlement offers, and a mandamus order that effectively requires the Government to settle at all costs would assuredly encourage far more holdouts from the LVA and SCF initiatives than would otherwise be the case.

3. The Department Should Have A Chance To Make Its Newly Expanded Settlement Initiatives (LVA and SCF) Work As Designed, Without the Deterrent of a Mandamus Order.

Instead of compelling the Department to clear the backlog on pain of contempt, which is likely to make it much harder to settle on merit-based terms, the Department's recent settlement efforts — the LVA settlement option and its expanded SCF program, both announced in November 2017 — should be given time to bear fruit.

These settlement efforts are designed to be as comprehensive as possible, a fact that AHA ignores. The LVA settlement initiative (which will be operationalized on February 5, 2018) is designed for low volume appellants, defined both in terms of the number of appeals pending at OMHA and the Medicare Appeals Council (fewer than 500) and the dollar amount at stake in those appeals ($9,000 or less).[12] McQueen Decl. ¶ 11a. For providers with qualifying appeals as of November 3, 2017, the Department has created an opportunity to settle these appeals for 62% of the net Medicare allowable amount — which is a better result than what the appellants would likely achieve otherwise given the 31% average success rate of providers before ALJs in 2017. McQueen Decl. ¶ 11(a). This initiative therefore directs immediate relief to providers who have not contributed to the growth of the backlog yet claim to have been adversely impacted by it. *See Am. Hosp. Ass'n v. Burwell*, 209 F. Supp. 3d 221, 226 (D.D.C. 2016) (discussing providers' allegations regarding harm to patient care). There is every reason to hope that, with willing counterparties, this settlement initiative will meaningfully reduce the current backlog. But it has little chance to succeed if the Court issues a new mandamus order compelling the Department to reduce the backlog by fixed percentages each year, and to eliminate the backlog by a date

[12] https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Low-Volume-Appeals-Initiative.html

certain. Doing so will cause providers to hold out for a more favorable, non-merits-based settlement.

For higher-volume appellants that are not eligible for LVA,[13] the expanded SCF program (which OMHA expects will go into effect in April 2018) is designed to offer individually-tailored settlement opportunities.[14] McQueen Decl. ¶ 7b. These programs work in tandem and are designed to be as comprehensive as reasonably possible. Indeed, OMHA estimates that after appeals posing known program integrity concerns are removed, over 90% of the remaining appeals in the backlog are potentially eligible for either LVA or SCF. *See* Supplemental Declaration of Nancy J. Griswold, February 1, 2018 ("Supp. Griswold Decl.") ¶ 3, attached hereto as Exhibit 1.[15] As noted, providers responsible for at least 41% of the backlog or around 219,000 appeals pending at OMHA have open DOJ investigations that preclude settlement. *See supra*. This makes it impossible for these efforts to successfully eliminate the entire backlog. But they should be given the best chance possible to succeed.

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[13] There may also be some low-volume appellants that do not qualify for LVA because they have appeals worth more than $9,000 that will be eligible for SCF — provided, of course, that they do not have serious program integrity issues.

[14] https://www.hhs.gov/about/agencies/omha/about/special-initiatives/settlement-conference-facilitation/index.html

[15] OMHA reached this conclusion after subtracting five categories of quantifiable appeals that are not eligible for LVA or SCF, most of which do not impact providers. *See id.* ¶¶ 5-6. The five ineligible appeals categories are (1) appeals brought by beneficiaries, which are generally processed within the statutory and regulatory timeframe; (2) appeals filed by State Medicaid agencies that were not settled as part of prior settlement negotiations; (3) non-provider Medicare Secondary Payer appeals; (4) appeals entailing an amount in controversy in excess of $100,000, which HHS cannot settle without first obtaining Department of Justice approval; and (5) certain appeals under Part C Medicare Advantage, certain health maintenance organization and competitive health plans, or health care prepayment plans, which can only be settled between the provider and the plan, not CMS. *See id*. The total number of ineligible appeals within these five categories amounts to only 4.4% of all appeals currently pending at OMHA. *See id. at* ¶ 7.

There is nothing in the record that should cause the Court to doubt the Department's commitment to reaching fair, merit-based settlements, such that a mandamus order would be the only means to promote serious settlement negotiations.[16] Instead, the evidence here demonstrates the Government's ongoing commitment to settle on reasonable terms as a means of reducing the backlog. The HASP settlements in 2014 and 2016, which involved a homogenous issue not present in the current backlog, allowed for the resolution of over 380,000 appeals. Because the overwhelming majority of these appeals were RAC-related, the HASP settlements helped make RAC-related appeals a relatively small part of the current backlog. McQueen Decl. ¶ 7a-b. And through the SCF program, the Government has reached settlements to resolve over 69,000 appeals with State Medicaid Agencies. McQueen Decl. ¶ 9. That is the record of a Department committed to settlement, and the new LVA and soon-to-be expanded SCF initiatives are likely to build on that success if given the chance.

For all the reasons set forth above, it is impossible for the Department to lawfully settle its way out of the backlog, but its past and current settlement efforts demonstrate that mandamus is not needed to further incentivize the Department to enter into reasonable settlements. Instead, the Department's new, robust settlement efforts should be given a chance to work without the deterrent effects of a mandamus order.

[16] AHA's attempts to cast doubt on the sincerity of the Government's efforts to settle by pointing to the Government's response to a settlement offer from a representative of certain Inpatient Rehabilitation Facilities (IRFs), which proposed settling with the Government at the rate of 80 percent. *See* Pls.' MSJ at 11 (citing Mills Dep. Tr. 149-151); *see also* Mills Tr., Exhibit 9. The fact that the Government in that case did not immediately respond with a counteroffer is evidence of sound negotiating tactics, not intransigence. *See id*. The Government is not required to accept unreasonable offers in negotiations, but instead must be careful to protect the Medicare Trust Funds and comply with the requirement to settle on merits-based terms. The Government continues to negotiate in good faith with the IRFs, and if these settlement negotiations are successful, another 15,000 appeals could be removed from the system. McQueen Decl. ¶ 10.

C. Further Changes To The RAC Program Will Not Make It Possible For The Department To Come Anywhere Close To Eliminating The Backlog.

AHA appears to concede that even if the Department eliminated the RAC program — which AHA admits is required to exist by law, Pls.' MSJ at 6 — "there would still be more appeals than capacity to adjudicate appeals." *Id*. at 9. And ***none*** of the further changes proposed by AHA to the RAC program will change the reality that it is impossible for the Department to lawfully comply with an order requiring it to eliminate the backlog by a date certain.

The reason that further changes to the RAC program would not have a significant impact on the backlog is due to the Department's success in settling RAC-related appeals and the many changes the Department has already made to the way RACs operate. In 2015, RAC-related appeals made up 57.7% of backlog. Griswold Decl. ¶ 19. In stark contrast, due in part to the HASP settlement initiative, which resolved approximately 380,000 appeals of short-stay inpatient hospitalizations (341,000 of which were appeals of RAC overpayment determinations), Mills Decl. ¶ 5, RAC-related appeals now make up only 14% of the current backlog. *Id*.

And RAC-related appeals are now a relatively small contributor to new OMHA appeal receipts due to the various procedural changes to the RAC program, such as restricting the number of topics RACs can review, limiting their authority to request additional documents, and limiting the lookback period for patient status reviews. In addition, the new RAC Statement of Work (SOW) includes new requirements for RACs to maintain an accuracy rate of over 95% as determined by an independent contractor and an overturn rate of less than 10% at the first level of appeal. It also includes financial inducements for achieving results beyond these minimum requirements. *See* Def's MSJ at 23-24; *see also* Griswold Decl. ¶ 19 (RAC-related appeals made up 12.2% of new appeals in FY 2017 compared to 53.8% in FY 2014).

AHA mistakenly claims that it is unclear if the new financial incentives in the RAC SOW "will have any impact on the backlog," and therefore a financial penalty is needed for RAC determinations that are overturned on appeal before ALJs.[17] Pls.' MSJ at 7-8, 19. The Government has already explained at length why such a financial penalty would be illegal. AHA makes no new arguments in this regard and therefore the Court is respectfully referred to the Government's prior arguments on this point. ECF No. 41 at 27-28. The current contingency-fee-structure of the RAC program and the new requirements (and financial inducements) in the RAC SOW for accuracy already create a powerful incentive for RACs to make proper claims determinations. Because RACs are paid on a contingency fee basis, this means that if their determinations are overturned on appeal, the RACs are paid ***nothing*** for their time spent reviewing such claims, nor do they receive any payment for associated overhead costs. Mills Decl. ¶ 8. Therefore, contrary to AHA's arguments, there are powerful downsides for RACs to make overpayment determinations that are overturned on appeal.[18] *See* Pls.' MSJ at 8 (suggesting that "denying claims comes only with upsides").

Furthermore, there is no doubt that the changes to the new RAC SOW are working. In FY 2017 — a year ***after*** the new RAC SOW went into effect — RAC-related appeals numbered

[17] In addition to the other fundamental problems with AHA's argument regarding financial penalties, its focus on judging the accuracy of RAC determinations at the ALJ level is misguided. CMS requires RACs to maintain an overturn rate of less than 10% at the first level of administrative review, because adjudicators at higher appeals levels may deviate from Medicare policy statements. *See* 42 C.F.R. §§ 405.968(b)(2). RACs are constrained by Medicare policy statements, and therefore CMS assesses RAC performance based on the evaluations of adjudicators that are also so constrained, for an apples-to-apples comparison. *See* Mills Tr. 56: 6-14.

[18] Perhaps it is not surprising, given the changes to the RAC SOW and the reality that RACs are paid on a contingency fee basis, that one of the incumbent RACs did not even submit a bid on the new contracts. Mills. Decl. ¶ 8.

just 13,782 (12.2% of total new appeals), a dramatic improvement over the 53.8% percent of RAC-related receipts in 2014 before the Department began negotiating a new SOW. Mills Decl. ¶ 6; Griswold Decl. ¶ 19; *see also* Def's MSJ at 23. "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; *see also* Bagel Tr. at 47:17-48:18 (explaining that the Department's success in reducing the number of RAC-related appeals is due to both the HASP settlement program and changes to the RAC SOW), ECF No. 72-2.

And because RAC-related appeals make up a relatively small portion of incoming appeals (only 12.2% in FY 2017), AHA's other proposed changes to the RAC program beyond financial penalties would have a negligible impact on reducing the backlog. *See* Pls.' MSJ at 19. However, they are virtually certain to come at great cost to the public fisc.[19] While it is true the Department has some discretion over the RAC program (discretion it has already exercised to reduce RAC-related appeals), the Department cannot downsize the RAC program out of existence. On the contrary, the Government has a clear duty to protect the Trust Funds and to avoid paying for fraudulent and unsubstantiated claims, which would inevitably increase if AHA's proposals were put into effect. As explained more fully in Part II below, in deciding whether to order RAC-specific mandamus relief, the D.C. Circuit's *TRAC* factors require the Court to ***balance*** the Department's duty to the Trust Funds and the requirement to pay for claims that satisfy Medicare coverage and payment requirements with its obligation to provide timely

[19] 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. *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.

ALJ hearings. After the many changes to the RAC program, and their demonstrated success, the Government submits that the Department has struck the right balance and that no further changes should be ordered.

AHA recognizes that changes to the RAC program will not eliminate the backlog, *see supra* — indeed, will have a negligible impact on the backlog — which begs the question of what AHA's goal is here. Is AHA trying to eliminate the backlog or the RAC program? AHA's arguments and litigation conduct suggest that AHA's action on the backlog is a means of attacking a program that Congress created and the Department is legally obligated to implement. In any event, it remains the case that it is legally impossible to comply with the Court's prior mandamus order or any similar order.

Given that AHA clearly recognizes that changes to the RAC program will not eliminate the backlog — indeed, that any changes will have a negligible impact on the backlog, *see supra*— its focus on the RAC program is puzzling. The focus of any mandamus order, after all (if an order is to issue) must be on an order that would seek to remedy the statutory violation that the Court has found. The Department has directed its efforts toward solutions to the backlog. AHA's attempts to attack a program that Congress created and the Department is legally obligated to implement, in contrast, do not offer any meaningful solution. In any event, it remains the case that it is legally impossible to comply with the Court's prior mandamus order or any similar order.

D. AHA's Proposal That The Department Toll Interest and Suspend Recoupment For Appeals Pending Before OMHA For More Than 90 Days Is Not Lawful And Will Not Solve The Backlog.

Plaintiffs urge this Court to order the Secretary to suspend recoupment and toll the accrual of interest on all appeals pending before OMHA for longer than 90 days. Pls.' MSJ at

12. However, AHA never suggests that doing so will enable the Department to eliminate the backlog by 2020 or any other date certain. On the contrary, this proposal will ***increase*** the number of new appeals, making the backlog substantially worse.

The Secretary lacks authority to implement AHA's proposals. *See generally* Def's Mot. for Summ. J., ECF No. 41 at 12-19, 21-23; Def's Reply in Supp. of Mot. for Summ. J., ECF No. 45-1 at 7-8; *see also* Supplemental Declaration of Ellen Murray ("Murray Suppl. Decl.") ¶¶ 27-36, ECF No. 41-1. Plaintiffs argue (as they did during the past round of summary judgment briefing) that the Secretary could circumvent the statutory restriction on his power to defer recoupment or to forgive interest by invoking statutes that authorize demonstration projects for particular purposes. Even assuming that the Secretary's decision not to invoke these authorities is judicially reviewable — *but see* Def's Mot. for Summ. J. (filed 2016) at 18-19 (explaining that it is not) — Plaintiff have not proposed any project that falls within any of their cited authorities. They have not proposed any "[i]ncentives for economy while maintaining or improving quality in provision of health services," 42 U.S.C. § 1395b-1, or any test of "innovative payment and service delivery models to reduce program expenditures," 42 U.S.C. § 1315a(a)(1). *See* Def's Mot. for Summ. J. (filed 2016), ECF No. 41 at 17-18. Rather than any meaningful test, Plaintiffs propose a simple suspension of recoupment and tolling of interest, which have nothing to do with improving the delivery of health care services.

Beyond being lawless, AHA's proposal would contribute to a substantial growth in the number of appeals in the backlog. "There are no filings fees in the administrative appeals process, and the amount in controversy required for an ALJ hearing (currently $150)[20] is relatively low." Murray Suppl. Decl. at ¶ 29. Consequently, "providers and suppliers who

[20] The amount-in-controversy required to request an ALJ hearing increased to $160 on January 1, 2018. https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/HearingsALJ.html.

ultimately lose their appeal effectively would receive an interest-free loan from the government for the duration of the appeals process, which would only grow longer as more providers use the appeals process to delay recoupments and accrual of interest." *Id*. As a matter of basic economics and plain common sense, AHA's proposals would make the backlog "substantially worse." *Id*.

This course of action also would have immediate adverse consequences for the Medicare Trust Funds. CMS collects, on average, approximately $153 million in principal and $15 million in interest a year on Medicare claims following the second level of appeal. Murray Supp. Decl. ¶ 31. The likelihood of recovering overpayments diminishes with time because providers may file bankruptcy, go out of business, or request a compromise from CMS. Thus, suspending recoupment and tolling the accrual of interest for appeals in the backlog would cost the Medicare Trust Funds — and the American taxpayer — hundreds of millions of dollars. *Id*. And this would come at a time when the Medicare program already lost billions of dollars as a consequence of the restrictions now imposed on the RAC program.

On the flip side, given the Department's new settlement initiatives, the financial hardship to providers of having to wait for OMHA decisions has significantly lessened. *See* Pls.' MSJ at 16 (justifying its proposal as a means of easing "the financial pain for providers and suppliers"). Contrary to AHA's insinuation that the Department lacks appropriate incentives to reduce the backlog, *id*., the elimination of the backlog is one of the Department's top priorities and, among other initiatives, has led it to implement the new LVA settlement option and expanded SCF program in order to provide settlement opportunities for providers waiting for ALJ decisions. Approximately 80% of such providers in the backlog are eligible for the LVA program and have the opportunity to receive immediate cash inflows of 62% of the value of their appealed claims

pending before OMHA. *See supra*. Together, these programs extend potential relief to approximately over 90% of pending appeals that do not present known program integrity concerns.[21] *See* Suppl. Griswold Decl. ¶ 3.

As discussed further in Part II, the Court must balance the Department's obligation to provide timely OMHA decisions with its obligation to the Medicare Trust Funds. *See infra*. Doing so makes clear that AHA's proposal — which will inevitably make the backlog much worse and impose huge costs on the public fisc — should be rejected.

For the reasons set forth above, it is now clear that it is literally impossible for the Department to legally comply with an order requiring it to eliminate the backlog by 2020 or any other date certain. Indeed, given AHA's concessions about the OMHA's ongoing adjudication gap, its recognition that RAC-related appeals make up a relatively small portion of incoming receipts, its acknowledgment that pervasive program-integrity concerns limit settlement, and its failure to even argue that tolling interest and suspending recoupment would eliminate the backlog, there is actually no real dispute between the parties that the predicate finding of "possibility" that would be needed for this Court to reissue its prior mandamus order is entirely absent here. *See Am. Hosp. Ass'n v. Price*, 867 F.3d 160, 169 (D.C.Cir. 2017) ("*AHA II*").

[21] It is also important to note that the recoupment and interest accrual requirements "do not affect all appellants — only those with claims that were denied after they had already been paid." *See* Murray Suppl. Decl. ¶ 28. Because a significant number of pending appeals in the backlog involve claims that were denied before payment, those appellants are not impacted by recoupment or interest requirements. *Id*. In addition, the Medicare statute already provides for an extended repayment plan for those appellants which may be experiencing financial hardship due to repayment. 42 U.S.C. § 1395ddd(f)(1); 42 C.F.R. § 401.607(c).

II. THE EQUITIES HAVE CHANGED, RESULTING IN ADDITIONAL REASONS WHY THE COURT SHOULD NOT ORDER ANY MANDAMUS RELIEF, BUT IF IT DOES, IT SHOULD REJECT AHA'S PROPOSALS.

This Court should not enter a new mandamus order. But if it does, it should order the relief proposed by the Secretary and reject AHA's proposals, which will make the backlog worse.

A. Because RACs-Related Appeals Are A Small Contributor To The Backlog, And The Department's Settlement Initiatives Provide Immediate Relief To Providers, The Equities Have Changed, Resulting In Even Less Support For Mandamus Relief.

As this Court well knows, the Medicare statute provides escalation as the remedy when OMHA fails to issue a decision within 90 days.[22] *See* Def's MSJ at 28. For preservation purposes, the Secretary continues to maintain that this indicates that Congress did not intend the 90-day deadline in the Medicare statute to be enforced through an equitable order from this Court. *Id*. However, even if the Court has the authority to issue mandamus, it should not do so here because the equities — to the extent they ever supported mandamus (and respectfully they did not) — have changed since its prior order. *In re Medicare Reimbursement Litig.*, 414 F.3d 7, 10 (D.C. Cir. 2005) (starting that a Court may grant equitable relief "only when it finds compelling equitable grounds" for doing so).[23]

[22] Indeed, appellants remain free to escalate their cases to federal court, and once there, have a variety of tools at their disposal to minimize the burden on them and the courts, which include the consolidation of related cases. *See* Fed. R. Civ. P. 42. Briefing in consolidated cases, for example, could be sequenced to allow common legal issues to be resolved in a lead case, which could facilitate the settlement of cases following rulings in bellwether cases.

[23] The D.C. Circuit clearly contemplated that this Court could revisit its prior mandamus order ***even*** if it found that it was technically possible to comply with an order to eliminate the backlog. *See* Def's MSJ at 27 (citing *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)).

This Court previously evaluated the six *TRAC*[24] factors, and determined that they weighed in favor of mandamus, relying on its finding that Department delay is having a "real impact on 'human health and welfare,'" based on plaintiff-hospitals' allegations 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 *Am. Hosp. Ass'n v. Burwell* , 812 F.3d 183,193(D.C. Cir. 2016) ("*AHA I*")). Although the Government disagrees with this finding, it is no longer the case, given the implementation of LVA and SCF. 80% of providers in the backlog, responsible for 30% of appeals, are eligible for LVA. *See supra*. AHA complains that the LVA settlement does not apply to all providers, but it provides immediate relief to 80% of providers. *Id*. In addition, for providers that are not eligible for LVA, there is the expanded SCF. Together, these settlement initiatives target over 90% of appeals in the backlog at OMHA, absent program integrity concerns, and would free ALJ team adjudication time for those appeals which are not eligible for settlement. *See* Supp. Griswold Decl. ¶ 3. Given these new facts, the Court's previous calculus for issuing its mandamus order has changed.[25]

The Government also explained that the fundamental premise of Plaintiffs throughout this litigation, as well as the D.C. Circuit panel in the first appeal — that the Department faced a choice between how it exercised its ***discretion*** to implement the RAC program and its ***mandatory*** duty to provide ALJ hearings within 90 days — is not accurate. *See* Def's MSJ at 22,

[24] These factors are so named for the D.C. Circuit's decision in in *Telecommunications Research & Action Center v. FCC* ("*TRAC"*), 750 F.2d 70, 74-79 (D.C. Cir. 1984), where it identified six factors to consider when a court determines whether an Department's delay justifies the extraordinary remedy of mandamus.

[25] In addition, 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).

26; *see also AHA I*, 812 F.3d at 193 (noting that it was "critical[]" to the panel's reasoning that Congress had given the Department substantial discretion to determine the RAC program's scope); *see id*. at 185 (describing the "heart" of the case as a conflict between the ninety-day timetable and the RAC program). The record now makes clear that further changes to the RAC program would not eliminate the backlog (and indeed, would not even significantly alleviate it). *See supra*. Thus, this case is not about a discretionary decision to violate a statutory mandate, or a refusal to take the "difficult' steps needed to eliminate the backlog. *See* Pls.' MSJ at 6. Instead, this case is about resource constraints. The appropriations power belongs to Congress, *see OPM v. Richmond*, 496 U.S. 414, 424 (1990), and if Congress does not appropriate the funds 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). 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). Accordingly, the Court should not enter any mandamus relief.[26]

B. If The Court Does Order Mandamus, It Should Reject AHA's Suggestions And Instead Adopt The Department's Proposal.

For the reasons discussed above, the Court should not require the Department to eliminate the backlog by a date certain. In the event the Court finds that it is appropriate to order some mandamus relief, it should, at a minimum, reject AHA's proposed alternatives that would compel the Department to engage in unwise settlement offers, toll interest and suspend

[26] HHS has repeatedly asked Congress for significant increases to OMHA's budget, as well as congressional enactment of 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. But Congress has yet to act. *See* Def's MSJ at 13-15.

recoupment, and make further changes to the RAC program that would have a negligible impact on the backlog but come at great cost to the Medicare Trust Funds.

AHA's Proposed Mandamus Relief With Respect to Settlement. AHA requests that the Court order the Department to settle with providers based only on their historic rates of success before OMHA or the historic overturn rates for claims of a similar type at the ALJ level. Pls.' MSJ at 19. This proposal is difficult to implement and will likely prove unpopular with many providers, given an average success rate of approximately 31% before OMHA in 2017. *See supra* (explaining that LVA pays 62% of the Medicare allowed amount for qualifying appeals). As for large volume providers, AHA overlooks that, with SCF, the Department ***already*** considers a provider's historic rate of success rates before ALJs— at least when such data are available. *See* McQueen Decl. ¶ 8. But, with SCF, government negotiators take additional steps as part of the process of reaching an individually tailored merits-based settlement, such as evaluating a sample of the provider's current set of appeals. *Id*. Relying ***only*** on historic success rates by themselves will be difficult at best, unworkable in many cases, and will be rejected by many providers, making AHA's proposal an inferior option to the Department's current SCF initiative. To identify only some of the problems with this approach: some providers may not have enough appeals to form a reliable data set, or the provider's past appeals may involve different issues than are present in the current batch of appeals. Payment policy changes may also make it difficult to have an apples-to-apples comparison between past and new appeals. Moreover, as noted, since the average rate of success before OMHA was around 31% in 2017, using this factor as the sole basis for settlement would be an unpalatable option for many providers. There is every reason to believe that the Department's LVA and SCF initiatives will be far more successful. Finally, AHA's additional proposed settlement-related relief — namely, asking the

Court to require the Department to maintain confidential settlement communications and legally privileged internal settlement analyses — will discourage providers from entering into settlement, potentially vitiate critical privileges, chill internal Department debate and impose an increased burden on Department resources better used on settling cases. Pls.' MSJ at 19. It should be rejected.

Tolling and Suspension of Recoupment. Likewise with AHA's request for the Court to order the Department to toll interest and suspend recoupment for all appeals pending before OMHA for more than 90 days — as mentioned, doing so would be illegal and would perhaps be the surest way to make the backlog worse. *See supra*.

AHA's Request for the Court to Order Further Changes to the RAC program. AHA's proposal to further reduce the RAC program is myopic and — given the Department's many successful changes to the RAC program — will have, at best, a negligible impact on the backlog. Indeed, a year after a new statement of work went into effect, RAC-related appeals amounted to just 12% of new appeals in FY 2017. Further changes to the RAC program would thus have only a small impact on the backlog but come at great cost to the public fisc. AHA's focus on the RAC program is understandable; it seeks to curtail a program that has been remarkably successful in recovering improper Medicare payments. That program is statutorily mandated, however, and the Department has an obligation to implement it in a way consistent with its duty to protect the public fisc. The Department has appropriately exercised its discretion to refine the RAC program in a manner that takes into account AHA's critiques, while at the same time allowing the program to operate as Congress intended it. Given the data showing the limited contribution of the RAC program to the backlog, no further revisions to it are warranted.

The DC Circuit's *TRAC* factors require the Court to balance the Department's duty to the Trust Funds with the obligation to provide ALJ hearings within 90 days. *See TRAC*, 750 F.2d at 80 (stating that, in evaluating whether to grant mandamus, "the Court should consider the effect of expediting delayed action on Department activities of a higher or competing priority") (internal quotation marks and citations omitted). The Department has ultimately struck the right balance between these competing considerations and its robust settlement efforts should be given a chance to bear fruit.

CONCLUSION

The Court should award summary judgment to the Government, and find that the Department cannot possibly lawfully eliminate the backlog by 2020, or any other date certain. The Court should not enter an order of mandamus. In the alternative, if the Court determines that some mandamus relief is appropriate, it could order the Department to submit quarterly status reports about the status of the backlog.

Dated February 1, 2018

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