**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

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| AMERICAN HOSPITAL ASSOCIATION, *et al.*,<br><br>Plaintiffs,<br><br>v.<br><br>SYLVIA M. BURWELL, in her official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,<br><br>Defendant. | Civil Action No. 1:14-CV-851-JEB |

**RESPONSE IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND REPLY IN FURTHER SUPPORT OF PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT**

Sheree R. Kanner (D.C. Bar No. 366926)
Mitchell E. Zamoff (D.C. Bar No. 439383)
Adam K. Levin* (D.C. Bar No. 460362)
Rebecca C. Mandel (D.C. Bar No. 976808)
Jaclyn L. DiLauro (D.C. Bar No. 1010951)
Hogan Lovells US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600

** Counsel of Record*

Melinda Reid Hatton (D.C. Bar No. 419421)
Lawrence Hughes (D.C. Bar No. 460627)
American Hospital Association
800 Tenth Street, N.W.
Two CityCenter, Suite 400
Washington, D.C. 20004
(202) 638-1100

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*Attorneys for Plaintiffs*

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Plaintiffs the American Hospital Association ("AHA"), Baxter Regional Medical Center ("Baxter"), Covenant Health ("Covenant"), and Rutland Regional Medical Center ("Rutland") (collectively, "Plaintiffs," and Baxter, Covenant, and Rutland collectively, "Plaintiff hospitals") respectfully submit this memorandum in further support of their Motion for Summary Judgment [DE 8] and in opposition to the Motion to Dismiss filed by the Secretary of Health and Human Services ("HHS" or "the Secretary") [DE 12].

**INTRODUCTION**

In opposing Plaintiffs' motion for summary judgment and moving to dismiss, HHS does not – because it cannot – deny the existence of unlawful and egregious delays in the adjudication of Medicare claim appeals. The Medicare Act is clear that appeals at the Administrative Law Judge ("ALJ") and Departmental Appeals Board ("DAB") levels of the process must be brought to a decision within ninety days. 42 U.S.C. § 1395ff(d)(1)(A); *id.* § 1395ff(d)(2)(A). At the end of August 2014, however, appeals at the ALJ level languished for an average of 495.6 days – more than *five times* what the law requires. HHS, Office of Medicare Hearings and Appeals ("OMHA"), *Important Notice Regarding Adjudication Timeframes*, *available at* www.hhs.gov/omha/important_notice_ regarding_adjudication_timeframes.html (last visited Oct. 2, 2014). Likewise, even HHS concedes that the DAB has a "workload [that] far exceeds [its] ability to keep up with the volume of incoming appeals." Def.'s Points and Authorities In Supp. of Her Mot. to Dismiss For Lack of Jurisdiction and in Opp'n to Pls.' Mot. for Summ. J. ("Br.") at 11. Appeals have "skyrocketed to unprecedented levels," *id.* at 1; HHS is facing a "dramatic increase" in appeals, *id.*; and its delays in adjudicating appeals are "significant," *id*. at 2, and "substantial," *id*. at 1.

HHS's failure to adjudicate appeals timely has led to an immense backlog of close to a million appeals of claim denials worth more than a billion dollars in Medicare reimbursement. As a result, the system is broken – not just for "hospitals with significant financial resources," as HHS callously asserts, *id*. at 2, but also for hospitals like Baxter, which has been unable to purchase basic equipment for patient care because critical funds are tied up in the Medicare appeals process.

Rather than address the situation in a meaningful way, however, HHS has responded to this lawsuit by throwing up its hands, denying blame, and asking for forgiveness based on two central arguments: First, that the ninety-day deadlines for deciding claims at the ALJ and DAB levels are not, in fact, deadlines that can be enforced; and, second, that "this action does not involve the sort of delays that are so egregious as to warrant exercise of the Court's discretion to enter the extraordinary remedy of mandamus." *Id*. at 2. HHS is wrong in both respects.

*First*, there can be no dispute that the ninety-day deadlines are statutory requirements to which HHS has failed to adhere. In 2000, HHS described the appeal deadlines as "*mandatory* time frames." 67 Fed. Reg. 69,312, 69,316 (proposed Nov. 15, 2002) (emphasis added). Likewise, in July 2014, the Medicare Chief ALJ, Nancy Griswold, agreed that "the law . . . *require[s]* a 90-day turnaround" and that "the intent of Congress was to have that 90-day turnaround." *Medicare Mismanagement Part II: Exploring Medicare Appeals Reform: Hearing Before the H. Oversight and Government Reform Subcomm. on Energy Policy, Health Care, and Entitlements*, 113th Cong., at 23:00-28:00 (July 10, 2014) (testimony of Nancy J. Griswold, Chief ALJ, Office of Medicare Hearings and Appeals) (emphasis added), *available at* http://oversight.house.gov/hearing/medicare-mismanagement-part-ii-exploring-medicare-appeals-reform (last visited Oct. 2, 2014); *see also id*. (testifying that the statute "envisions a

ninety-day processing" period). It is only now, as a defendant in litigation, that HHS has taken the incredible position that the ninety-day deadlines are mere suggestions by Congress that the Secretary is at liberty to exceed by years.

Under HHS's strained interpretation of the Medicare Act, HHS would not be required to meet *any* deadlines for deciding Medicare claim appeals – a view that is at odds not only with the plain language of the statute, which should end the inquiry, but also the structure of the law and the intent behind it. To support this newly-adopted legal interpretation, HHS relies exclusively on the existence of an "escalation" process within the Medicare Act, which permits claims to be "escalated" from one level to the next at the election of the Medicare appellant. But the escalation process is neither an excuse to ignore the applicable statutory deadlines, nor an adequate remedy for the unlawful, systemic backlogs in the appeals process. Indeed, if HHS were right, then Plaintiff hospitals and all other adversely-affected Medicare appellants would be forced to choose between two equally inadequate options: (1) wait out the years-long delays, while continuing to provide patient care and make needed capital improvements without critical Medicare funds; or (2) escalate appeals, and thereby shift the lengthy wait to a different level, while forfeiting the critical right to a hearing in the process. That is not, and cannot be, the law.

*Second*, there is no basis for HHS's contention that judicial intervention is unwarranted. The undisputed record shows that HHS's delays are "so egregious as to warrant mandamus" under the well-established factors in *Telecomms. Research & Action Ctr. v. FCC*, 750 F.2d 70, 79-80 (D.C. Cir. 1984) ("*TRAC*"). HHS has refused to address unlawful delays resulting from the burgeoning number of Medicare appeals in any meaningful way. Those delays have reached a crisis point and are causing ongoing harm to providers of critical health care services, like Plaintiff hospitals.

HHS's response is to claim that it faces "competing priorities and limited resources" that inhibit relief. Br. at 2. But these are misplaced policy arguments, not legal justifications for denying mandamus. It is simply not true, for example, that an order of mandamus would "force OMHA and the DAB to rearrange their priorities to put hospital appeals ahead of beneficiary appeals as well as appeals by other health care providers." *Id*. at 22. In fact, granting relief for Plaintiffs would necessarily benefit *all* Medicare appellants, including beneficiaries. Likewise, HHS can hardly make a "limited resources" argument, given its own concession that the Secretary has statutory authority to transfer funds within the Department, *see id.* at 22-23 – and that, until last year, she had not even requested additional appropriations for the appeals office. The record shows that the Secretary has refused to avail herself of funds within HHS that could be used to eliminate the current backlog or take steps that could reduce the growing volume of appeals.

Accordingly, Plaintiffs respectfully request that the Court grant their motion for summary judgment, enter an order of mandamus, and deny HHS's motion for dismissal. As explained more fully below and in Plaintiffs' opening brief, no relief other than mandamus will suffice to resolve HHS's statutory violations and to provide Plaintiff hospitals with their indisputable rights under the Medicare Act.

## ARGUMENT

The Court may simultaneously resolve Plaintiffs' Motion for Summary Judgment and HHS's Motion to Dismiss pursuant to Federal Rules of Civil Procedure 12(b)(1) and 12(b)(6). These inquiries are coextensive here because "[t]he question of whether mandamus jurisdiction exists frequently merges with the merits of the claim for relief." *In re Medicare Reimbursement Litig.*, 309 F. Supp. 2d 89, 95 & n.4 (D.D.C. 2004) (denying motion to dismiss pursuant to Rules

12(b)(1) and 12(b)(6) and granting plaintiffs' motion for summary judgment), *aff'd* 414 F.3d 7 (D.C. Cir. 2005); *see also Muwekma Tribe v. Babbitt*, 133 F. Supp. 2d 30, 31 (D.D.C. 2000) (denying defendants' motion to dismiss and granting in part the plaintiff's motion for summary judgment).

The parties agree on the standards to be applied to both motions: Mandamus relief should be granted to a plaintiff who demonstrates that (1) it has a clear and indisputable right to relief, (2) the agency has a clear duty to act, and (3) the plaintiff has no other adequate remedy. *United States v. Monzel*¸ 641 F.3d 528, 534 (D.C. Cir. 2011); *see also* Br. at 14 (citing *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. 2002)). Where a mandamus claim is based on agency delay, the court also must consider whether the agency's delay is "so egregious as to warrant mandamus." *TRAC*, 750 F.2d at 79; *see also* Br. at 17 (citing *TRAC*).

In this case, Plaintiffs have demonstrated their entitlement to mandamus relief. As shown below, the Medicare Act creates an absolute duty for HHS to act within the established deadlines, as well as a concomitant right to relief for the violation of those deadlines. HHS's years-long delays are not justified by competing agency priorities or its asserted good faith, particularly in view of the severe harm the delays cause hospitals. Further, there is no adequate alternative remedy to mandamus. For these reasons, HHS's Motion to Dismiss should be denied and Plaintiffs' Motion for Summary Judgment should be granted.

## I. HHS IS IN VIOLATION OF ABSOLUTE STATUTORY DEADLINES.

HHS's lead argument against mandamus is based on the implausible contention that the ninety-day deadlines at the ALJ and DAB levels of appeal are not statutory requirements because Medicare appellants are permitted to escalate their claims to the next level if the deadlines are

missed. But the text, structure, and overall statutory scheme of the Medicare Act belie that contention.

**A. The Text: "Shall" Means "Shall."**

The Medicare Act's mandatory language could not be clearer: "[A]n administrative law judge *shall* conduct and conclude a hearing . . . and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed." 42 U.S.C. § 1395ff(d)(1)(A) (emphasis added). Similarly, "[t]he Departmental Appeals Board . . . *shall* conduct and conclude a review of the decision on a hearing . . . and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed," *Id.* § 1395ff(d)(2)(A) (emphasis added).

HHS asks this Court to read "shall" as "may." Br. at 16. But it is a bedrock principle of statutory construction that the word "shall" is mandatory, while "may" is permissive. *See Ass'n of Civilian Technicians v. Fed. Labor Relations Auth.*, 22 F.3d 1150, 1153 (D.C. Cir. 1994) ("The word 'shall' generally indicates a command that admits of no discretion on the part of the person instructed to carry out the directive."). And Congress clearly understood the difference between the two, as evidenced by its use of "may" elsewhere within the Medicare Act for conduct intended to be permissive. For example, the Secretary "*may* reopen or revise any initial determination or reconsidered determination . . . under guidelines established by the Secretary in regulations," 42 U.S.C. § 1395ff(b)(1)(G) (emphasis added), and an individual seeking reconsideration "*may* be granted such additional time as the individual specifies . . . for the qualified independent contractor to conclude the reconsideration," *id.* § 1395ff(c)(3)(C)(iv). There simply is no basis to vitiate the plain meaning of Congress's choice of the word "shall"

here: "The rule of construction is settled: '(W)hen the same [statute] uses both "may" and "shall," the normal inference is that each is used in its usual sense [–] the one act being permissive, the other mandatory.'" *Oljato Chapter of Navajo Tribe v. Train*, 515 F.2d 654, 662 (D.C. Cir. 1975) (quoting *Anderson v. Yungkau*, 329 U.S. 482, 485 (1947)).

HHS's interpretation of "shall" as "may" also is untenable because it would undercut numerous other usages of the term "shall" within the Medicare Act. The "normal rule of statutory construction" provides that "identical words used in different parts of the same act are intended to have the same meaning." *Dep't of Revenue of Or. v. ACF Indus., Inc.*, 510 U.S. 332, 342 (1994) (internal quotation marks and citation omitted). Under HHS's construction, the phrases "shall promulgate," "shall be concluded," "shall be mailed," "shall provide," "shall include," "shall be available," and many more mandatory directives in the Medicare Act also would be interpreted as permissive. *See Beaty v. Food & Drug Admin.*, 853 F. Supp. 2d 30, 39 (D.D.C. 2012) ("Under defendants' theory, the phrases 'shall furnish,' 'shall request,' 'shall deliver,' 'shall cause,' and 'shall be paid' must be interpreted as permissive."). As in *Beaty*, "[t]he more reasonable interpretation, however, is that 'shall' in all of these phrases is mandatory, especially when it is used in conjunction with specified exceptions." *Id.* Thus, the Court should read the text of the applicable provisions exactly as they are written – as mandatory deadlines that HHS plainly has not met.

**B. The Structure: Escalation Is An Option, Not An Exemption.**

HHS's construction of the statutory deadlines for the Medicare appeals process hinges entirely on the escalation process, Br. at 16, and a claim that the existence of an escalation option means HHS was never required to act in the first place. But simply because Congress anticipated that HHS might not always be able to comply with its deadlines, and created an

alternative that might be invoked by Medicare appellants in some circumstances, does not mean that HHS lacks a "clear duty to act" or that Plaintiffs lack a "clear right to relief." *Id.* at 15.[1]

This conclusion is reinforced by the language in the statute surrounding escalation itself. The choice to escalate rests in the hands of the Medicare appellants, not HHS. As HHS recognizes, "the *claimant may* escalate its claim to the next administrative appeal level." Br. at 16 (emphasis added). That escalation is at the option of the claimant demonstrates Congress's intent to provide a measure of protection for potential violations, not to exempt HHS from its obligations to meet the statutory deadlines.

Further, at both the ALJ and DAB levels of review, the statute describes escalation as occurring only in the event of "*failure*. . . to render a decision by the end of the [prescribed] period." 42 U.S.C. § 1395ff(d)(3)(A) (ALJ failure); § 1395ff(d)(3)(B) (DAB failure) (emphasis added). Indeed, both escalation provisions are found within a subsection entitled "Consequences of failure to meet deadlines." *Id.* § 1395ff(d)(3). And that is the whole point: The very treatise cited by HHS recognizes that "[c]ourts often find that where a deviation from the direction of a statute implies a consequence, the statute is mandatory." *See* 3 *Sutherland Statutes and Statutory Construction* § 57:8.

There is only one exception to the statutory deadlines, and it has nothing to do with escalation. Set forth in subparagraph (B), it provides for a *waiver* of the statutory deadlines by Medicare appellants, not HHS: "The 90-day period under subparagraph (A) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period." 42 U.S.C. § 1395ff(d)(1)(B). Aside from this exception, the statutory deadlines are mandatory: "*Except as provided in subparagraph (B)*, an administrative law judge *shall* conduct and

[1] Nor does it mean that escalation is the "exclusive remedy" for HHS's failure to meet its statutory deadlines. *See infra* pp. 25-26.

conclude a hearing . . . and render a decision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed." *Id.* § 1395ff(d)(1)(A) (emphasis added). Congress's specific exception only in the event of an appellant's voluntary waiver of the deadlines demonstrates that the escalation process was not intended as an exception to those deadlines. *See TRW Inc. v. Andrews*, 534 U.S. 19, 28-29 (2001) ("Where Congress explicitly enumerates certain exceptions to a general prohibition, additional exceptions are not to be implied, in the absence of evidence of a contrary legislative intent.") (internal quotation marks omitted).

Another court in this district has recognized that an option to escalate does not negate the mandatory nature of Congress's statutory deadlines for agency action. A remarkably similar escalation provision in 8 U.S.C. § 1447 provides: "If there is a failure to make a determination under section 1446 of this title before the end of the 120-day period after the date on which the examination is conducted under such section, the applicant may apply to the United States district court for the district in which the applicant resides for a hearing on the matter." 8 U.S.C. § 1447(b). That court rightly recognized the 120-day deadline for what it was, a mandatory deadline in which "'Congress intended to constrain the USCIS to adjudicate a [naturalization] application . . . .'" *See Beshir v. Holder*, __ F. Supp. 2d __, No. Civ. 10-652 (JDB), 2014 WL 284886 at *8 (D.D.C. 2014) (quoting *Orlov v. Howard*, 523 F. Supp. 2d 30, 34 (D.D.C. 2007)). Thus, the ability of the *applicant* to seek a hearing in district court did not render the 120-day period a mere suggestion by Congress. The same is true here. The escalation process does not render the ninety-day deadlines in the Medicare Act permissive.

**C. The Statutory Scheme: Congress Intended To Impose Strict Deadlines.**

HHS's argument also fails because it is inconsistent with the entire purpose of what Congress designed: A statutory process for timely hearings and decisions of Medicare appeals. The D.C. Circuit has held that mandamus relief is appropriate where "Congress undoubtedly knew the enormous demands placed upon the Secretary and nonetheless limited her time to act." *In re People's Mojahedin Org. of Iran*, 680 F.3d 832, 837 (D.C. Cir. 2012) (granting mandamus where time was limited on a petition for revocation to 180 days). So too here. The "specificity" and "relative brevity" of the ninety-day deadlines for both the ALJ- and DAB-levels of the appeals process "manifest[] the Congress's intent that [HHS] act promptly" on Medicare appeals. *See id.* And that intent to set a deadline for hearing and decision by the ALJ, and for a decision by the DAB, should be enforced – not dismissed by HHS as nothing more than suggested timeframes for agency action. *See* Br. at 15-17.

Indeed, that is particularly so in this case, where the deadlines at issue were added to *shorten* the statutory claim review deadlines in the Medicare Act. *See* Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 ("BIPA"), Pub. L. No. 106-554, App. F, 114 Stat. 2763. In fact, at the time BIPA was passed, HHS conceded that the Act provided for the "establishment of drastically reduced *mandatory* time frames for appeals decisions." 67 Fed. Reg. at 69,316 (emphasis added). It reaffirmed that understanding very recently, explaining that it "is unable to continue its past successes for adjudicating claims within 90 days, *as mandated by* the Benefits Improvement and Protection Act (BIPA) 2000." HHS, OMHA, *Justification of Estimates for Appropriations Committees, Overview of Performance, Fiscal Year 2015* 7 (2014), *available at* http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf.

Critically, the deadlines in the Medicare Act appear in the statute itself, not merely in regulations. Deadlines provided by Congress bind the agency. *See In re Bluewater Network*, 234 F.3d 1305, 1315-16 (D.C. Cir. 2000); *Beshir*, 2014 WL 284886, at *8. In contrast, where timeframes are provided by regulation rather than statute, some courts have held those timeframes to be non-binding for purposes of mandamus. *See Action on Smoking & Health v. Dep't of Labor*, 100 F.3d 991, 993 (D.C. Cir. 1996); *Liberty Fund, Inc. v. Chao*, 394 F. Supp. 2d 105, 114 (D.D.C. 2005). These cases, which are relied upon by HHS, thus are distinguishable because the relevant deadlines were provided by *the agency*, not by Congress. *See id.* The fact that *Congress* did not set the deadlines was important to the court in both *Action on Smoking* and *Liberty Fund*. In *Action on Smoking*, the regulations specifically provided that "'[t]he failure of the Secretary to comply with the required timeframes shall not be a basis to set aside any standard or to require the issuance of a new proposal on any individual substance.'" 100 F.3d at 993 (quoting 29 C.F.R. § 1990.147(b)). Therefore, the court concluded that they reflected an "optimistic policy goal rather than a realistically achievable schedule." *Id.* at 993. In *Liberty Fund*, both parties agreed that "there is no *statutory* timetable governing the agency action at issue." 394 F. Supp. 2d at 114 (emphasis added).

Here, the statutory timetable is clear: Both the ALJ and DAB levels of review must be conducted and concluded within ninety days. There is no provision in the Medicare Act allowing the Secretary "flexibility to set aside statutory deadlines." *See In re United Mine Workers of Am. Int'l Union*, 190 F.3d 545, 550 (D.C. Cir. 1999) (explaining that such a provision was "the main reason" a deadline was held to be non-mandatory in a previous case). A deadline here means exactly what HHS itself said, what Congress intended, and what it means everywhere else: A "mandatory time frame[]" in which action must be completed. 67 Fed. Reg. at 69,316.

## II. HHS'S VIOLATIONS ARE SUFFICIENTLY EGREGIOUS TO WARRANT THIS COURT'S INTERVENTION.

Despite perfunctorily listing all six *TRAC* factors that courts in this circuit consider in determining whether to grant mandamus, Br. at 17-18, HHS tellingly glosses over the majority of them in its analysis. Indeed, HHS gives short shrift to the first two *TRAC* factors and fails entirely to address factor five, "the nature and extent of the interests prejudiced by delay." *TRAC*, 750 F.2d at 80. The D.C. Circuit has affirmed that the first two *TRAC* factors – those that address Congress's statutory timetable for agency decisionmaking – are the "most important." *See People's Mojahedin*, 680 F.3d at 837. And HHS's reason for ignoring the fifth factor is clear: It simply has no answer to the tremendous financial consequences that hospitals and other Medicare providers are suffering as a result of HHS's delays.

HHS's attempt to elevate the importance of the fourth *TRAC* factor relating to competing agency priorities and, to a lesser extent, the sixth *TRAC* factor regarding lack of bad faith, fails. Even with respect to those factors, HHS does not offer a compelling case. HHS does not identify a single competing priority that explains its failure to address its unlawful delays in adjudicating Medicare claim appeals. Further, HHS's protestations about its lack of resources are exaggerated and disingenuous. Finally, HHS should receive no mandamus "credit" for its admittedly insufficient efforts to resolve the backlog, when there is more that it can – and is required – to do.

When all of the *TRAC* factors are viewed together, it is clear that the egregiousness of the delays and the threat to the nation's hospitals counsel in favor of mandamus relief.

### A. HHS's Delays Are Unreasonable.

HHS's effort to dismiss the first two *TRAC* factors out of hand because "appeals need not be resolved within 90 days," Br. at 20, fails for the reasons set forth above, *supra* pp. 5-11. In

fact, those two factors – the "most important of the *TRAC* factors," *People's Mojahedin*, 680 F.3d at 837 – weigh heavily in favor of mandamus relief. Even if the appeal deadlines were not mandatory, Congress's "indication of the speed with which it expects the agency to proceed" would nonetheless supply the content for the "rule of reason" contained within the first two *TRAC* factors. *TRAC*, 750 F.2d at 80. HHS's years-long delays far exceed the ninety-day rule of reason. *See Sandoz, Inc. v. Leavitt*, 427 F. Supp. 2d 29, 40 (D.D.C. 2006) ("Congress's 180-day action requirement provides a strong indication that the FDA's nearing 1000-day response time is unreasonable."); *United Mine Workers*, 190 F.3d at 551 (quoting *TRAC*, 750 F.2d at 80) (explaining that a multi-year delay is "simply not in the same ballpark as the ninety-day period contained in the statute").

The D.C. Circuit has held on numerous occasions that mandamus was warranted where, as here, an agency has delayed years in taking statutorily-required action. *Ganem v. Heckler*, 746 F.2d 844, 854 (D.C. Cir. 1984) (five years); *see Pub. Citizen Health Grp. v. Auchter*, 702 F.2d 1150, 1157 (D.C. Cir. 1983) (three years); *MCI Telecomms. Corp. v. FCC*, 627 F.2d 322, 327 (D.C. Cir. 1980) (over three years). In such circumstances, mandamus is necessary to "prevent the Act [at issue] from being transformed into a set of hollow promises." *Ganem*, 746 F.2d at 854. The Court should reach the same result in this case.

### B. HHS Has Not Asserted A Competing Priority That Justifies Its Unreasonable Delays Or The Severe Prejudice Caused By Those Delays.

HHS attempts to elevate just one of the six *TRAC* factors above all others – the fourth *TRAC* factor regarding "agency activities of a higher or competing priority." Br. at 18 (seeking application "chiefly" of the fourth factor to deny mandamus). But HHS has not asserted a single agency activity that would suffer if mandamus expedited HHS's resolution of the unlawful Medicare appeals delays. Any logistical hurdles HHS would face if ordered to meet its statutory

obligations can be resolved by the agency and pale in comparison to the ongoing prejudice suffered by hospitals while the delays continue.

**1. Plaintiffs' pursuit of timely adjudication of their Medicare appeals does not harm beneficiaries.**

HHS's "competing priorities" argument fundamentally is based on a strawman, namely that granting mandamus relief to Plaintiffs will harm "the claims of beneficiary appellants whom OMHA and the [DAB] recognize as the most vulnerable group of appellants." Br. at 21; *see also id.* at 22 ("OMHA and the DAB have made the policy determination that appeals filed by individual Medicare beneficiaries should have priority over other appeals, including hospitals' appeals."). But Plaintiffs do not seek to jump the line – they seek HHS's compliance with the Medicare Act's deadlines broadly, as HHS itself recognizes elsewhere in its brief. Br. at 1 ("Plaintiffs . . . seek a writ of mandamus that would compel HHS to resolve *all* Medicare payment appeals at the ALJ and DAB levels of the administrative process within 90 days") (emphasis added).[2]

This is a cry for relief that the beneficiaries themselves echo: At least two lawsuits brought by beneficiaries are currently pending to challenge delays in the Medicare appeals process. *See Calif. Clinical Lab. Ass'n, et al. v. Sec. of Health & Human Servs.*, No. 1:14-CV-673-KBJ (filed in D.D.C. Apr. 18, 2014; HHS's motion to dismiss pending); *Lessler, et al. v. Burwell*, No. 3:14-CV-1230 (filed in D. Conn. Aug. 26, 2014; plaintiffs' motion to certify class pending). Because Plaintiffs do not seek to pass beneficiaries in the appeals queue, beneficiaries

[2] Further, HHS's own data reflect that providers and suppliers are disproportionately affected by the delays. Of the 390,491 hearings requested in fiscal years 2011 and 2012, only 8,942 were requested by beneficiaries and 12,470 were requested by state Medicaid agencies. By contrast, 287,138 were requested by providers and suppliers. HHS, OMHA, *Receipts by Fiscal Year: Data Set, Fiscal Year 2011-2012, available at* http://www.hhs.gov/omha/resources/index.html (click on "Receipts by Fiscal Year" and download the Fiscal Year 2011-2012 dataset) (last visited Oct. 2, 2014).

themselves would necessarily *benefit* from a grant of mandamus by this Court. HHS's reliance on *In re Barr Laboratories, Inc.*, 930 F.2d 72 (D.C. Cir. 1991), thus is misplaced. There, the court addressed an issue with which this Court is not faced: Whether mandamus should issue when "putting [the plaintiff] at the head of the queue simply moves all others back one space and produces no net gain." *Id.* at 75. HHS's purported concern about beneficiaries is the only agency "priority" specifically cited in opposing mandamus. Br. at 25.

**2. HHS ignores the extreme prejudice and threat to health and human welfare caused by its unreasonable delays.**

HHS predictably glosses over the severe adverse impacts on hospitals deprived of the challenged Medicare reimbursement. HHS glibly suggests that the delays in the process "are generally being experienced by providers and suppliers, including large organizations such as hospitals with significant financial resources." Br. at 2. But the delays that HHS so offhandedly dismisses for America's hospitals amount to billions of dollars in total reimbursement held by HHS in the interim. *See* Mot. Summ. J. at 22 (citing Ex. 5 (RAC*Trac* Survey) at 47; Decl. of C. Steinberg ¶ 17). HHS's disregard for the effect of the delays on hospitals willfully ignores the real, measurable, and severe harms described by the Plaintiff hospitals, of which Plaintiffs' Motion for Summary Judgment detailed just a few. For example, Baxter lacks funds for basic equipment and may soon need to shut down its twenty-year-old catheterization laboratory. Decl. of I. Holleman ¶ 14. Its bond rating is at risk and it remains unable to replace the failing roof over its surgery department. *Id.* ¶¶ 14, 17. Covenant currently has a negative operating margin, due in large part to delays in the Medicare appeals process. Decl. of J. Geppi ¶ 19. Rutland has initiated two rounds of cost reductions, resulting in the elimination of thirty-two jobs. Decl. of J. Wallace ¶ 19.

These hospitals, and others like them, are the same facilities, of course, to which "elderly and disabled Medicare beneficiaries," Br. at 2, turn for care. In fact, it is largely *because* these hospitals treat so many Medicare patients that they have so many claims in the appeals system. For example, Medicare is responsible for sixty-five percent of Baxter's gross revenue – in 2013, it was named by Moody's Investor Service as America's fifth-most Medicare-dependent hospital. Decl. of I. Holleman ¶ 7. Medicare represents fifty-five percent of Covenant's gross revenue, Decl. of J. Geppi ¶ 8, and forty-seven percent of Rutland's gross revenues, Decl. of J. Wallace ¶ 10.

This Court – and HHS – should not ignore the profound harms that have befallen Plaintiffs and other hospitals as a result of these endless delays. The third and fifth *TRAC* factors require the Court to weigh the extent to which "human health and welfare are at stake" and to consider, more broadly, "the nature and extent of the interests prejudiced by delay." *TRAC*, 750 F.2d at 80. It is not enough to say at a high level, as HHS does, that all of its priorities affect health and human welfare. Br. at 21. HHS has not demonstrated that its priorities or logistical hurdles are sufficient to thwart mandamus in the face of both extraordinary delay and demonstrable harm to human health and welfare.

**3. HHS has not articulated a restraint on its resources that would prevent it from timely adjudicating Medicare claim appeals.**

HHS otherwise seeks to defeat mandamus on the basis of circumstances "largely outside the agency's control" and "practical constraints" that HHS faces. Br. at 31. HHS essentially argues impossibility, claiming that even if it were to shift all of its available resources to deciding hospital appeals, it still would not be able to issue legally sufficient decisions within the ninety-day time period because it would need to hire and train significant numbers of additional personnel and does not have unlimited resources on which it can draw. *Id.* at 22-23. But, as the

D.C. Circuit has confirmed, "[n]othing in the statute authorizes the Secretary to adopt a position of impossibility." *Ganem*, 746 F.2d at 854. "However many priorities the agency may have, and however modest its personnel and budgetary resources may be, there is a limit to how long it may use these justifications to excuse inaction in the face of the congressional command to act within ninety days." *United Mine Workers of Am. Int'l Union*, 190 F.3d at 554. In short, the ALJ delay problem is a problem that HHS is equipped to, and must, handle.

Further, there is no basis for HHS's impossibility defense. Plaintiffs are keenly aware that current years-long delays in ALJ hearings cannot be eliminated overnight. Plaintiffs seek mandamus only in order to compel the Secretary to put in place the necessary measures to meet her statutory obligation to provide for an ALJ hearing and decision within ninety days. The Secretary simply has refused to avail herself of funds within HHS that could be used to eliminate the current backlog or to ask Congress for sufficient additional funds. The Secretary also has been unwilling to take steps to stem the increase in appeals volume in the first place. *See infra* pp. 22-25. And unless this Court requires her to act, the Secretary has no incentive to do so, because all funds relating to challenged Medicare reimbursement at the ALJ and DAB levels are held by HHS during the pendency of the appeals process. *See* 42 C.F.R. §§ 405.378(f), 405.379.

HHS's resources are not nearly as constrained as it suggests. Even without seeking new appropriations from Congress, HHS is a large department that can bring substantial resources to bear on its priorities, and the Secretary has wide discretion to make use of funds from a variety of sources. As HHS itself acknowledges, Br. at 23, Congress explicitly granted the Secretary authority to transfer money from any other HHS appropriation to OMHA up to a capped amount. HHS Appropriations Act, 2014, Pub. L. No. 113-76 Div. H, Title II, 128 Stat. 363, 382 (Jan. 17, 2014).

Indeed, the Secretary has diverted funds from other agency programs to great effect in the past to acquire much larger sums than those likely to be required here. In 2013, for example, Secretary Sebelius utilized $1.6 *billion* in "reprogrammed" funds to implement the Affordable Care Act without additional congressional appropriations, including $113 million by operation of her transfer authority. Brett Norman and David Nather, *The Obamacare Money Under the Couch*, Politico, Mar. 7, 2014.[3] The additional funds needed to hire enough ALJs to make a meaningful difference in the appeals backlog pale in comparison to HHS's multi-billion dollar discretionary spending budget. Indeed, the entire OMHA budget amounts to barely *0.1 percent* of the discretionary budget authority that Congress granted to HHS in fiscal year 2014. *Compare* HHS, *Fiscal Year 2015 Budget-in-Brief: Strengthening Health and Opportunity for All Americans* 13-14 (2014), *available at* http://www.hhs.gov/budget/fy2015/fy-2015-budget-in-brief.pdf, *with* HHS, Departmental Management, *Justification of Estimates for Appropriations Committees, Departmental Management Overview, Fiscal Year 2015* 8 (2014), *available at* http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf.

Even if there were not enough resources available to the Secretary within existing HHS appropriations, she could ask for additional appropriations for OMHA from Congress in an amount that is sufficient to eliminate the current backlog and manage the increased appeals volume resulting from RACs and other factors. She has not done so.

Specifically, when Congress instructed the Secretary to establish independent ALJs for Medicare claim appeals within HHS in 2003, it clearly contemplated the Secretary requesting and receiving additional resources to "ensure timely action on appeals before administrative law

[3] Secretary Sebelius diverted more than $450 million from the Prevention and Public Health Fund as well as $300 million from the Non-Recurring Expenses Fund and $268 million from the general program operations account at the Centers for Medicare and Medicaid Services. *Id.*

judges and the Departmental Appeals Board" in accordance with the deadlines established in 42 U.S.C. § 1395ff. *See* Medicare Modernization Act of 2003, Pub. L. No. 108-173 § 931, 117 Stat. 2396, 2398. Congress explicitly authorized the Secretary to use funds, once appropriated, to "increase the number of administrative law judges (and their staffs)." *Id.* § 931(c). This "preauthorization" eliminated the need for the Secretary to ask Congress to authorize the hiring of more ALJs. Instead of the typical two-step congressional authorization and appropriation process, here only an appropriation request was required.

But the Secretary has never made an appropriations request sufficient to address the growing volume of appeals and backlog, even though—by HHS's own account—the problem has been escalating for years. OMHA reports that it began to experience an upward trend in the number of requests for ALJ hearings in fiscal year 2010, which took "an unexpectedly sharp turn" upward from fiscal year 2011 through fiscal year 2013. Ex. 1 to Decl. of N. Griswold at 3. And yet the Secretary did not even bother to increase her 2012, 2013 or 2014 budget requests for OMHA; instead, she sought roughly the same amount of appropriations for fiscal years 2012 through 2014.[4] At the same time, Congress again showed not only that it is concerned about this problem, but also that it is willing to devote resources if asked by the Secretary. *See* Sen. Rep. No. 113-71, at 149 (2013), *available at* http://www.gpo.gov/fdsys/pkg/CRPT-

[4] *See* HHS, Departmental Management, *Justification of Estimates for Appropriations Committees, Departmental Management Overview, Fiscal Year 2012* 1 (2011), *available at* https://wayback.archive-it.org/3920/20140402145428/http:/www.hhs.gov/about/budget/fy2012/gdm_cj_fy2012.pdf (seeking $81 million for OMHA); HHS, Departmental Management, *Justification of Estimates for Appropriations Committees, Departmental Management Overview, Fiscal Year 2013* 7 (2012), *available at* https://wayback.archive-it.org/3920/20140403203233/http:/www.hhs.gov/budget/fy2013/hhs-general-budget-justification-fy2013.pdf (seeking $84 million for OMHA); HHS Departmental Management, *Justification of Estimates for Appropriations Committees, Departmental Management Overview, Fiscal Year 2014* 2 (2013), *available at* http://www.hhs.gov/budget/fy2014/secretary-congressional-justification.pdf (seeking $82 million for OMHA).

113srpt71/pdf/CRPT-113srpt71.pdf (expressing concern about "both the growing backlog of cases at OMHA at the high rate of claims overturned by the Office" and recommending an award of the full amount requested for OMHA in the President's budget for FY 2014); Pub. L. No. 113-76, 128 Stat. at 380 (awarding the full amount requested). And even the requested increase in budget authority for OMHA for fiscal year 2015—a mere $18 *million* out of the more than $77.1 *billion* in requested HHS discretionary budget authority[5]—falls far short of being enough to have any real effect on the current backlog or the management of the increased appeals volume going forward.

**C. HHS's Efforts Are Concededly Inadequate.**

HHS's claimed good faith and efforts-to-date also do not justify the denial of mandamus. As HHS admits, its efforts are not viable remedies for the egregious delays that exist. Br. at 10 (HHS's "current initiatives are not sufficient to resolve the backlog"). Indeed, most of the measures described by HHS involve triaging appeals (*e.g.*, prioritizing beneficiary claims and deferring assignment of new claims, *id.* at 8-9[6]) or administrative reforms likely to have only minimal impact on the backlog (*e.g.*, "maximizing" the productivity of each ALJ by improving support, *id.* at 8, "developing an adjudicative business process manual to standardize its business practices," *id.* at 9, "converting its paper-based process to an electronic one," *id.*, and developing templates for routine word processing, *id.*).

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[5] *See The President's Fiscal Year 2015 Budget: Hearing Before the S. Comm. On Finance,* 113th Cong., at 4 (2014) (Statement of Kathleen Sebelius, Secretary, HHS), *available at* http://www.finance.senate.gov/imo/media/doc/041014%20Senate%20Finance%20testimony%20-%20Sebelius%20FINAL.PDF.

[6] HHS's characterization of the moratorium on assignment of new claims to ALJs, which it describes as the "defer[al of] appeal assignments," as an action taken to "address" the backlog strains credulity. Br. at 8 n.5. Even if this "first in/first out" system, which is articulated publicly for the first time in this litigation, does "not cause any additional delays in ALJ hearings and decisions," Br. at 9, it formalizes HHS's intention not to clear the backlog for at least the two years the moratorium is expected to last. HHS does not contest that unassigned claims are not being heard or decided.

HHS also has implemented two OMHA pilot programs for claim resolution, Br. at 10, but these too are insufficient to address the pending backlog. As to the first, a statistical sampling claims adjudication process, most hospitals are not even eligible. Only the largest hospitals or multi-hospital health systems will have the requisite number of claim appeals pending at the ALJ level. *See* OMHA, Statistical Sampling Initiative, http://www.hhs.gov/omha/statistical_sampling_initiative.html (last visited Oct. 2, 2014). The second, an alternative dispute resolution process, likewise is of almost no use to hospitals. *See* OMHA, Settlement Conference Facilitation Pilot, http://www.hhs.gov/omha/settlement_conference_facilitation_pilot.html (last visited Oct. 2, 2014).

HHS also recently offered to pay sixty-eight cents on the dollar to certain hospitals for a subset of their appeals involving one issue—a dispute over whether a patient should have been admitted as an inpatient— in exchange for withdrawal of those appeals. CMS, Inpatient Hospital Reviews, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html (last visited Oct. 2, 2014). This settlement offer, yet another acknowledgement by HHS that it has an obligation to alleviate the backlog, is proof that it can find funds to do so. But it is not a remedy for the backlog in appeals at issue here, much less an adequate one, even if some hospitals settle some claims. First, as a one-time retroactive lookback, any settlement will not reduce the continuing growth in appeals. And, second, the settlement is remarkably narrow. Many types of hospitals and other Medicare providers and suppliers are not eligible for it. *See id.* Claims for services furnished after October 1, 2013 are not eligible for it. *Id.* And all

claims for inpatient rehabilitation services, and vast numbers of claims for inpatient hospital services and other items and services, are not eligible for it. *Id.*

While the variety and extent of HHS's various efforts implicitly demonstrate that HHS understands the egregiousness of its violations – and belie its position in this litigation that it is not bound to any statutory deadlines – none of them comes close to resolving the current appeals backlog or reducing the multi-year delays in ALJ hearings and decisions. HHS's lack of progress on the underlying backlog distinguishes this case from two cases heavily relied upon by HHS in opposing mandamus. Although mandamus was not granted in either *In re Monroe Communications Corp.*, 840 F.2d 942 (D.C. Cir. 1988) or *In re United Mine Workers of American International Union*, 190 F.3d 545 (D.C. Cir. 1999), in both cases, the court retained jurisdiction to hold the agency to its claims of progress in making the administrative decisions at issue. In *Monroe Communications*, the court explained that "[m]ost importantly" for its ruling, "the proceeding is now moving." *Id.* at 946. In fact, counsel for the FCC "assured [the court] that the outstanding issues will be resolved expeditiously." *Id.* The court held counsel to that promise, retaining jurisdiction over the case until the license at issue was awarded to ensure the FCC "adhere[s] substantially to the schedule it set for itself by its representations . . . through counsel." *Id.* at 947. So too in *United Mine Workers*. 190 F.3d 545. There, the court retained jurisdiction after requiring the agency to file "a definite schedule for [coming into compliance with the deadlines at issue] and an explanation justifying that schedule." *Id.* at 554.

Although HHS both trumpets its efforts and acknowledges their insufficiency, it has failed to take actions that actually can address the delays. In addition to the transfer of funds, deployment of resources, and request for additional appropriations described above, *supra* pp. 16-20, HHS can make policy changes that will stem the tide of new appeals: It can rein in the

Recovery Audit Contractors ("RACs"). Although HHS would have the Court believe that it is a victim of the ALJ crisis, that simply is not true. The circumstances driving the appeals backlog are not "largely beyond HHS's control," as HHS claims. Br. at 2. HHS explains that OMHA's increased workload is attributable to a "combination of factors" including "more beneficiaries; increased utilization of Medicare-covered services . . . ; [and] increased Medicaid State Agency appeals," but the clear root of the problem is "the additional appeals from audits conducted under the RAC Program . . . ," Br. at 6-7 – a factor over which HHS *does* have significant control.

The impact of the RACs on the volume of appeals is undeniable. In fiscal year 2009, the last full fiscal year before the permanent RAC program was instituted, there were 35,831 ALJ appeals. Mot. for Summ. J. Ex. 4 (*Important Notice*). In comparison, in fiscal year 2013, well after the implementation of the RACs, 384,151 appeals were filed at the ALJ level—more than ten times as many as only four years earlier. *Id.*; *see also* Mot. for Summ. J. Ex. 2 (OMHA Forum Presentation) at 17. No other factor cited by the Secretary has anywhere near the same effect on the number of appeals as RAC activities.[7] Even the Chair of the DAB characterizes the unprecedented increase in appeals as due "in large part" to RAC audit activities. Decl. of C. Tobias ¶ 4.

Further, despite HHS's characterization of the RACs as a "critical tool for fighting improper Medicare payments," Br. at 23, the high percentage of RAC claim denials that are overturned on appeal strongly suggests that the RACs have gone far beyond identifying improper

[7] In justifying her fiscal year 2015 budget request to Congress, the Secretary reported that OMHA received only 20,000 appeals of RAC determinations through fiscal year 2009, but in fiscal year 2013, it received 192,000, and projects that it will receive 250,000 annually for the next two years. HHS, OMHA, *Justifications of Estimates for Appropriations Committees, Fiscal Year 2015* 15-16 (2014), *available at* http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf. The Secretary also reported a 317 percent increase in the number of Medicare Part A ALJ appeals received in fiscal year 2013 compared to fiscal year 2012, the "vast majority" of which are due to the RACs. *Id.* at 16.

Medicare payments. According to data provided to Plaintiff AHA through the first quarter of 2014, hospitals reported that RAC denials were overturned sixty-six percent of the time on appeal. Mot. for Summ. J. Ex. 5 (RAC*Trac* Survey) at 4, 55.

If HHS ensured that RAC denials truly represented improper payments, fewer hospitals would appeal to the ALJ level, reducing the influx of appeals at the front-end and preventing further growth of the backlog. The Secretary could restrain the scope of the RACs' auditing approach, which she is well-equipped to do. Congress may have created the RAC program, but it also tasked the Secretary with implementing it. *See* Medicare Modernization Act of 2003, Pub. L. No. 108-173 § 306, 117 Stat. 2066, 2256-57; Pub. L. 109-432, 120 Stat. 2922 (2006) (codified at 42 U.S.C. § 1395ddd). And, recently, Congress itself has urged HHS to "work with providers at the early stages of the audit process so that only a small number of cases are ultimately appealed and the loss of provider time, energy, and resources due to incorrect audit results are limited." Sen. Rep. No. 113-71, at 149 (2013), *available at* http://www.gpo.gov/fdsys/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf.

Plaintiffs do not purport to ask this Court to tell HHS that it must fix the RAC program; but HHS should not be permitted to avoid mandamus by maintaining that the RAC program is not at the root of the problem or that changes to the program would not remedy it. Moreover, reforming the RAC program would provide a long-term solution that would prevent the backlog from recurring in the future. *See* Michelle M. Stein, *MedPAC Takes on Short Hospital Stays, SNF Qualifying Stays, RAC Audits,* Inside Health Policy (Sept. 15, 2014), *available at* http://insidehealthpolicy.com/medpac-takes-short-hospital-stays-snf-qualifying-stays-rac-audits (explaining calls for RAC reform by Medicare Payment Advisory Commissioner, including that "if the RACs aren't reformed, there could be similar problems with the appeals process down the

road"). HHS cannot allow appeals to languish as it refuses to implement a solution that would stem the growing backlog and prevent this crisis from repeating.

## III. THERE IS NO ADEQUATE REMEDY OTHER THAN MANDAMUS.

Mandamus is the only meaningful remedy for HHS's unlawful and egregious delays. In this case, the parties agree that the delays are "substantial," Br. at 1, and further that HHS's current initiatives are "not sufficient" to resolve them, *id.* at 10. HHS has professed a disinclination either to obtain additional funds or to rein in the RACs, Br. at 22-24, and instead is content to condemn hospitals to wait in the years-long line, or consign them to an escalation process that is neither equipped to provide the hearing to which hospitals have a right under the Medicare Act nor to handle the massive backlog of claims. *See* Br. at 27 ("The Medicare statute effectively gives Plaintiffs and other appellants a choice between an ALJ hearing after the current wait time and escalated review without ALJ hearing."). "When the Secretary refuses to perform her statutory duties, mandamus is an appropriate remedy to force her to do so." *Ganem*, 746 F.2d at 854 (granting mandamus relief compelling HHS to "make as expeditious a determination as possible").

As it does in trying to argue that the Medicare Act contains no deadlines for decision, HHS leans heavily on the escalation option in contending that Plaintiffs have an adequate remedy short of mandamus. But escalation is not the panacea HHS presents it to be. In fact, it is no remedy at all for HHS's widespread, egregious, and unlawful delays.

As an initial matter, escalation is not the "exclusive" remedy available to Plaintiffs and other hospitals, as HHS contends. Br. at 26-27. Just as HHS attempts to render mandatory deadlines in the statute permissive, it attempts to render permissive remedies in the statute mandatory. Thus, HHS misleadingly describes the escalation *option* as "the mechanism" for

addressing delays in administrative appeals. Br. at 27. But escalation is entirely at the discretion of the Medicare appellant. If escalation were the exclusive remedy for delays, it would be automatic, or at least at the election of HHS, not Medicare appellants. This Court should not accept HHS's attempt to convert an option intended to protect Medicare appellants into one that prevents them from getting relief.

Escalation also is not adequate under the circumstances here. As HHS recognizes, the escalation process involves forfeiture of the right to a hearing. *See* Br. at 27.[8] HHS's effort to minimize the importance of the hearing is unconvincing. Although it claims that "in Medicare payment appeals, the determination typically does not involve questions of credibility and veracity," Br. at 28, just five pages earlier in its brief, HHS argues that Medicare is "dependent on . . . presumed honesty and accuracy of providers of services," *id.* at 23. Without a hearing, at which hospitals can demonstrate the credibility and veracity of their claims through the oral testimony of clinicians, HHS has no meaningful way in which to judge a claim's legitimacy.

As Plaintiffs have demonstrated – without meaningful rebuttal by HHS – an oral hearing is critical. It provides hospitals "the opportunity to present testimony based on clinical factors that are critical to accurate decisions in denial of complex hospital claims." Decl. of I. Holleman ¶ 12. Moreover, hospitals can respond to questions posed by the ALJ in real-time and explain the written materials in the record. Decl. of J. Geppi ¶ 14. Prior to this litigation, HHS *itself* agreed that escalation would require an appellant to lose something of value: When first implementing the new appeals provisions required by Congress, it cautioned appellants to

[8] Confusingly, HHS also contends that "Plaintiffs' assertion that they must forego a hearing if they escalate their claim to the Appeals Council level or to district court is also incorrect." Br. at 28. However, this argument appears directed to whether the loss of that hearing nonetheless comports with due process. Although HHS half-heartedly holds open the possibility that the DAB could conduct a hearing, *id.*, it does not dispute that the DAB has stated it will not do so, *see* Def's Resp. to Pls.' Statement of Undisputed Material Facts in Support of Mot. for Summ. J., Statement 32.

"carefully consider the type of review that is best to resolve their case before deciding to escalate an appeal" and noted that "when a case is escalated from the ALJ level to the MAC, an appellant will *lose the right* to present his or her case during an oral hearing." 67 Fed. Reg. at 69,329 (emphasis added).

HHS also does not dispute that "hospitals are most likely to succeed in their appeals at the ALJ level," although it misattributes the reason for that result. Br. at 31. Only a fraction of Medicare Part A claims denials are overturned by the Medicare Administrative Contractor ("MAC") or the Qualified Independent Contractor ("QIC") at the lower levels of appeal.[9] By contrast, OMHA reported that in fiscal year 2013, nearly half of the Medicare claims appealed to the ALJ level were overturned in whole or in part. *See* OMHA, Decision Statistics, http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html (last visited Oct. 2, 2014).

In fact, beneficiaries, whose appeals HHS claims to have prioritized, Br. at 2, have filed a putative class action to address delays in the Medicare appeals process, in which they note that "[o]ver the last five years, the rates at which redetermination and reconsideration decisions have reversed denials of coverage have been falling dramatically and are now usually at 5% or less." *Lessler, et al. v. Burwell*, No. 3:14-CV-1230-JAM (D. Conn.), Compl. ¶ 24 [DE 1], *available at* http://www.medicareadvocacy.org/wp-content/uploads/2014/08/00083998.pdf. At the ALJ level, by contrast, "denial of coverage is generally reversed at least half the time." *Id.* ¶ 26 (citing OIG (HHS), *Improvements Are Needed at the Administrative Law Judge Level of*

[9] MACs issued unfavorable redetermination decisions in approximately eighty-one percent of appealed Part A claim denials in 2013 and the QIC issued unfavorable reconsideration decisions in approximately eighty-five percent of Part A appeals in 2013. *See* CMS, Original Medicare Fact Sheet for 2013, *available at* http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/ReconsiderationbyaQualifiedIndependentContractor.html (click to download Appeals Fact Sheets) (last visited Oct. 2, 2014).

*Medicare Appeals*¸OEI-02-10-00340 (Nov. 2012), at 10, for the proposition that in fiscal year 2010, sixty-two percent of all ALJ decisions on home health and hospice claims were fully favorable).

HHS also has no answer for the obvious inadequacy of escalation in light of the nearly one million claim appeals at issue here. Despite professing its own inability to wade through the backlog of appeals when that argument suits its purposes, HHS ignores the reality of what would occur if all of those cases were escalated. By HHS's own account, the DAB is in no better position to adjudicate Plaintiff hospitals' claims than are the ALJs. As HHS itself admits, "the size of the DAB case backlog at the end of fiscal year 2013 was 5,108 cases." Decl. of C. Tobias ¶ 3. The DAB "expects to receive between 4,000 and 5,000 Medicare appeals in fiscal year 2014." *Id.* "As a result of the lack of resources to address the current volume of appeals, the DAB is unlikely to meet the 90-day timeframe for issuing decisions in most appeals." Br. at 11. HHS thus offers the false "remedy" of an escalation process that will only move claims from the ALJ line to the back of the DAB line – and forfeit the hearing in the process. It provides no explanation for how a move from one stagnant queue to the next constitutes an "adequate" remedy for HHS's failure to provide a hearing and decision by an ALJ within the statutory timeframe.

Escalation from the DAB, in turn, risks flooding the federal courts, an expensive proposition for both the hospitals and the judiciary. And HHS either misunderstands or simply ignores Plaintiffs' argument regarding the inadequacy of federal court escalation. Plaintiffs explained that escalation to federal court is essentially untenable in the vast majority of cases because the costs associated with pursuing a claim in federal court very often exceed the dollar value of the claims themselves. HHS's response that escalation from the *ALJ* level to the *DAB*

level allows aggregation of claims misses the mark. Br. at 29. It does not even attempt to address the real problem presented by Plaintiffs: That the costs and time required to pursue federal litigation would render it infeasible for most providers and suppliers in most cases. *See* Decl. of I. Holleman ¶ 13; Decl. of J. Geppi ¶ 15; Decl. of J. Wallace ¶ 16.

In short, HHS offers no scenario in which Plaintiffs and other hospitals receive timely adjudications of their Medicare claims. HHS's "tough luck" proposal to keep Medicare appellants in one line or another until HHS happens to decide their claims not only is inadequate, but it is also precisely the type of situation in which court intervention through mandamus is warranted.

## CONCLUSION

For the foregoing reasons, Defendant's Motion to Dismiss should be denied and Plaintiffs' Motion for Summary Judgment should be granted.

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Respectfully submitted,

/s/ Adam K. Levin
Sheree R. Kanner (D.C. Bar No. 366926)
Mitchell E. Zamoff (D.C. Bar No. 439383)
Adam K. Levin* (D.C. Bar No. 460362)
Rebecca C. Mandel (D.C. Bar No. 976808)
Jaclyn L. DiLauro (D.C. Bar No. 1010951)
Hogan Lovells US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600

** Counsel of Record*

Melinda Reid Hatton (D.C. Bar No. 419421)
Lawrence Hughes (D.C. Bar No. 460627)
American Hospital Association
800 Tenth Street, N.W.
Two CityCenter, Suite 400
Washington, D.C. 20004
(202) 638-1100

*Attorneys for Plaintiffs*