IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

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

PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES
IN OPPOSITION TO DEFENDANT'S MOTION FOR STAY

Catherine E. Stetson (D.C. Bar No. 453221)
Sheree Kanner (D.C. Bar No. 366926)
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
Tel. (202) 637-5600
Fax (202) 637-5910
cate.stetson@hoganlovells.com

Dated: June 13, 2016

Counsel for Plaintiffs

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTRODUCTION 1

BACKGROUND 2

ARGUMENT 6

I. The Secretary Has Not Demonstrated That Any Serious Harm Would Occur Absent A Stay 6

II. A Stay Would Be Inconsistent With The Court Of Appeals' Opinion And The Balance Of Interests 7

CONCLUSION 15

CERTIFICATE OF SERVICE

TABLE OF AUTHORITIES

Page(s)

CASES:

Am. Hosp. Ass'n v. Burwell,
76 F. Supp. 3d 43 (D.D.C. 2014) 3

* *Am. Hosp. Ass'n v. Burwell*,
812 F.3d 183 (D.C. Cir. 2016) .... *passim*

Doe v. Sipper,
869 F. Supp. 2d 113 (D.D.C. 2012) 6

King v. Burwell,
No. 14-114, 2015 WL 916473 (Mar. 4, 2015) (U.S.) 10

Landis v. N. Am. Co.,
299 U.S. 248 (1936) 6, 7

Telecomm. Research & Action Ctr. v. FCC,
750 F.2d 70 (D.C. Cir. 1983) 3, 6

Wrenn v. Dist. of Columbia,
No. CV 15-162, 2016 WL 1555675 (D.D.C. Apr. 15, 2016) 6, 9

STATUTES & LEGISLATION:

42 U.S.C. § 1395ddd(h) 13

42 U.S.C. § 1395ff(a)(3)(C)(ii) 2

42 U.S.C. § 1395ff(c)(3)(C)(i) 2

42 U.S.C. § 1395ff(d)(1)(A) 2

42 U.S.C. § 1395ff(d)(2)(A) 3

Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015,
S. 2368, 114th Cong. (2015) 11, 12

OTHER AUTHORITIES:

American Hospital Association, *Trendwatch Chartbook 2013: Trends Affecting Hospitals and Health Systems* (2013) 14

HHS, *Office of Medicare Hearings and Appeals (OMHA): Current Workload – Decision Statistics* (May 4, 2016) 4

TABLE OF AUTHORITIES – CONTINUED

Page(s)

HHS, *Office of Medicare Hearings and Appeals (OMHA): Requests Submitted After April 1, 2013—Deferred Assignment Filing Alert for Requests and Additional Documentation* (Apr. 29, 2015) 5

HHS FY 2017 Budget in Brief (Feb. 16, 2016) 11

Office of the Inspector General, HHS, *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness* (Oct. 2013) 10

Senate Committee on Appropriations, *FY2017 Labor, HHS & Education Appropriations Bill Cleared for Senate Consideration* (June 9, 2016) 11, 12

United States Government Accountability Office, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process* (May 2016) 5, 10, 11

INTRODUCTION

The Secretary's motion to stay is nothing if not bold. On appeal from this Court's initial denial of mandamus relief, the Court of Appeals held that the Secretary of Health and Human Services (HHS) had violated her "clear duty . . . to comply with the statutory deadlines" for adjudicating hospitals' Medicare claim appeals. *Am. Hosp. Ass'n v. Burwell*, 812 F.3d 183, 192 (D.C. Cir. 2016). The Court of Appeals remanded with instructions for this Court "to consider the problem as it now stands," *id.* at 185, and to assess whether the necessary conditions for a writ of mandamus "now exist," *id.* at 192. It further indicated that, given the Secretary's blatant statutory violation, it would be "appropriate" for mandamus to issue unless this Court were to "determine[] on remand that Congress and the Secretary are making significant progress toward a solution" to the egregious delays in processing the appeals. *Id.* at 193.

In response, the Secretary has sought a *fifteen-month*-plus stay of these proceedings. She insists that HHS and Congress are indeed making "significant progress" and asks this Court for a stay through September 30, 2017 to allow those efforts to bear fruit (although magnanimously offering to submit status reports every six months). The "significant progress" the Secretary touts is a fiction. The delays continue to worsen even now, and the Secretary has neither developed nor even offered any realistic plan for resolving the backlog of appeals. Instead, the Secretary enumerates a hodgepodge of administrative initiatives that, even according to HHS's *own* best estimates, will not allow the Secretary to come close to meeting the mandatory statutory deadlines. And the stalled legislative proposals in which she places so much stock are virtually assured never to become law. Such half-measures and vain hopes hardly constitute the "significant progress" the Court of Appeals' opinion requires.

This Court should see the Secretary's stay motion for what it is: an attempt to turn the Court of Appeals' demand for action into a license for further delay. Granting the Secretary's request would contravene the Court of Appeals' mandate and the balance of interests, which favors the hospitals struggling to provide adequate patient care while millions of dollars in Medicare reimbursement remain tied up in an endless appeals process.

The Secretary's motion does, however, make at least one thing clear: Absent a court order, HHS remains unwilling to take the immediate, concrete, and feasible steps necessary to bring itself into compliance with the statutory deadlines. A writ of mandamus is thus the only way to effectuate the Court of Appeals' mandate that the Secretary "obey the law" and resolve Medicare claim appeals by the statutorily prescribed deadlines. 812 F.3d at 193.

The Secretary's motion should be denied, and mandamus should issue.

BACKGROUND

The plaintiff hospitals, joined by the American Hospital Association (AHA), brought this mandamus action to require the Secretary to resolve the massive delays plaguing the Medicare appeals process. As this Court is aware, the Medicare Act establishes four levels of administrative appellate review for the denial of claims submitted by Medicare providers and suppliers. Each of those levels of review must be completed within a statutorily defined period: (1) redetermination by a Medicare Administrative Contractor (MAC), which must be completed within sixty days, 42 U.S.C. § 1395ff(a)(3)(C)(ii); (2) reconsideration by a Qualified Independent Contractor (QIC), which also must generally be completed within sixty days, *id.* § 1395ff(c)(3)(C)(i); (3) a hearing by an Administrative Law Judge (ALJ) in HHS's Office of Medicare Hearings and Appeals (OMHA), which generally must be completed within ninety days, *id.* § 1395ff(d)(1)(A); and (4) review by the Medicare Appeals Council within the

Departmental Appeals Board (DAB), which must be completed within ninety days, *id.* § 1395ff(d)(2)(A). While acknowledging that Medicare claim appeals were taking far longer than these mandated periods, this Court dismissed Plaintiffs' complaint for lack of jurisdiction. *Am. Hosp. Ass'n v. Burwell*, 76 F. Supp. 3d 43 (D.D.C. 2014).

The Court of Appeals reversed, holding that the complaint satisfied the threshold requirements for mandamus jurisdiction because the Secretary had a "clear duty" to comply with the statutory deadlines and was flagrantly violating that duty. *See Am. Hosp. Ass'n*, 812 F.3d at 190-192. The Court of Appeals remanded the case for this Court to determine in the first instance whether equitable considerations warrant issuance of mandamus. *Id.* at 192.

The Court of Appeals did, however, identify a number of factors that should guide this Court's analysis. On the one hand, it noted the desirability of a political resolution. *Id.* at 192-193. On the other hand, it identified "several significant factors" that favor immediate relief. *Id.* at 193. The first was the "real impact" the delays were having on "human health and welfare." *Id.* (quoting *Telecomm. Research & Action Ctr. v. FCC*, 750 F.2d 70, 80 (D.C. Cir. 1984) (*TRAC*)). The second—which the Court of Appeals pronounced "critical[] to [its] thinking about this case"—was the fact that the Secretary has "substantial discretion" over the Medicare Recovery Audit Program and the recovery audit contractors (RACs) who administer it. *Id.* That meant that the RAC program might ultimately have to yield to the statutory deadlines, as "congressionally imposed mandates and prohibitions trump discretionary decisions." *Id.*

The Court of Appeals suggested that this Court—"more than a year after its first denial and with the problem only worsening—might find it appropriate to issue a writ of mandamus ordering the Secretary to cure the systematic failure to comply with the deadlines." *Id.* And even that discretion had limits: The court further explained that the "clarity of the statutory duty

likely will *require* issuance of the writ" if the political branches failed to make "meaningful progress" in reducing the backlog "within a reasonable period of time—say, the close of the next full appropriations cycle." *Id.* (emphasis added). After all, while it might perhaps be "ideal[]" for the political branches to resolve the problem, "[f]ederal agencies must obey the law," and the judiciary's "ultimate obligation is to enforce the law as Congress has written it." *Id.*

The Court of Appeals instructed this Court, in deciding whether to grant the writ, to take account of the fact that "the situation has worsened" since the initial denial of mandamus relief. *Id.* at 192. That was four months ago. Since early February of this year, the situation has worsened further still; indeed, in the second quarter of this year, the state of affairs at OMHA reached a new low. The ALJ hearings that, under the Medicare Act, must be completed within 90 days are now taking an average of 860.6 days. HHS, *Office of Medicare Hearings and Appeals (OMHA): Current Workload – Decision Statistics* (May 4, 2016), http://www.hhs.gov/omha/Data/Current%20Workload/index.html. That means appeals that should clear the entire third level of OMHA review within three months are stuck there for nearly two-and-a-half years—sometimes longer, since this number (as astounding as it is) is only the average. That is 2.5 times as long as the *entire appeals process* should take under the statute. *See Am. Hosp. Ass'n*, 812 F.3d at 186 (noting that the entire appeals process should be completed "within about a year"). And the flood of new appeals has by no means abated: HHS reports that, "[a]s of March 31, 2016, OMHA was receiving approximately 3,500 new appeals per week, and the [DAB] was receiving approximately 250 new appeals per week." Decl. of Ellen Murray

("Murray Decl.") ¶ 8, ECF No. 30-1. In the meantime, the Secretary's 2013 decision suspending by more than two years the mere assignment of appeals to ALJs remains in full effect.[1]

As the Court of Appeals recognized, the RAC program is a primary culprit in creating and sustaining this still-swelling backlog of appeals. *See Am. Hosp. Ass'n*, 812 F.3d at 186. The Secretary attempts to downplay the RAC program's role, noting, among other things, the large increase in the number of individual Medicare beneficiaries in recent years. Murray Decl. ¶ 10. But a recent report from the Government Accountability Office (GAO)—aptly titled "Opportunities Remain to Improve Appeals Process"—shows that RAC-related appeals outnumber beneficiary appeals by almost 100 to 1 at the ALJ level. *See* United States Government Accountability Office, *Medicare Fee-for-Service: Opportunities Remain to Improve Appeals Process* 61 (May 2016) (hereinafter *GAO Report*). In 2014, the latest year for which data were available, beneficiaries appealed only 2,962 claims to the ALJ level; in the same year, 219,850 RAC-related claims were appealed. *Id.*

Moreover, while RAC-related appeals may account for a somewhat smaller share of incoming appeals so far this fiscal year, Murray Decl. ¶ 15, that is not likely to be a lasting trend, given that HHS "expects the number of incoming appeals to increase again when new [RAC] contracts are awarded and the [RAC] program resumes full operation." *GAO Report* 38. Nor does the statistic account for all of the appeals generated by other Medicare contractors, whose decisions exhibit many of the same pathologies as those made by RACs. *See* Murray Decl. ¶ 16.

Meanwhile, there has been zero progress on the legislative front since the Court of Appeals' decision. No great surprise there; like the staggering backlogs in the appeals process,

---

[1] *See* HHS, *Office of Medicare Hearings and Appeals (OMHA): Requests Submitted After April 1, 2013—Deferred Assignment Filing Alert for Requests and Additional Documentation* (Apr. 29, 2015), http://www.hhs.gov/omha/important_notice_regarding_adjudication_timeframes.html#requests.

the lack of any real progress on the legislative front has remained constant since this suit was filed more than two years ago.

There has been one other constant: The plaintiff hospitals continue to have millions of dollars tied up in the appeals process, leaving hospitals to make do with insufficient resources and their employees and patients to pay the price.

ARGUMENT

I. The Secretary Has Not Demonstrated That Any Serious Harm Would Occur Absent A Stay.

"To prevail on a motion to stay, the movant needs to satisfy a high burden." *Doe v. Sipper*, 869 F. Supp. 2d 113, 116 (D.D.C. 2012) (citing *Landis v. N. Am. Co.*, 299 U.S. 248, 254-255 (1936)). Specifically, "a party requesting a stay of proceedings 'must make out a clear case of hardship or inequity in being required to go forward, if there is even a fair possibility that the stay for which he prays will work damage to some one else.' " *Wrenn v. Dist. of Columbia*, No. CV 15-162, 2016 WL 1555675, at *1 (D.D.C. Apr. 15, 2016) (quoting *Landis*, 299 U.S. at 255).

Here, there is a certainty—not just a "fair possibility"—that a stay would "work damage" to the plaintiff hospitals and the patients they serve. "The Secretary, of course, does not dispute that the backlog has resulted in an adverse impact on some hospitals' interests." Def.'s Mot. for Stay & Mem. of Points & Authorities in Supp. ("HHS Mem.") 11, ECF No. 30. That is an understatement. As the Court of Appeals found, "the record demonstrates that the delays are having a real impact on 'human health and welfare.' " *Am. Hosp. Ass'n*, 812 F.3d at 193 (quoting *TRAC*, 750 F.2d at 80). The court considered those effects "unsurprising" and "common sense." *Id.* Prolonging these proceedings would only compound the harm, forcing the hospitals to (among other things) forgo additional essential improvements to their facilities. Common sense dictates as much.

On the other side of the balance, the Secretary has not made a "clear case of hardship or inequity in being required to go forward." *Landis*, 299 U.S. at 255. Indeed, she has not made any case at all on that front. If one can construe the Secretary's motion to allege any "hardship or inequity" at all, it appears to stem from the judiciary's supposedly precipitous interference with HHS's and Congress's initiatives to address the delays in adjudicating Medicare claim appeals. But many of those initiatives show no signs of ever coming to fruition, and those few that have been implemented are wholly inadequate to the task of ensuring HHS's compliance with the statutory deadlines. The Court of Appeals raised the possibility of deferring issuance of mandamus so that the political branches might reach an accommodation that would allow HHS to comply with "the law as Congress has written it," *Am. Hosp. Ass'n*, 812 F.3d at 193, not to license HHS to continue violating the law for another year and a half. The Secretary has not met her "high burden" for obtaining a stay.

II. A Stay Would Be Inconsistent With The Court Of Appeals' Opinion And The Balance Of Interests.

The Secretary's motion to stay depends on a fundamental misconception of the Court of Appeals' opinion: that the Court of Appeals invited a stay by stating that the political branches' efforts should be evaluated at "the close of the next full appropriations cycle." *See* HHS Mem. 8-9 (quoting *Am. Hosp. Ass'n*, 812 F.3d at 193). The Court of Appeals said nothing of the sort. What it actually said is that this Court should consider *now* whether to exercise its discretion to grant mandamus. *Am. Hosp. Ass'n*, 812 F.3d at 185 ("[W]e reverse and remand with instructions to the district court to consider the problem as it now stands—worse, not better."); *id.* at 192 ("On remand, the district court should determine whether 'compelling equitable grounds' now exist to issue a writ of mandamus."). The Court of Appeals acknowledged that this Court "might find it appropriate to issue a writ of mandamus" immediately. *Id.* at 193. It then set as an outer

boundary the very latest point at which mandamus should issue, explaining that mandamus would "likely [be] require[d]" if there is no "meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle." *Id.*

That outer boundary does not mean that HHS gets a free pass until October 2017, while lobbing in a semiannual status report. It means that HHS must at least achieve "meaningful progress" within that time period. Nothing in the Secretary's motion suggests that HHS has any plans to do so. The Secretary identifies various administrative initiatives and legislative proposals that, she contends, in combination "are expected to reduce the number of pending OMHA cases to 50,000 by the end of FY 2020, and to completely eliminate the backlog by FY 2021." HHS Mem. 6-7. But even by the Secretary's own description, her current administrative measures will still leave what the Assistant Secretary in her declaration candidly describes as a "cumulative backlog" of over *one million* appeals in 2020—a backlog that in fact *grows* from 2016 onward. *See* Murray Decl. Ex. 1. And the legislative half of the plan is fanciful: There is virtually no chance that the legislative proposals will become law, much less during the period for which the Secretary seeks a stay. Staying these proceedings until October 2017, when the Secretary's own administrative projections still leave a massive unresolved backlog and when legislative help is nowhere to be found, would make a mockery of the "meaningful progress" that the Court of Appeals required to forestall issuance of mandamus. *Am. Hosp. Ass'n*, 812 F.3d at 193. That is especially so when there are a number of alternatives available that *would* allow HHS to make truly "meaningful progress."

1. Many of the administrative initiatives outlined in Assistant Secretary Murray's declaration come with a crucial caveat: "[I]t is not currently possible to quantify the extent of their impact." Murray Decl. ¶ 21. In other words, HHS has no idea whether they will actually

reduce the delays in processing Medicare claim appeals, let alone by how much. Still others are limited experiments—"demonstrations," in HHS's bureaucratic jargon. *Id.* ¶ 19(c), (d). And in the case of one of those demonstrations, HHS concedes that it "is not in a position at this time . . . to determine how quickly or to what extent the demonstration should be expanded"—that is, whether it is actually working and will be put into practice. *Id.* ¶ 19(d)(iii). The required "clear case" for a stay, *Wrenn*, 2016 WL 1555675, at *1 (citation omitted), cannot be based on such rank speculation.

As for the other administrative initiatives discussed in the Assistant Secretary's declaration, HHS's own estimates make clear that they will fall woefully short of achieving full compliance with the statutory deadlines. Some are aimed at reducing the number of new appeals filed or allowing OMHA to process more appeals; others seek to reduce the existing backlog. But in all events, HHS's own data show that, even assuming every initiative comes to fruition and goes according to plan, there will *still* be a backlog of more than *one million* appeals in fiscal year 2020, Murray Decl. Ex. 1—i.e., three years *after* the end of the period for which the Secretary seeks a stay. In other words, far from impelling the Secretary to meet her statutory obligations, the Secretary's chosen administrative measures would leave HHS in 2020 with a larger backlog than the one it faces today. To make matters worse, that projected backlog will *grow* by hundreds of thousands of appeals between 2016 and 2020. *Id.* Even if the backlog might have been larger still absent HHS's administrative measures, that is not the gauge for success under the Court of Appeals' mandate; an ever-growing backlog of over one million appeals does not constitute "meaningful progress" toward the goal of meeting the statutory deadlines.

There is, moreover, reason to doubt some of HHS's sanguine estimates regarding the impact of its initiatives on the backlog. For example, HHS says it will modify its RAC program contracts to "pay [RACs] only after a reconsideration decision by a QIC at the second level of appeal if the [RACs'] decisions are upheld at that level, or after the timeframe to file an appeal at the second level has expired." Murray Decl. ¶ 19(b). It anticipates that this change will contribute to a reduction in the number of appeals that reach OMHA of "more than 22,000 appeals." *Id.* That assumes, however, that the QICs provide a meaningful check on RACs. In fact, HHS's own data show that QICs basically rubber-stamp the RACs' decisions. *See* Office of the Inspector General, HHS, *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness* 26-28 tbls. A3-A11 (Oct. 2013).[2] In 2014, for example, QICs upheld the RACs' Medicare Part A decisions almost 80% of the time, compared to the RACs' meager 42% success rate before ALJs. *GAO Report* 67, 70. There is thus little reason to expect that this proposed change will deter RACs from continuing to improperly deny claims. Even the underwhelming predicted benefits of HHS's administrative measures, then, may be overstated.

2. Given the fact that HHS's administrative initiatives come up so short, the motion to stay makes clear that the Secretary is depending primarily on Congress to swoop in and fix the problem. *See* HHS Mem. 9. But this Court should greet that Pollyannish strategy with the skeptical response the Solicitor General offered to the suggestion that Congress could fix a defect in the Affordable Care Act: "[T]his Congress . . . [?]" Tr. of Oral Arg., *King v. Burwell*, No. 14-114, 2015 WL 916473, at *55 (Mar. 4, 2015).

---

[2] *See* http://oig.hhs.gov/oei/reports/oei-01-12-00150.pdf.

The Secretary identifies two legislative proposals—the President's budget for fiscal year 2017 and the Senate bill known as the Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015 ("AFIRM Act"), S. 2368, 114th Cong. (2015). These are the same legislative solutions it has hoped for before, *see* Br. for Appellee 11, 14, *Am. Hosp. Ass'n*, 812 F.3d 183 (No. 15-5015), with an updated fiscal year. But neither promises any realistic progress in reducing the backlog in Medicare claim appeals. The President's fiscal year 2017 budget request for OMHA proposes to increase OMHA appropriations by only $13 million, from $107 million to $120 million. *See HHS FY 2017 Budget in Brief* (Feb. 16, 2016), http://www.hhs.gov/about/budget/fy2017/budget-in-brief/omha/index.html. It also includes a legislative package that would allow HHS to use RAC collections—an anticipated $125 million annually—to supplement those appropriations. *Id.* By the Secretary's own admission, those additional resources would allow OMHA to adjudicate only 101,000 more appeals each year. Murray Decl. ¶ 22(b). That is not nearly enough to address the backlog, given that more than 240,000 new appeals were filed in fiscal year 2015 *alone*. *Id.* Ex. 1. In other words, even if the President's request were granted in full, the backlog would not only remain unaddressed; it would continue to *grow* by more than 100,000 appeals each year. Indeed, the GAO recently confirmed as much, observing that the requested $20 million appropriation increase for fiscal year 2016 was "unlikely to mitigate the growing appeals backlog." *GAO Report* 38.

The actual appropriation, moreover, will almost certainly be even less than the President's modest request. Rather than appropriating the $120 million requested, the Senate will consider an appropriations bill that allocates only $112.4 million to the Medicare appeals process, a scant $5.4 million more than the current appropriation. Senate Committee on Appropriations, *FY2017 Labor, HHS & Education Appropriations Bill Cleared for Senate*

Consideration 5 (June 9, 2016).[3] And that is assuming an appropriations bill is in fact passed. With only about 50 and 65 days remaining in the respective House and Senate calendars this year, a lame-duck Administration, and a contentious election in full swing, this Court should not await the conclusion of an appropriations process that will do little to address the backlog in appeals—if it does anything at all.

The Senate's AFIRM Act provides no stronger grounds for a stay. For one thing, it would be no panacea: The Secretary's own statistics show (again) that, even if enacted in its current form, the bill would leave a substantial backlog. Murray Decl. Ex. 1. In any event, as the Court of Appeals observed, "the bill remains only a bill." *Am. Hosp. Ass'n*, 812 F.3d at 188. It has made zero "progress," *id.* at 193, in the Senate since it was introduced in that chamber on December 8, 2015. The Court of Appeals may have hoped for action after two months of waiting; this Court should be less hopeful after more than six. And for many of the same reasons that OMHA is unlikely to obtain its fiscal year 2017 budget request, it is highly unlikely that the AFIRM Act will be enacted during the period for which the Secretary seeks a stay—a period that includes a presidential election campaign, a lame-duck session of Congress, and a new President's initial push to enact his or her top legislative priorities. The AFIRM Act is simply too speculative a basis for delaying issuance of mandamus.

3. Finally, the Secretary insists that "a denial of the stay would not meaningfully address the harm that some hospitals may be experiencing; the political branches are proceeding as expeditiously as possible to address the backlog." HHS Mem. 11. Not so. If this Court grants mandamus relief, the Secretary would presumably employ all available solutions to comply with a court order. For more than two years now, the AHA has identified multiple

[3] *See* http://www.appropriations.senate.gov/imo/media/doc/060916-FY17-LaborHHS-Approps-Full-Committee-Markup-Summary-Web.pdf.

solutions that would go a long way toward eliminating the backlog or at least mitigating the financial strain the prolonged delays impose on hospitals. *See* Pls.' Mem. of Points & Authorities in Supp. of Mot. for Summ. J. 24-25 (July 11, 2014), ECF No. 8; Resp. in Supp. of Pls.' Mot. for Summ. J. 22-24 (Oct. 2, 2014), ECF No. 15; Br. for Appellee 11, 14, *Am. Hosp. Ass'n*, 812 F.3d 183 (No. 15-5015). With the exception of seeking some additional funding from Congress, the Secretary has pursued none of them.[4]

The simplest and broadest-sweeping solution might be settlement. The Secretary could offer broader settlements of claims for hospitals and other Medicare providers and suppliers, which could eliminate hundreds of thousands of appeals in short order. But the settlements that she has already offered have been remarkably limited. *See* Murray Decl. ¶ 19(a).

Critically, too, the Secretary has made no meaningful effort to reform the RAC program. As the Court of Appeals recognized, Congress "has left [the Secretary] with substantial discretion to implement [the program] and determine its scope." *Am. Hosp. Ass'n*, 812 F.3d at 193 (citing 42 U.S.C. § 1395ddd(h)). She could exercise that discretion by imposing a financial penalty on RACs when a denial is overturned on appeal. Or she could require a physician to review and approve all complex review denials by RACs. Or she could promulgate regulations permitting RACs to consider only the evidence available to the treating physician at the time of treatment.

And even if the Secretary did not make substantive changes to the operation of the RAC program, she could at least mitigate the harm caused to hospitals by the egregious delays. To name just a couple of examples, she could wait until an ALJ decision to assess interest on claims

---

[4] And the Secretary only half-heartedly pursued even that single course of action. The Secretary has not reprogrammed 2016 funds. Nor has she requested supplementary 2016 appropriations. Nor has she supplemented the 2017 budget request in hearings before Congress.

that were paid but later denied by RACs or other contractors. She also could allow hospitals to delay repayment of disputed claims until an adverse ALJ decision—a form of relief that would be particularly welcomed by the almost 30% of hospitals operating with negative margins. *See* American Hospital Association, *Trendwatch Chartbook 2013: Trends Affecting Hospitals and Health Systems* 39, chart 4.1 (2013), http://www.aha.org/research/reports/index.shtml.

These are only a handful of the options available to—but thus far forgone by—the Secretary. Her plea that she is doing the best she can rings hollow.

But even taking the Secretary's professions of diligence at face value, the Court of Appeals already rejected her contention that insufficient resources can excuse compliance with the statutory deadlines. Those deadlines, the court held, "dictate that the Secretary will have to curtail the RAC program or find some other way to meet them" if HHS's other initiatives come up short and if Congress does not come through with the necessary additional funding. *Am. Hosp. Ass'n*, 812 F.3d at 193.

The time has come. HHS's own data make clear that its initiatives will not come close to eliminating the backlog, and there is no realistic prospect of significant congressional action anytime soon. The Secretary cannot continue to defer compliance with her legal obligations through illusory promises of "progress," especially in the face of significant, ongoing harm to the plaintiff hospitals and their patients. Semiannual status reports will do nothing to ameliorate that harm.

The Secretary has not made the requisite "clear case" for a stay. And given her failure to come forward with a plan for "meaningful progress," the appropriate course is to grant the writ. *Id.*

CONCLUSION

For the foregoing reasons, the Secretary's motion for a stay should be denied and mandamus should issue.

Respectfully submitted,

/s/ Catherine E. Stetson
Catherine E. Stetson (D.C. Bar No. 453221)
Sheree Kanner (D.C. Bar No. 366926)
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
Tel. (202) 637-5600
Fax (202) 637-5910
cate.stetson@hoganlovells.com

Dated: June 13, 2016

Counsel for Plaintiffs

CERTIFICATE OF SERVICE

I hereby certify that on June 13, 2016, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system.

/s/ Catherine E. Stetson
Catherine E. Stetson