UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION, *et al.*, Plaintiffs, v. SYLVIA M. BURWELL, in her official capacity as Secretary of Health and Human Services, Defendant.	Civil Action No. 14-cv-00851 (JEB)

DEFENDANT'S MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF HER MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

This case now stands in a significantly different posture than it did when the Secretary briefed her motion to stay. The Secretary explained in her stay briefing that, at that time, she could not provide estimates for the effect that some of her new measures would have on the backlog of Medicare appeals pending before the Office of Medicare Hearings and Appeals (OMHA). But now her initiatives have started taking effect, and that effect can be more accurately measured. The Secretary, moreover, has added powerful new measures in the meantime and is working on more. As a result, the backlog is finally decreasing, and at a rate that substantially exceeds the Department of Health and Human Services' (HHS) previous projections. With Congressional action, the backlog will continue to decrease until it is eliminated completely by the end of fiscal year (FY) 2019, two years earlier than it previously projected. Another significant change is that Recovery Audit Contractor (RAC)-related appeals accounted for only 9.5% of appeals filed with OMHA in FY 2016, compared to 50.3% in FY 2013.

Because HHS has implemented multiple measures to combat the backlog and is working to add more while the Audit & Appeal Fairness, Integrity, and Reform in Medicare (AFIRM) bill remains pending, the Secretary respectfully submits that the Court should not take the extraordinary step of issuing a writ of mandamus. In the event that the Court nevertheless decides to issue the writ, it should craft an order of remedies that does not conflict with statutory restrictions on the Medicare program and does not jeopardize the Medicare Trust Funds. The Secretary's initiatives satisfy both criteria. Plaintiffs' proposed initiatives, in contrast, do not.

BACKGROUND

The size of the OMHA backlog has decreased markedly since the Secretary moved for a stay in the spring.[1] As set forth in the Supplemental Declaration of Ellen Murray, Assistant Secretary for Financial Resources and Chief Financial Officer of HHS, the agency estimates that there has been a nearly 26% reduction in the number of pending appeals over the course of FY 2016 (658,307 appeals pending at the end of FY 2016 as compared to 886,418 at the beginning of FY 2016) as a result of HHS' administrative measures. Supplemental Murray Decl. ¶ 3 (attached hereto as Ex. 1). HHS projects that at the end of FY 2017, there will have been a nearly 37% reduction in the backlog as compared to the beginning of FY 2016 (560,663 appeals pending at the end of FY 2017 as compared to 886,418 at the beginning of FY 2016). *Id*. And HHS now estimates that, with the combination of administrative and legislative measures, the backlog will be eliminated completely by the end of FY 2019, not FY 2021 as projected at the time of Ms. Murray's declaration in the spring. *Id.* ¶ 2. The statistics that Plaintiffs cite are from July and do not reflect the recent decline in the backlog that HHS now can measure. Pls.' Mot. for Summ. J. at Mem. of Points and Authorities in Supp. (Pls.' Mot.) at 4, ECF No. 39 (Oct. 14, 2016).

HHS' strategy of targeting initiatives to the largest classes of appellants is efficiently eliminating substantial parts of the existing backlog by both resolving pending claims and stemming the flow of incoming appeals. The Centers for Medicare & Medicaid Services (CMS) has revised its projections of the impact of the 2014 hospital settlements of inpatient claims. CMS now projects that the settlements removed 288,726 appeals from OMHA's docket—30,380 more than previously projected. *Id.* ¶ 12. The recently announced reopening of the hospital

[1] The procedural background of this action is set forth in the Court's September 19, 2016 Memorandum Opinion. ECF No. 38.

settlement offer for inpatient status claims is projected to resolve another large swath of the backlog—approximately 95,000 currently pending appeals. *Id.* OMHA is also expanding its Settlement Conference Facilitation by adding 11 trained facilitators before the end of the calendar year and is planning additional expansions to encompass additional appellants and claim types.[2] *Id.* ¶ 14. Ms. Murray explains that HHS is currently targeting State Medicaid Agency appeals, which make up a considerable portion of the backlog, for resolution through another expansion of the existing Settlement Conference Facilitation project, and HHS estimates that this initiative could reduce the appeals backlog by at least 55,000 appeals as of early calendar year 2017. *Id.* ¶¶ 15-16.

CMS' efforts to decrease the number of incoming RAC appeals are also bearing fruit. The percentage of RAC-related appeals filed with OMHA in FY 2016 dropped to 9.5%, from 14.1% in FY 2015, 53.8% in FY 2014, and 50.3% in FY 2013. *Id.* ¶ 9. This reduction in RAC appeals at OMHA is due to several factors, only one of which is the temporary decrease during CMS' negotiation of a new Statement of Work with the RACs that Plaintiffs emphasize. *Id.* ¶ 11. Notably, patient status reviews, which CMS initially prohibited in October 2013, and Congress further prohibited through September 2015, previously accounted for a substantial portion of RAC appeals, and CMS has since instituted a new process for reviewing patient status claims. *Id.* Additionally, CMS implemented revised Additional Documentation Request limits that became effective in January 2016. Under these new limits, the total number of inpatient hospital claims reviewed by RACs, which had previously accounted for the majority of RAC appeals at OMHA, has been substantially reduced. *Id.* And CMS recently re-vamped the

[2] Ms. Murray's spring declaration describes the Settlement Conference Facilitation project. Murray Decl. of May 25, 2016 ¶ 19(e), ECF No. 30-1.

Recovery Audit program with a new Statement of Work for RACs that strengthens the financial incentives for RACs to audit accurately. In addition to the contingency payment system already in place whereby RACs are paid only when their review results in overpayment collection or underpayment returned to the provider, and must return to CMS any payments earned for determinations that were subsequently reversed on appeal, the new RAC Statement of Work adds two financial incentives for RACs to make accurate claim determinations: a 0.1% contingency fee increase for each percentage point below 10% that RACs maintain their overturn rate; and a 0.2% contingency fee increase for each percentage point above 95% that RACs maintain their accuracy rate. *Id.* ¶¶ 18-19. And where a RAC's overturn rate exceeds 10% or its accuracy rate drops below 95%, CMS may take a series of actions designed to bring the RAC into compliance with the requirements of a maximum overturn rate of 10% and a minimum accuracy rate of 95%. *Id.* ¶ 20. CMS estimates that the Statement of Work changes will reduce RAC-related appeals to OMHA by 26,000 through the end of FY 2021. *Id.* ¶ 22. In addition, CMS has reduced the look-back period for patient status reviews, meaning that RACs can only review these claims within six months of the date of service on the claim, in cases where the hospital submits its claim within three months of the date of service, unlike other claim types where RACs are allowed to look back up to three years from the date the claim was paid. *Id.* ¶ 23. This reduction gives providers the opportunity to rebill for medically necessary Part B inpatient services, instead of having to file an appeal. *Id.*

ARGUMENT

I. Legal Standards.

Summary judgment may be entered under Federal Rule of Civil Procedure 56 if "the movant shows that there is no genuine dispute as to any material fact and the movant is entitled

to judgment as a matter of law." Fed. R. Civ. P. 56(a); *accord Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

"'The remedy of mandamus is a drastic one, to be invoked only in extraordinary circumstances.'" *Am. Hosp. Ass'n ("AHA") v. Burwell*, 812 F.3d 183, 189 (D.C. Cir. 2016) (quoting *Power v. Barnhart*, 292 F.3d 781, 784 (D.C. Cir. 2002)). "To show entitlement to mandamus, plaintiffs must demonstrate (1) a clear and indisputable right to relief, (2) that the government agency or official is violating a clear duty to act, and (3) that no adequate alternative remedy exists." *Id.* "Even when the legal requirements for mandamus jurisdiction have been satisfied, however, a court may grant relief only when it finds compelling equitable grounds." *Id.* "The party seeking mandamus has the burden of showing that its right to issuance of the writ is clear and indisputable." *Id.* (internal quotation omitted).[3]

II. Mandamus Should Not Issue.

The D.C. Circuit directed this Court on remand to "determine whether 'compelling equitable grounds' now exist to issue a writ of mandamus" and outlined the factors counseling for and against mandamus. *AHA*, 812 F.3d at 192; *see also id.* at 189-90 (discussing application of factors identified by the Circuit in *Telecomm. Research & Action Ctr. v. FCC*, 750 F.2d 70, 80 (D.C. Cir. 1984)). Given the increased strength of HHS' administrative measures, *see* Supplemental Murray Decl. ¶¶ 2-22, and the continued possibility of Congressional action, the Secretary respectfully submits that on balance the factors weigh against issuance of the writ.

[3] The Secretary respectfully incorporates her prior briefing, before this Court and before the D.C. Circuit, which demonstrated that mandamus should not issue. The Secretary respectfully preserves her contention that the Medicare statute does not impose a mandatory duty on her to ensure that her administrative law judges decide appeals within 90 days, but recognizes that this Court and the D.C. Circuit panel held to the contrary. *Contrast Cumberland Cty. Hosp. Sys. v. Burwell*, 816 F.3d 48, 55 (4th Cir. 2016) (concluding that 90-day timeline is not mandatory).

Indeed, it is important to emphasize that while the backlog had been worsening when this case was before the D.C. Circuit on appeal and when it was remanded this spring, *see AHA*, 812 F.3d at 193, Mem. Op. of Sept. 19, 2016 at 1-2, ECF No. 38, the situation has begun to improve and will continue to do so if Congress increases HHS' authorities and funding. *See supra* at 2. Ms. Murray's first declaration explained that HHS expected the backlog to worsen until the administrative measures began to have effect. Murray Decl. ¶ 18, ECF No. 30-1 (May 25, 2016). And now the measures are having their intended effect. Again, HHS estimates that in the past fiscal year there has been a nearly 26% reduction in the number of pending appeals at OMHA, that there will be a further almost 37% reduction during the current fiscal year, and that with legislative action, the backlog (appeals exceeding 90 days) will be eliminated completely by the end of FY 2019. Supplemental Murray Decl. ¶¶ 2-3.

That HHS' administrative measures are now reducing the backlog and with legislative action will continue to do so strengthens the factors that the D.C. Circuit identified as weighing against mandamus, *AHA*, 812 F.3d at 192-93. In particular, the "extraordinary and intrusive nature" of the writ counsels against its issuance, given that the writ "risks infringing on the authority and discretion of the executive branch." *Id.* That risk would be heightened if, as Plaintiffs request, mandamus "would, in effect, probably require the agency to make major changes to its operations and priorities, including drastically limiting the scope of a statutorily mandated program that has recovered billions of dollars in incorrectly paid funds." *Id.* at 192. Moreover, the Secretary's "good faith efforts to reduce the delays," *id.*, now weigh heavily against the issuance of the writ, given that the effect of her efforts on the backlog is now measurable and it is clear that the situation is improving considerably. In addition, as the D.C. Circuit noted, the availability of escalation as the statutorily-prescribed remedy for any delays in

administrative law judge (ALJ) decisions counsels against issuing the writ. *Id.* Congress' continued awareness of the backlog also weighs against mandamus. *Id.* In sum, given the strength of HHS' good faith efforts, it is not necessary to take the extraordinary step of infringing on Executive authority by ordering mandamus.

On the other side of the balance, the D.C. Circuit identified possible effects on health and welfare stemming from payment delays as weighing in favor of mandamus. *AHA*, 812 F.3d at 193. On this score, it is important to note that escalation is available for particular hospitals that fear such an effect. Additionally, the Medicare statute authorizes extended repayment plans for providers suffering hardship as a result of recoupment of Medicare payments. *See* 42 U.S.C. § 1395ddd(f)(1)(B). The D.C. Circuit also identified the Secretary's authority to structure the RAC program as a factor weighing in favor of mandamus. The Secretary, in addition, has already implemented a series of initiatives that have improved the accuracy of the RAC program, which program again is statutorily required, *see* 42 U.S.C. § 1395ddd(h). And, in any event, that program simply was not, and is not, the primary source of the backlog; in FY 2016, RAC appeals comprised only 9.5% of appeals filed with OMHA. Supplemental Murray Decl. ¶ 9.

In light of these significant additional reforms and their impact on the OMHA backlog, the Secretary respectfully submits that at present the appeal delays are not so egregious as to warrant the extraordinary and intrusive writ of mandamus.

III. Any Writ of Mandamus Should Order Remedies that Comport with HHS' Statutory Obligations and Create Incentives to Reduce, Not Increase, Appeals.

Again, the Secretary submits that the present circumstances are such that a writ of mandamus is not appropriate. But in the event that the Court concludes otherwise, the Secretary addresses the question of remedies below.

The measures that the Secretary can take to address the backlog are necessarily constrained by statutory requirements and obligations. Any order of mandamus must likewise operate within the limits set by Congress:

> Courts of equity can no more disregard statutory and constitutional requirements and provisions than can courts of law. A Court of equity cannot, by avowing that there is a right but no remedy known to the law, create a remedy in violation of law.

INS v. Pangilinan, 486 U.S. 875, 883 (1988) (internal quotations omitted). It is telling that Plaintiffs are unable to identify a remedy that would not cause the Secretary to violate her other obligations under the Medicare statute. As noted, the Secretary remains of the view that the Medicare statute does not impose a mandatory duty that ALJ appeals be decided within 90 days. But if the statute is read to impose such a duty, the result would be conflicting commands within the statute itself, which would be left to the Secretary's discretion to resolve. "When an agency thus resolves statutory tension, ordinary principles of administrative deference require us to defer." *Scialabba v. Cuellar de Osorio*, 134 S. Ct. 2191, 2207 (2014) (plurality opinion). *See also National Assn. of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 666 (2007) (When a statutory scheme contains "a fundamental ambiguity" arising from "the differing mandates" of two provisions, "it is appropriate to look to the implementing agency's expert interpretation" to determine which "must give way").

A. Current Initiatives

If the Court does decide to issue a writ of mandamus despite the decrease in pending appeals at OMHA and improved outlook for projected appeal levels in future years and elimination of the backlog, the writ should incorporate the significant new initiatives that HHS

has undertaken since Ms. Murray's May 2016 declaration.[4] Thus, it would order the Secretary to proceed with (1) the reopening of the settlement offer to hospitals for inpatient status claims, (2) the expanded Settlement Conference Facilitations apart from the proposal concerning State Medicaid Agency appeals,[5] (3) the sampling and extrapolation demonstration project for State Medicaid Agency appeals, and (4) the new RAC Statement of Work. The Secretary thus submits that an appropriate set of remedies would be as follows:

- HHS will continue the administrative measures described in Ms. Murray's May 25, 2016 Declaration, ECF No. 30-1, ¶¶ 19, 21.
- HHS will reopen the offer of settlement of inpatient status appeals as described in the Supplemental Murray Declaration, ¶ 12.
- HHS will expand Settlement Conference Facilitations as described in the Supplemental Murray Declaration, ¶ 14.
- HHS will continue to utilize the RAC Statement of Work that is currently set forth in Recovery Audit contracts.

B. Additional Initiatives

Because resolution of the OMHA backlog is a top priority for HHS, whenever the agency has identified administrative measures to reduce the backlog that are within its power and do not

[4] The Secretary remains of the view that it would be inappropriate to issue a writ of mandamus directing the agency to undertake particular measures in response to the backlog of appeals. *See, e.g., In re Barr Labs.*, 930 F.2d 72, 76 (D.C. Cir. 1991). The Secretary offers these measures, however, in recognition that the Court has directed the parties to propose the specific form that a writ of mandamus should take.

[5] The Settlement Conference Facilitations with individual State Medicaid Agencies—which are projected to reduce the backlog by an additional 55,000 pending appeals, Supplemental Murray Decl. ¶ 16—would not be an appropriate subject of a mandamus order because it is the subject of negotiations for a Memorandum of Understanding between the State Medicaid Agencies and HHS.

conflict with statutory obligations or jeopardize the Medicare Trust Funds the agency has pursued them. *See* Murray Decl.; Supplemental Decl. In addition, HHS continues to pursue legislative and funding proposals to obtain additional resources and flexibilities to address the appeals workload. In the event that the Court nevertheless concludes that additional measures are needed, the Court should limit the remedies that it imposes to measures that are consistent with the Secretary's statutory duties, protect the Medicare Trust Funds, and are targeted to the harms that Plaintiffs have identified.

For currently pending appeals, HHS could offer a settlement to providers and suppliers based on extrapolation from that particular provider's or supplier's historic success rate or, in the absence of a sufficient history of decided appeals, a sampling and extrapolation of the provider's or supplier's pending appeals, as described in the Supplemental Murray Declaration, paragraph 39. For future appeals, HHS could conduct sampling and extrapolation to adjudicate a provider's or supplier's appealed claims if the provider or supplier appeals more than a certain number of claims within a given time period, as described in the Supplemental Murray Declaration, paragraph 40. And HHS could prioritize the appeals of providers and suppliers experiencing financial hardship as a result of appeal delays, as described in the Supplemental Murray Declaration, paragraph 41, which would address the particular harm that Plaintiffs allege in petitioning for mandamus relief.

Any relief ordered could also include a direction to CMS that it extend its initiative reducing the look-back period for RAC claims for patient status reviews to six months where the provider bills within three months of the date of service until the backlog is resolved. *Id.* ¶ 23. CMS also could limit the look-back review period for all claims subject to RAC review to one year until the backlog is resolved. *Id.*

IV. The Remedies that Plaintiffs Have Proposed Are Inappropriate.

Plaintiffs have proposed a series of measures that they contend the Court should order if it were to issue the writ of mandamus. Tellingly, Plaintiffs do not even attempt to contend that their proposals would serve to eliminate the backlog of appeals—only the administrative measures described above, coupled with legislative action, will accomplish that. Mandamus should not be used to order relief that is not even designed to resolve the alleged statutory violation that is at issue. *See Weber v. United States*, 209 F.3d 756, 760 (D.C. Cir. 2000) (writ "is not to be granted in order to command a gesture"); *Realty Income Trust v. Eckerd*, 564 F.2d 447, 458 (D.C. Cir. 1977) ("equity should not require the doing of a 'vain or useless thing'").

A. The Scope of the Reopened Settlement Offers is Appropriate and Should Not Be Expanded.

Plaintiffs' proposal of expanding CMS' reopened settlement offer to all hospitals or all Medicare Part A providers, Pls.' Mot. at 4-5, is not a means of reducing the backlog. It instead would likely have the opposite effect and worsen the backlog. A remedy that worsens, rather than alleviates, the asserted statutory violation should not be ordered.

Offering settlement to all hospitals or providers would skew providers' incentives away from settling meritorious claims and towards appealing and settling every claim, resulting in an increase in the backlog. Ms. Murray explains:

> If the blanket settlement offer were voluntary and substantially under 100%, providers and suppliers would be incentivized to only settle claims that they believe would not be ultimately paid on appeal, and they would continue to appeal their stronger claims to receive higher payment. Providers and suppliers would be incentivized to appeal every denial and adverse opinion decision and to continue to pursue any non-meritorious appeals in order to receive the settlement offer and perhaps in anticipation of future settlement offers.

Supplemental Murray Decl. ¶ 37. Expanding the settlement offer beyond the "large homogenous universe of claims denied for the same reason," *id.* ¶ 13, to encompass providers without regard

to individual error rate or concerns about fraudulent or abusive billing would likely drain the Medicare Trust Funds. *See id.* ¶ 37 ("If providers and suppliers receive a blanket global settlement not based on their individual error rates and not taking into account any concerns CMS or law enforcement have about fraudulent or abusive billing, the Medicare Trust Funds could be forced to pay out substantially more than they would had the claims been adjudicated in the normal course.").

By contrast, the Secretary has given careful consideration to the aggregate settlement offers that she could make consistent with her obligation to protect the Medicare Trust Funds, and she has determined to extend a settlement offer that appropriately targets a large swath of pending appeals that share the same characteristics and that she can responsibly settle on the same terms. *See id.* ¶ 13.

Moreover, the power to settle pending claims is an inherently Executive function, and it is doubtful that a Judicial order seeking to supervise how the Executive implements its claims-settling duties could be manageable or could be consistent with the Judicial role. *See Baltimore Gas and Elec. Co. v. F.E.R.C.*, 252 F.3d 456, 460 (D.C. Cir. 2001) (agency's decision to settle and not take enforcement action was "a paradigmatic instance of an agency exercising its presumptively nonreviewable enforcement discretion") (citing *Heckler v. Chaney*, 470 U.S. 821, 832 (1985); *New York Dep't of Law v. F.C.C.*, 984 F.2d 1209, 1215 (D.C. Cir. 1993)).

B. The Proposals of Delayed Repayment and Tolled Interest Accrual Are Not Targeted to Remedying the Backlog, Are Statutorily Foreclosed, and Would Likely Increase the Backlog.

At the October 4, 2016 status conference, the Court directed the parties to propose remedies that would reduce the backlog. Plaintiffs have proposed delaying repayment and tolling interest accrual until a claim is decided by an ALJ "to alleviate the financial

consequences" that they allege are tied to the backlog. Pls.' Mot. at 5. Because those proposals are not designed to reduce the backlog, they are non-responsive to the Court's request for remedies and should be rejected for that reason alone. Plaintiffs' proposed remedy also should be rejected because (1) it would increase, rather than alleviate, the backlog; (2) it conflicts with the Secretary's statutory obligations; and (3) that statutory violation cannot be excused by referring to the Secretary's authority to enter into demonstration projects.

1. The relief that Plaintiffs propose would not alleviate the backlog. Worse, their proposal would serve only to increase it. Delaying a provider's repayment obligation for, or tolling the accrual of interest on, denied claims that have been appealed to the ALJ level would likely encourage claimants to appeal to that level, resulting in an increase in the backlog of appeals with OMHA. Suspending recoupment and/or accrual of interest thus can be expected to *increase* the backlog as it would incentivize providers and suppliers to appeal all claims denied as an overpayment and pursue all levels of appeal on such claims without regard to individual claim merits. Supplemental Murray Decl. ¶ 29. In addition, the impact of such a policy on the Medicare Trust Funds could be disastrous; CMS collects an average of $153 million in principal and $15 million in interest a year after the second level of appeal. *Id.* ¶ 31. Delaying recoupment and accrual of interest could have the further negative effect of aiding fraudulent claimants and thereby encouraging fraud. *See id.* ¶ 32.

The recoupment and interest requirements do not affect all appellants—only those with claims that were denied after they had already been paid. *Id.* ¶ 28. A significant number of pending appeals involve claims that were denied before payment, and those appellants are not affected by recoupment or interest requirements. *Id.* It is nevertheless appropriate to recognize that the Medicare statute and the Secretary's regulations already provide a remedy for financial

hardship posed by recoupment: under 42 U.S.C. § 1395ddd(f)(1) and 42 C.F.R. § 401.607(c), providers and suppliers for whom recoupment would create financial hardship may request an extended repayment plan. Supplemental Murray Decl. ¶ 34.

In addition to these fundamental problems with Plaintiffs' proposal, the Secretary possesses no lawful means of delaying repayment or interest accrual, as explained below.

2. Not only would delaying repayment and interest accrual be impractical and self-defeating -- it would violate federal law. Regarding interest, the Medicare statute requires the Secretary to charge interest on Medicare fee-for-service debts that remain outstanding for more than 30 days after the determination of overpayment or underpayment. 42 U.S.C. § 1395g(d) ("Whenever a final determination is made that the amount of payment made . . . to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance . . ."); *id.* § 1395l(j) ("[I]nterest shall accrue" on Medicare fee-for-service debts that remain outstanding for more than 30 days after the date of the determination of an overpayment or underpayment); *see also* 42 U.S.C. § 1395ddd(f)(2)(B) (for appeals that reach the ALJ level and beyond, "[i]nsofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment"). Neither mandatory provision provides for waiver or tolling of interest. Consistent with the Medicare statute and the Federal Claims Collection Act (FCCA), CMS regulations allow waiver of interest charges on overpayments only if the overpayment is "completely liquidated within 30 days" from the date of the determination that an overpayment occurred, or if CMS determines that the "administrative cost of collecting" the interest charges on the overpayment exceeds those interest charges. 42 C.F.R.

§ 405.378(f)(1). The FCCA generally provides that an agency head may suspend collection on a claim (below a monetary threshold) when it appears that the cost of collecting the claim is likely to be more than the amount recovered. 31 U.S.C. § 3711(a)(3).

Plaintiffs' policy argument that there should be a waiver of interest accrual in light of the appeal delays, Pls.' Mot. at 7-8, does not solve the problem that the Medicare statute and FCCA mandate interest accrual. Moreover, they incorrectly assert, and, respectfully, the D.C. Circuit erred in stating, that the statute contemplates that appeals will move through the administrative process in approximately one year; taking into account the time necessary to prepare and submit filings, the actual time is in the vicinity of two years. *See* Supplemental Murray Decl. ¶ 43.

Contrary to Plaintiffs' argument, Pls. Mot. at 8 & n.3, the fact that, during certain periods when the provider or supplier contributes to adjudicatory delay, a regulation tolls the accrual of interest assessed against HHS (if that provider's or supplier's appeal succeeds), 42 C.F.R. § 405.378(j)(3)(iv), (v), does not mean that there is a basis for the blanket tolling that they seek. The Medicare statute imposes different rules regarding the assessment of interest against a provider or supplier based on an overpayment than it does against the Secretary based on an underpayment; it specifies when interest starts running against providers, but does not specify when interest starts running against the government. 42 U.S.C. § 1395ddd(f)(2)(B) ("Insofar as the determination on such appeal is *against the provider of services or supplier, interest on the overpayment shall accrue on and after* the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.") (emphasis supplied).

Plaintiffs' arguments for delaying repayment fare no better. The Medicare statute suspends recoupment of an overpayment through the reconsideration level of appeal. *See* 42 U.S.C. § 1395ddd(f)(2)(A). As Plaintiffs emphasize, 45 C.F.R. § 30.29(c) provides a narrow exception to allow further suspension on a case-by-case discretionary basis. What Plaintiffs seek, by contrast, is a broad waiver that would apply without any case-by-case analysis of the circumstances of individual providers or suppliers. Such a broad waiver would conflict with the Secretary's obligation to timely and aggressively pursue debts owed to the agency. The FCCA requires federal agencies to collect a claim for money arising out of the activities of the agency. 31 U.S.C. § 3711(a) ("The head of an executive, judicial, or legislative agency [] shall try to collect a claim of the United States Government for money or property arising out of the activities of, or referred to, the agency."). And the Federal Claims Collection Standards that govern all federal agencies' collection activities (set forth in the Department of the Treasury's regulations) require HHS to promptly and aggressively pursue any debts owed to it. 31 C.F.R. § 901.1(a) ("Federal agencies shall aggressively collect all debts arising out of activities of, or referred or transferred for collection services to, that agency. Collection activities shall be undertaken promptly with follow-up action taken as necessary."); *see also* 45 C.F.R. § 30.10(a) ("The Secretary shall aggressively and timely collect all debts arising out of activities of, or referred or transferred for collection actions to, the Department.").

Additionally, such a waiver would undermine the Secretary's fiduciary duty to protect the Medicare Trust Funds (comprised of the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund) by paying only legitimate claims and combatting fraud, abuse and improper payments, and by aggressively pursuing outstanding Medicare overpayments. *See* 42 U.S.C. § 1395i(b) (naming Secretary as member of Board of Trustees of

Federal Hospital Insurance Trust Fund); 1395i(h) (authorizing payments from the Federal Hospital Insurance Trust Fund for services provided for by Medicare statute and administrative expenses); *id.* § 1395t(b) (naming Secretary as member of Board of Trustees of Federal Supplementary Medical Insurance Trust Fund); *id.* § 1395t(g) (authorizing payments from the Federal Supplementary Medical Insurance Trust Fund for services provided for by Medicare statute and administrative expenses); *see also id.* § 1395f (authorizing payment for services to providers only if specified requirements are met); Supplemental Murray Decl. ¶ 27.

Plaintiffs are off-base when they suggest that the Secretary is not appropriately incentivized to exercise her best efforts for resolving the backlog. Pls.' Mot. at 9. They suggest no basis for concluding that her efforts are not her best, and Ms. Murray has explained that resolving the OMHA delays is a top agency priority. Murray Decl. of May 25, 2016 ¶ 3, ECF No. 30-1. It is also noteworthy that while Plaintiffs suggest that the Secretary lacks an appropriate financial incentive to resolve the backlog, Pls.' Mot. at 9, they simultaneously assert that HHS is paying interest on frequently overturned categories of claims, *id.* at 7. They cannot have it both ways.

3. Contrary to Plaintiffs' contention, the Secretary's authority to create demonstration projects does not authorize her to delay repayment or interest accrual on denied claims. Plaintiffs first point to the Secretary's demonstration authority under 42 U.S.C. § 1395b-1, Pls.' Mot. at 6-7, but that provides for the Secretary to create "[i]ncentives for economy while maintaining or improving quality in provision of health services." 42 U.S.C. § 1395b-1 (title). The Secretary uses that authority to test different ways of paying for Medicare services and to improve the post-payment review process. Supplemental Murray Decl. ¶ 35. Delaying repayment and interest accrual would not incentivize economy in Medicare service payments or

improve the post-payment review process. *Id.* Further with regard to Plaintiffs' deferred repayment proposal, while 42 U.S.C. § 1395b-1(b) authorizes the Secretary to waive certain parts of the Medicare statute, it does not authorize waiver of other requirements imposed by other statutes. The Secretary's obligation to recoup funds is grounded in the FCCA, 31 U.S.C. § 3711, and Federal Claims Collection Standards, 31 C.F.R. § 901.1, as well as her obligation to protect the Medicare Trust Funds. *See supra* at 15.

Plaintiffs "[a]lternatively" focus on 42 U.S.C. § 1315a(a)(1). Pls.' Mot. at 7. That provision creates within CMS a Center for Medicare and Medicaid Innovation (CMMI) with authority "to test innovative payment and service delivery models to reduce program expenditures." 42 U.S.C. § 1315a(a)(1). Suspension of recoupment and interest obligations would have nothing to do with reducing expenditures of the Medicare program, and instead would likely increase expenditures; in some cases CMS would be unable to recoup the principal owed, and providers would be incentivized to file more appeals than they currently do. Supplemental Murray Decl. ¶¶ 31-33, 36. And with regard to the deferred repayment proposal, again it is foreclosed by the statute. Section 1315a(a)(1)'s waiver authority extends only to certain requirements of the Medicare statute, 42 U.S.C. § 1315a(d)(1), and not beyond the Medicare statute to the FCCA or other statutes.

Additionally, the demonstration authority under 42 U.S.C. § 1395b-1 and CMMI's authority under 42 U.S.C. § 1315a are committed to the agency's exclusive discretion, and there is no basis on which the Court could direct the Secretary to exercise that discretion in a particular way. Nowhere does the Medicare statute specify that the Secretary must initiate a demonstration project under 42 U.S.C. § 1395b-1 where particular conditions are met or otherwise. The statute thus vests complete discretion in the Secretary as to whether to undertake a demonstration

project. *See Heckler v. Chaney*, 470 U.S. at 830 ("[R]eview [under the Administrative Procedure Act] is not to be had if the statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion. In such a case, the statute ('law') can be taken to have 'committed' the decision-making to the agency's judgment absolutely."). Section 1315a affirmatively commits the decision of what models to test or expand as well as related decisions to CMMI's sole discretion by precluding administrative or judicial review thereof. 42 U.S.C. § 1315a(d)(2). Because Congress entrusted the decision of whether to initiate a demonstrate project under 42 U.S.C. § 1395b-1 entirely to the Secretary's judgment and whether to initiate a model under 42 U.S.C. § 1315a entirely to the CMMI's judgment, there is no basis on which the Court could direct the Secretary to exercise that discretion in a particular way. *See Connecticut v. Spellings*, 453 F. Supp. 2d 459, 495 (D. Conn. 2006), *aff'd*, 612 F.3d 107 (2d Cir. 2010) (Secretary of Education's decision, under analogous provision, not to enter into a demonstration project is committed to her discretion and thus not reviewable); *see also Com. of Pennsylvania, by Sheppard v. National Ass'n of Flood Insurers*, 520 F.2d 11, 26–27 (3d Cir. 1975) (while a court can issue a writ of mandamus to compel an agency to exercise its discretion, it cannot dictate the outcome of the agency's exercise of that discretion), *overruled on other grounds by Pennsylvania v. Porter*, 659 F.2d 306 (3d Cir. 1981); *McQueary v. Laird*, 449 F.2d 608, 611 (10th Cir. 1971) ("This court has held that the 1962 Act relating to mandamus against federal officers, employees and agencies authorizes the court to issue mandamus only to require the exercise of permissible discretion, or to compel performance of ministerial duties. In no event, however, may the court direct the manner in which discretionary acts are to be performed nor may it direct or influence the exercise of discretion in making that decision.") (internal citations omitted).

C. While Performance Incentives and Disincentives Comport with Government Contract Law, Penalty Provisions Do Not.

As described above, the Secretary is implementing contract-based measures to increase RAC accuracy incentives. *See supra* at 3-4; Supplemental Murray Decl. ¶¶ 17-22. Plaintiffs' proposal of penalties on RACs, Pls.' Mot. at 9-10, however, is precluded by federal government contract law.

Plaintiffs argue that the Court should order the Secretary to impose financial penalties on RACs for high reversal rates. Penalty provisions in government contracts, however, are generally unenforceable on grounds of public policy. *See* Restatement (Second) of Contracts § 356 cmt. a (1981) ("Punishment of a promisor for having broken his promise has no justification on either economic or other grounds and a term providing such a penalty is unenforceable on grounds of public policy."); *accord Monsanto Co. v. McFarling*, 363 F.3d 1336, 1345 (Fed. Cir. 2004) ("penalty clauses are impermissible because they are "designed primarily to compel performance" at the time of contracting) (quoting *Wilt v. Waterfield*, 273 S.W.2d 290, 295 (Mo. 1954), and citing, *inter alia*, Restatement (Second) of Contracts § 356 cmt. a). Consequently, for example, while liquidated damages provisions may often be used to approximate actual damages of breach to the government, such provisions cannot be "so disproportionate to any damage reasonably to be anticipated in the circumstances disclosed that we must hold the provision is for an unenforceable penalty." *DJ Mfg. Corp. v. United States*, 86 F.3d 1130, 1134 (Fed. Cir. 1996) (citing *Kothe v. R.C. Taylor Trust*, 280 U.S. 224 (1930)); *see also* Restatement (Second) of Contracts § 356(2) ("Damages for breach by either party may be liquidated in the agreement but only at an amount that is reasonable in the light of the anticipated or actual loss caused by the breach and the difficulties of proof of loss. A term fixing unreasonably large liquidated damages is unenforceable on grounds of public policy as a

penalty."); 48 C.F.R. § 11.501(b) (Federal Acquisition Regulation provision: "Liquidated damages are not punitive and are not negative performance incentives. Liquidated damages are used to compensate the Government for probable damages. Therefore, the liquidated damages rate must be a reasonable forecast of just compensation for the harm that is caused by late delivery or untimely performance of the particular contract.") (internal citation omitted). Thus, the Secretary does not have the authority to modify her contracts with the RACs to impose penalties, which would be in the nature of an unenforceable liquidated damages clause.

Incentive contracts, on the other hand, are an appropriate vehicle for motivating government contractors, e.g., to incentivize RACs to audit claims accurately. The Federal Acquisition Regulations ("FAR") specifically authorize the government to incentivize good performance and disincentivize poor performance through contractual provisions such as those HHS has already included in RAC Statement of Work. FAR 16.402-1 authorizes cost incentives "which take the form of a profit or fee adjustment formula and are intended to motivate the contractor to effectively manage costs," 48 C.F.R. § 16.402-1, and FAR 16.402-2 authorizes (indeed, encourages) government agencies to tie such incentives to contractor performance, either positive or negative, 48 C.F.R. § 16.402-2(a)-(b). HHS' contract provisions establishing incentives and disincentives based on RAC performance, *see* Supplemental Murray Decl. ¶¶-18-21, are the appropriate means of motivating RACs to audit claims accurately and to achieve and maintain low error rates.

Adopting Plaintiffs' suggestions that HHS preclude claim denials when providers fail to comply with claim documentation requirements and that HHS prevent RACs from reviewing whether services for which Medicare claims were submitted were reasonable and necessary, Pls.' Mot. at 11, would improperly increase the risk of payments from the Medicare Trust Funds for

services that are not covered by Medicare. Supplemental Murray Decl. ¶ 26. However, HHS is amenable to shortening the RAC look-back period as previously discussed. *See id.* ¶ 23.

Lastly, it is important to correct Plaintiffs' misstatement that the first and second levels of appeal are merely a "rubber stamp" of RAC decisions. Pls.' Mot. at 10. This contention is not borne out by statistics; in FY 2015, at the first level appeal the overturn rate was 57%. Supplemental Murray Decl. ¶ 25.

D. Hard Deadlines and Default Judgments Would Violate the Medicare Statute's Requirement that No Payment be Made Except for Legitimate Services.

Plaintiffs ask in the alternative that the Court (1) "affirm the legal availability" of their proposals of an expanded settlement offer, delayed repayment and interest accrual, and RAC penalties, and (2) order the Secretary to meet certain goals in reducing the backlog by certain dates. Pls.' Mot. at 12-13. The first alternative request should be rejected for the reasons set forth above; expanding the scope of the recently reopened hospital settlements to all providers would likely worsen the backlog and jeopardize the Medicare Trust Funds, and delayed repayment and interest accrual and RAC penalties would incentivize meritless appeals and conflict with applicable law. *See supra* at 11-19.

The second alternative request for an order compelling the Secretary to meet certain benchmarks by certain deadlines with the sanction of default judgment if the deadline for eliminating the backlog is not met would violate the Medicare statute as well as create perverse incentives for providers and suppliers to appeal non-meritorious claims. Such an order would require the Secretary to make Medicare payments based on calendar deadlines rather than proper claim substantiation. The Medicare statute, however, authorizes payment to providers and suppliers only for services that are covered by Medicare. *E.g.*, 42 U.S.C. § 1395f (specifying conditions of and limitations on payment to providers for Part A services). And it expressly

prohibits payment where a claim has not been properly substantiated. 42 U.S.C. § 1395g(a) ("no payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period"). *See also* 42 U.S.C. § 1395y(a)(1)(A) ("No payment may be made . . . for any expenses incurred for items and services . . . which . . . are not reasonable and necessary"). An order requiring the Secretary to make payment on Medicare claims regardless of the merit of those claims would squarely conflict with the Medicare statute.

What is more, an order imposing deadlines with the sanction of default judgment for not meeting them also would skew providers' and suppliers' incentives toward appealing every claim without regard to merit. Any provider could pursue any claim with the expectation that the end result would be payment, no matter how little merit in the claim. *See* Supplemental Murray Decl. ¶ 37. Such skewed incentives, coupled with the prospect of default judgments, could endanger the Medicare Trust Funds. *Id.*

E. Quarterly Status Reports Would Be Appropriate.

The Secretary agrees that periodic status reports on HHS' progress in reducing the backlog, with updated statistics and information about significant changes relating to the backlog, would be appropriate. Quarterly status reports would be most efficient; more frequent reports, such as every 60 days as Plaintiffs request, Pls.' Mot. at 13, would force the agency to divert resources from work on the backlog to preparing reports. Supplemental Murray Decl. ¶ 42. Reports every three months would have the additional benefit of allowing natural fluctuations in appeal receipts to normalize and allowing evaluation of the impact of administrative measures. *Id.*

CONCLUSION

For the foregoing reasons, the Court should grant Defendant's motion for summary judgment and deny Plaintiffs' motion for summary judgment. If the Court issues the writ, it should limit the remedy that it imposes to measures that are consistent with the Secretary's statutory obligations and that protect the public fisc.

Respectfully submitted,

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