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Battle of the Backlog: How Congressional Inaction Threatens the Integrity of Medicare

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I. Introduction

Medicare was established in 1965 to provide health insurance to all Americans aged sixty-five or older, regardless of income or medical history.[1] At that time, roughly half of all American seniors lacked health insurance, largely a function of the high cost of ensuring the elderly.[2] Today, Medicare provides health insurance to virtually all seniors, and in total serves over fifty five million Americans.[3] Medicare provides a full spectrum of medical services to forty six million seniors as well as specialized coverage for nine million Americans of all ages with permanent disabilities.[4]

Medicare has grown considerably since its inception and as more services were added over time.[5] Part A and Part B, referred to as "Original Medicare," comprised hospital and medical insurance.[6] Later, in 1972, more people became eligible for Medicare, including many Americans with disabilities.[7] The biggest change to Medicare came in 2003, with the addition of Medicare Part C, Medicare Advantage Plans, and Part D,

1. Juliette Cubanski et al., *Primer on Medicare: Key Facts About the Medicare Program and the People It Covers*, HENRY J. KAISER FAM. FOUND. (Mar. 20, 2015), https://www.kff.org/medicare/report/a-primer-on-medicare-how-does-medicare-pay-providers-in-traditional-medicare/ (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

2. *See id.* ("Prior to 1965, roughly half of all seniors lacked medical insurance; today virtually all seniors have health insurance under Medicare.").

3. *Id.*

4. *Id.*

5. *See CMS' Program History*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/about-cms/agency-information/history/index.html (last updated Sept. 14, 2017) (describing each additional layer of expansion to the Medicare program since its inception in 1965) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

6. *Id.*

7. *Id.*

prescription drug benefits.[8] In 2010, the Affordable Care Act brought more changes to Medicare.[9]

These expansions have made today's Medicare an enormous federal program, accounting for fifteen percent of total federal spending in 2015, a total of $633 billion dollars.[10] The sheer amount is staggering, and it comes as little surprise that the federal government is the country's single largest purchaser of prescription drugs.[11] Medicare's status as the country's largest healthcare provider and customer of drugs have made Medicare payments a critical source of revenue for hospitals across the country.[12]

Rural hospitals rely heavily on Medicare payments to provide much needed services in their communities.[13] Take, for example, some of the plaintiff hospitals in the cases that are the subject of this note. Mountain Head, Arkansas' Baxter Regional Medical Center derives sixty-five percent of its gross revenue from Medicare.[14] Its co-plaintiffs derived forty-seven and fifty-five percent of their total revenue from Medicare.[15] These hospitals are

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8. *Id.*

9. *See id.* (describing the changes the Affordable Care Act made to Medicare and Medicaid).

10. CONGRESSIONAL BUDGET OFFICE, BUDGET & ECONOMIC OUTLOOK: 2016 TO 2026, Table F-5 (2016).

11. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES 2016 HIGHLIGHTS 2 (2017), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf (noting that "the federal government accounted for the largest share of health care spending") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

12. See Cubanski et al., *supra* note 1 ("Out of $597 billion in total benefit spending in 2014, Medicare paid $376 billion (63%) for benefits delivered by health care providers in traditional Medicare.").

13. See AM. HOSP. ASS'N, FACTSHEET 1 (2017) https://www.aha.org/system/files/2018-02/2017-01-rural-fs_0.pdf (noting that "[r]ural hospitals' patient mix also makes them more reliant on public programs and, thus, particularly vulnerable to Medicare and Medicaid payment cuts") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

14. See Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 188 (D.C. Cir. 2016) ("Baxter Regional Medical Center, a 268-bed regional hospital in Arkansas that derives 65% of its gross revenue from Medicare.").

15. See *id.* ("Covenant Health . . . derives 55% of its gross revenue from Medicare [and] . . . Rutland Regional Medical Center . . . derives 47% of its revenues from Medicare.").

highly vulnerable to any disruption in being paid for rendering Medicare services.[16]

In recent years, many of these payments have been delayed indefinitely due to an enormous backlog of claims at the Department of Health and Human Services.[17] Ostensibly, hospitals are paid for rendering services to Medicare patients by submitting claims to government contractors.[18] If those claims are denied, they enter a complex claim and appeal process that is intended to be resolved within one year.[19] A massive influx of claims made this process completely break down, creating a backlog of over 800,000 cases nationwide that the Department simply could not handle.[20] Statutory deadlines for processing claims became ignored and hospitals were not being paid.[21] In fact, many claims failed to resolve for up to a decade.[22] The Department simply lacked the resources necessary to handle the claims, and Congress failed to provide them.[23]

This Note will examine the extensive litigation and ongoing controversy arising from this backlog of Medicare claims. The central issue in these cases was whether the courts have the authority to order the Department to resolve the backlog. Under the status quo, the department routinely violates statutory deadlines, as claims that should have been solved within ninety days were not decided for years at a time.[24] However, as will be discussed below, the department could not resolve the backlog

16. *See id.* (discussing the dependence of plaintiffs' hospitals on Medicare).

17. *See id.* (noting the backlog of claims at the Department of Health and Human Services).

18. *See id.* at 186 (explaining that hospitals get paid for rendering services to Medicare patients by submitting claims to government contractors).

19. *See id.* at 187–90 (describing the Medicare appeals process).

20. *See id.* at 187 ("OMHA still has the capacity to process only 72,000 appeals per year, a far cry from . . . the over 800,000 appeals that composed its backlog in 2014.").

21. *See id.* at 188–89 (indicating that hospitals were not being paid because of large delays in the appeals process).

22. *See id.* at 187 ("[S]ome already-filed claims could take a decade or more to resolve.").

23. *See id.* at 187–88 (discussing Congress' failure to give appropriate resources to the Department of Health and Human Services).

24. *See* DEP'T OF HEALTH & HUM. SERVS., *infra* note 33, at 2 (describing how much time an ALJ has to issue a ruling).

without violating other congressional mandates. This situation has significant implications for the separation of powers: to fashion an effective remedy, the courts had to decide whether to dictate the affairs of an executive agency or refuse to enforce congressional mandates.[25] Neither made for a desirable outcome.

Part II will provide a more detailed description of how the Medicare payment system works and then explain how the backlog developed. Part III will discuss why this issue has proven so difficult to solve. Parts IV through VI will examine the procedural history of this issue, which includes multiple appeals and remands, as well a considerable split between the Fourth and D.C. Circuits.[26] Part VII will compare the approaches of the two circuits and argue that both circuits should have placed far greater impetus on Congress to address this issue. Each court here concluded that the Department was put in a bind and could not address the situation without additional resources.[27] Despite this, Congress has taken no remedial action and it has been nearly four years since this litigation began.[28] Without needed assistance, the courts have been unable to resolve this crisis and no end appears in sight.

II. Medicare's Administrative Appeals System and the "Incontrovertibly Grotesque" Backlog[29]

This section will outline how the appeals system works, reasons for the formation of the backlog, and the scale of the problem. Section A will first provide a detailed overview of the administrative appeals process, laying out the various stages a

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25. *See id.* at 189 ("The remedy of mandamus is a drastic one, to be invoked only in extraordinary circumstances.").

26. *Compare* Cumberland Cty. Hosp. Sys. v. Burwell, 816 F.3d 48, 57 (4th Cir. 2016) (ruling that mandamus jurisdiction was not warranted to address the Medicare backlog), *with* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.C. Cir. 2016) (ruling that mandamus jurisdiction was warranted to address the Medicare backlog).

27. *See, e.g.*, *See Am. Hosp. Ass'n*, 812 F.3d at 187–88 (concluding that the Department cannot address the backlog without more resources).

28. *See id.* (stating that Congress has not acted to fix the lack of resources).

29. *See Cumberland Cty. Hosp. Sys.*, 816 F.3d at 50 (describing the administrative process and appeals backlog for Medicare reimbursement as "incontrovertibly grotesque").

claim goes through before a healthcare provider receives payment. Section B will discuss the backlog itself, demonstrating how much of a problem it has become, and how unequipped the Department is to address it. Section C will discuss the RAC program, a component of the Affordable Care Act that is seen as the primary driver of the backlog. Finally, Section D will look at attempts to fix the backlog, and why those attempts have failed.

A. Detailed Overview of the Medicare Administrative Appeals Process

The administrative appeals system at issue is a five-step process.[30] First, after a hospital or other health care provider performs Medicare eligible services, they submit a claim to a Medicare Administrative Contractor (MAC).[31] A MAC is a private health care insurer that has been awarded a geographic jurisdiction to process certain Medicare claims.[32] MACs process an estimated 1.2 billion fee-for-service clams for more than 33.9 million beneficiaries every year.[33] MACs are multi-state, regional contractors, which serve as the primary contact between Medicare and healthcare providers.[34] The MAC decides whether or not to pay the healthcare provider's claim.[35]

If the claim is denied, the Medicare Act provides a four-level administrative appeals process followed by judicial review.[36] The

30. *See Am. Hosp. Ass'n*, 812 F.3d at 185 ("If a claim is denied, the Medicare Act provides a four-level administrative appeal process, followed by judicial review.").

31. *See id.* (explaining the first step of the Medicare appeals process).

32. *What is a MAC*, CENTERS FOR MEDICARE & MEDICAID SERVICES, https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html (last updated Oct. 26, 2017) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

33. DEP'T OF HEALTH & HUM. SERVS., HHS PRIMER: THE MEDICARE APPEALS PROCESS 1 (2017) http://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

34. *What is a MAC*, *supra* note 32.

35. *See* Am. Hosp. Ass'n. v. Burwell, 812 F.3d 183, 185 ("The MAC decides whether to pay or deny the claim.").

36. *See id.* ("If a claim is denied, the Medicare Act provides a four-level administrative appeal process, followed by judicial review.").

first step is an appeal to the MAC for "redetermination."[37] At this level, the appellants have 120 days from the initial claim denial to file a request for redetermination.[38] There is no amount-in-controversy requirement.[39] The MAC is to complete a redetermination within sixty days after the MAC receives the appeal.[40]

The second level of appeal is "Reconsideration" by a Qualified Independent Contractor (QIC).[41] Parties dissatisfied with the MAC's decision have 180 days from the day they receive the redetermination decision to file a request for reconsideration.[42] There is no amount-in-controversy requirement.[43] QICs utilize "a comprehensive data system . . . give weight to carrier and fiscal intermediary local coverage determinations, and conduct a panel review of all medical necessity denials."[44] The Center for Medicare and Medicaid Services (CMS) awards contracts to and oversees the decisions made by MACs and QICs.[45]

The third level, and most important for the purposes of this note, is de novo review by an administrative law judge (ALJ), which includes a hearing.[46] This level is overseen by the Office of Medicare Hearings and Appeals (OMHA).[47] A party has sixty days

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37. *See* DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 1 (describing the first step in the Medicare appeals process).

38. *See id.* (stating the timeframe for first step Medicare appeals).

39. *See id.* (explaining how there is no amount in controversy requirement).

40. *See id.* (discussing how long a MAC has to issue a decision).

41. *See id.* at 1–2 (explaining the second step in the Medicare appeals process).

42. *See id.* at 1 (stating the timeframe for second step Medicare appeals).

43. *See id.* (explaining how there is no amount in controversy requirement).

44. CTRS. FOR MEDICARE & MEDICAID SERVS., *Qualified Independent Contractors (QIC) Fact Sheet* 1 (2007) [hereinafter *Qualified Independent Contractors (QIC) Fact Sheet*], https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/QIC_Fact_Sheet.pdf (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

45. *See What is a MAC*, *supra* note 32 ("CMS procures all MAC contracts according to the Federal Acquisition Program."); *see also Qualified Independent Contractors (QIC) Fact Sheet*, *supra* note 44 (noting that CMS awarded QIC contracts to eight contractors to provide reconsiderations).

46. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016) (detailing the third level of Medicaid appeals).

47. *See id.* (indicating who oversees third level Medicare appeals).

after receiving the QIC decision to file a request for a hearing with an ALJ at OMHA.[48] There is a $150 amount in controversy requirement.[49] Critically, the ALJ is required to "conduct a hearing and render a decision within ninty days beginning on the date the request for hearing is filed."[50] The ALJ stage is crucial for hospitals because the ALJ hearings are conducted de novo, whereas the higher stages of review use a deferential standard.[51] ALJ hearings are the only opportunity for the healthcare provider to present evidence to rebut the Department's factual record.[52] The huge volume of appeals has rendered OMHA unable to render decisions within ninety days, resulting in a case backlog that has reached over 800,000 cases.[53] The D.C. Circuit noted that, at the time of its ruling, it may take as long as a decade to sort through the entire backlog.[54] In fact, the situation became so dire that OMHA suspended assigning appeals to ALJ dockets.[55]

If the ALJ does not render a decision within the statutory timeframe, the appellant may request a review by the Medicare Appeals Council at the HHS Departmental Appeals Board (DAB).[56] This is the fourth and final level of appeal before judicial review in a district court.[57] Parties may appeal an ALJ ruling within sixty

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48. *See* DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 2 (explaining the timeframe for third level Medicare appeals).

49. *See Am. Hosp. Ass'n*, 812 F.3d at 185 (stating that there is a $150 amount in controversy requirement for third level Medicare appeals).

50. *See* DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 2 (describing how much time an ALJ has to issue a ruling).

51. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185–89 (D.C. Cir. 2016) (noting that at the DAB stage, a hearing is conducted only if an "extraordinary question" is presented).

52. *See id.* at 188 (noting that delays at the ALJ stage are particularly difficult for hospitals, because the Department recoups funds before reaching the ALJ hearing).

53. *See id.* at 187 ("[I]n December 2013, OMHA's Chief ALJ sent a memorandum informing various hospitals that OMHA had temporarily suspended assigning appeals to ALJ dockets, that the suspension would last 'at least 24 months,' and that the agency 'expect[ed] post-assignment hearing wait times [would] continue to exceed 6 months.'").

54. *See id.* ("These figures suggest that at current rates, some already filed claims could take a decade or more to resolve.").

55. *Id.*

56. DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 2.

57. *Id.*

days from receiving the decision.[58] Parties may also file a request to "escalate" the appeal from the ALJ level if the ALJ has not rendered a decision within ninety days.[59] This process of "escalation" essentially skips the ALJ hearing and proceeds to the DAB board.[60] The Council must render a decision within ninety days of receiving the appeal.[61] If the ninety day deadline is not met, the appellant may request that the appeal be "escalated" to district court.[62] Similar to the ALJ stage of the process, an overwhelming number of appeals has left the DAB unable to comply with the ninety day framework.[63]

B. The Backlog

If all of these time periods are met, appeals work through the administrative process within about a year.[64] For context, more than 1.2 billion Medicare fee-for-service claims were processed in fiscal year 2015.[65] Ten percent of these claims, or 123 million, were denied.[66] Of these, 3.7 million or three percent of all denied Medicare claims were appealed.[67] From fiscal year (FY) 2010 to FY 2015, OMHA received a 442 percent increase in its annual number of appeals.[68] Despite the flood of claims, funding for the Department during this period remained largely stagnant, leaving it completely unable to adjudicate the claims in compliance with the statutory framework.[69] By the end of FY 2015, 884,017 appeals

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58. *Id.*

59. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 186 (D.C. Cir. 2016) (outlining the escalation process providers must use to advance appeals to the next stage including "the DAB stage if the ALJ fails to act within the required ninety days").

60. *Id.*

61. *Id.*

62. *Id.*

63. DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 3.

64. *See Am. Hosp. Ass'n*, 812 F.3d at 186 (explaining the timeline of the appeals process).

65. DEP'T OF HEALTH & HUM. SERVS., *supra* note 33, at 3.

66. *Id.*

67. *Id.*

68. *Id.*

69. *See id.* ("However, while the volume of appeals has increased

were pending before OMHA.[70] The Department estimated that given its current resources and without any additional appeals, it would take eight years for OMHA to process its backlog.[71]

OMHA, and more broadly the Department, can only process roughly 75,000 appeals per year.[72] As a result, OMHA suspended assigning appeals to ALJ dockets and noted that the suspension would last "at least 24 months."[73] By statute, appeals at this stage are supposed to be heard by an ALJ within ninety days of OMHA receiving the matter.[74] Notwithstanding, "as of February 2015, the decisions ALJ's were releasing had been pending for an average of 572 days" and "some already-filed claims could take a decade or more to resolve."[75]

C. Causes of the Backlog, the RAC Program

The D.C. Circuit found that the main driver of the backlog has been the implementation of the Medicare Recovery Audit Program.[76] The Recovery Audit program was implemented in 2010 as part of the Affordable Care Act, with the responsibility of "identifying underpayments and overpayments and recouping overpayments."[77] The program had an expansive mandate as Congress specified it must have "nationwide coverage."[78] The recovery audit contractors (RAC's), are paid on a contingent basis

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dramatically, funding has remained comparatively stagnant.").

70. *Id.*

71. *Id.*

72. *See id.* at 6 (noting annual adjudication capacity of 65,000 in FY 2012, 72,000 in FY 2014, and 87,000 in 2016).

73. *Id.*

74. *See* 42 U.S.C. § 1395ff(d)(1)(A) (2014) ("[A]n administrative law judge shall conduct and conclude a hearing . . . and render a decision on such hearing" within ninety days.").

75. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 187 (D.C. Cir. 2016).

76. *See id.* at 186–87 (summarizing the D.C. Circuit's finding that the administrative appeals process functioned within the statutory time frames until 2010 when the Department Secretary fully implemented the Medicare Recovery Audit Program which included the RAC appeals program).

77. *Id.* at 186 (citing 42 U.S.C. § 1395ddd(h)(1)(2016)).

78. *See id.* ("Congress also specified certain other features of the program, such as that it must have '[n]ationwide coverage,' . . . it left the Secretary broad discretion to determine many other program details.").

for collecting overpayments.[79] The RAC program has been quite successful, recovering $2.3 billion and $3.65 billion in overpayments in FY 2012 and FY 2013, respectively.[80]

The RAC program has also created an enormous problem. RAC decisions are appealable through the same administrative process outlined above.[81] The result was an enormous increase in appeals before the Office of Medicare Administration.[82] In FY 2011, before the RAC program was fully implemented, the total number of administrative appeals was a manageable 59,600, well within the Department's capacity.[83] By FY 2013, the total number of backlogged cases grew to more than 384,000.[84] When the case got to the D.C. Circuit, the backlog reached over 800,000.[85] Simply put, the RAC program has recovered billions of dollars in waste, fraud and abuse, but, it has also created a backlog of appeals "that makes compliance with the statutory time frames impossible."[86]

The RAC program's role in driving the backlog is clear, as forty-six percent of the appeals before OMHA originated from the RAC program.[87] While there are some other contributors, the RAC program is seen as the primary culprit.[88]

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79. *Am. Hosp. Ass'n*, 812 F.3d at 186.

80. *Id.* at 187.

81. *Id.*

82. *See id.* ("Thus, the number of appeals filed ballooned from 59,600 in fiscal year 2011 to more than 384,000 in fiscal year 2013.").

83. *Id.*

84. *Id.*

85. *Id.*

86. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016) (explaining that the plaintiffs seek a writ of mandamus to compel the Secretary to act within the statutory time frames for the RAC program).

87. *See id.* at 187 ("[B]ecause RAC denials are appealable through the same administrative process as initial denials, the RAC program has contributed to a drastic increase in the number of administrative appeals.").

88. *See* DEP'T OF HEALTH & HUM. SERV., *supra* note 33 (listing one of "four primary drivers" of the backlog as the "National implementation of the Medicare fee-for-service Recovery Audit Program (RAP)").

D. Attempts to Fix the Backlog

DHHS has taken steps to alleviate the backlog, some of which have been marginally effective.[89] For example, OMHA has doubled the number of cases the average ALJ resolves each year.[90] It also secured funding for seven additional ALJ's in FY 2014, a ten percent increase in staff.[91] More recently the Department has created a new position, attorney adjudicator, authorized to issue a decision in any case that does not require a hearing.[92] However, attorney adjudicators have not done much to resolve the backlog. The backlog consists of claims that are awaiting a hearing by an ALJ, so attorney adjudicators cannot address them.[93] The Department also created its "Low Volume Appeals Initiative" whereby service providers with smaller numbers of claims could settle them in bulk for a specified amount.[94]

The Department's successes have been limited considering that OMHA can only resolve about 70,000 appeals per year.[95] This is completely inadequate in the face of 400,000 appeals in FY 2013 and over 800,000 appeals in FY 2014.[96] The root cause of the issue

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89. *See Am. Hosp. Ass'n*, 812 F.3d at 187 ("The Secretary has worked to address the backlog and corresponding delays.").

90. *Id.*

91. *Id.*

92. *See* Christopher Cheney, *Medicare Claims-Appeal Backlog: New Rules Push Faster Processing*, HEALTH LEADERS MEDIA (June 30, 2017), http:// www.healthleadersmedia.com/finance/medicare-claims-appeal-backlog-new-rules-push-faster-processing ("Attorney adjudicators are a new position at the ALJ level created this year to help clear the appeal backlog.") (on file with Washington & Lee Journal of Civil Rights & Social Justice).

93. *See id.* (specifying that attorney adjudicators may not preside over claims which require a hearing).

94. *See* CENTERS FOR MEDICARE & MEDICAID SERV., *Low Volume Appeals Initiative* (Jan. 18, 2018), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html (describing program that allows service providers with 500 or fewer pending appeals to apply for bulk settlement for 62% of the amount in controversy) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

95. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 187 (D.C. Cir. 2016) ("OMHA still has the capacity to process only about 72,000 appeals per year, a far cry from the almost 400,000 appeals it received in fiscal year 2013, or from the over 800,000 appeals that composed its backlog in July 2014.").

96. *Id.*

is a dramatically increased workload with stagnant funding for the Department.[97] The D.C. Circuit noted that it believes many of these appeals will not be heard by an ALJ for at least a decade.[98] OMHA recognized its position, and in a December 2013 memorandum, informed various hospitals that it would temporarily suspend assigning appeals to ALJ dockets for at least twenty-four months.[99]

Congress has considered a bill to increase funding for OMHA, as well as to reform the overall process.[100] The Senate Finance Committee has held hearings on the issue, and its chairman, Orrin Hatch, noted that the Department cannot effectively address its backlog without Congressional action.[101] A bill known as the AFIRM Act would provide $125 million in additional annual funding to OMHA, as well as to other reforms.[102] The D.C. Circuit noted that "the bill remains only a bill" and at the time of this writing the bill has not proceeded out of committee.[103]

Compounding the sheer size of the backlog is the success rate of these appeals.[104] The American Hospital Association performed

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97. *See* DEP'T OF HEALTH & HUM. SERV., *supra* note 33, at 3 ("[W]hile the volume of appeals has increased dramatically, funding has remained comparatively stagnant.").

98. *See Am. Hosp. Ass'n*, 812 F.3d at 187 ("These figures suggest that at current rates, some already-filed claims could take a decade or more to resolve.").

99. *Id.*

100. *See id.* ("Congress is fully aware of both the backlog and its connection to the RAC program.").

101. *See* Orrin Hatch, Chairman, Senate Fin. Comm., Opening Statement at Finance Hearing on Medicare Audit and Appeals (Apr. 28, 2015), http://www.finance.senate.gov/chairmans-news/hatch-statement-at-finance-hearing-on-medicare-audit-and-appeals ("The Office of Medicare Hearings and Appeals has also taken steps to address its backlog, but there is only so much the agency can do with their current authorities and staffing.") (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

102. *See* Am. Hosp. Assoc. v. Burwell, 812 F.3d 183, 188 (D.C. Cir. 2016) (showing how the increase in funding combined with other reforms to the appeal process can address the backlog issue).

103. *See* Am. Hosp. Ass'n v. Burwell, No. CV14-851, 2016 WL 5106997, at *230 (D.D.C. Sept. 19, 2016) ("No debate or vote has been scheduled, and the Secretary offers no evidence that any legislative action is imminent, that the bill has support in the House of Representatives, or that the President would sign it.").

104. *See Am. Hosp. Assoc.*, 812 F.3d at 188 ("If the vast majority of these delayed appeals were ultimately denied, they might amount to little more than an unfortunate nuisance. The record suggests, however, that many have merit.").

a survey of hospitals, finding that fifty-two percent of RAC denials were appealed, and sixty-six percent of those appeals were successful.[105] DHHS admitted that at least as many as forty-three percent of all appeals, both RAC and non-RAC denials, are successful.[106] The success rate of these appeals, and the plaintiff hospitals' reliance on revenue from Medicare, underscored the necessity of resolving the backlog.

The backlog's concentration at the ALJ stage of the appeals process is highly significant. HHS recoups funds after the QIC stage, the stage which immediate precedes ALJ review.[107] The plaintiff hospitals derive most their revenue from treating Medicare patients, therefore "they are often deprived of access to significant funds to which they are entitled."[108] This, coupled with hospitals' high success rate at the ALJ level, imposes a heavy toll upon hospitals.[109] The ALJ review is also important for evidentiary reasons. An ALJ hearing provides for de novo review, while the "escalate[d]" review uses a more deferential standard.[110]

III. The Issue Before the Courts

The issue in these cases considered whether a court has the power to compel the Department to resolve the backlog.[111] On the surface, this case seemed straightforward, as the statutory deadlines are quite clear. For the Department to grant the relief requested, it would have been necessary to scrap or severely curtail the RAC program.[112] If the court gave such an order, it would

105. *See id.* (citing a survey conducted in 2014 by one of the plaintiffs in this case that hospitals responded to).

106. *Id.*

107. *Id.* (citing 42 U.S.C. § 1395ddd(f)(2)(A) (2016).

108. *See id.* (describing how these hospitals have been forced to cut back services to Medicare patients, as the hospitals are wary of performing certain services because they are not sure when or if they will be paid).

109. *See id.* (noting that the plaintiff hospitals derived roughly forty-seven to sixty-five percent of their gross revenue from Medicare).

110. *Id.* at 185–86.

111. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 45–46 (D.D.C. 2014) ("Plaintiffs brought this suit against the Secretary of Health and Human Services for an order compelling her to process their administrative appeals in accordance with statutory timelines.").

112. *See* Am. Hosp. Assoc. v. Burwell, 812 F.3d 183, 185–87 (D.C. Cir. 2016)

create a separation of powers issue.[113] In most circumstances, a court has no right to order the affairs of an executive agency.[114] To provide relief, the court would have had to make determinations of how to allocate the department's resources, and dictate to the Secretary how much can be spent on the RAC program, backlog alleviation, or other priorities.[115] This potential "intrusion" on the inner workings of an agency presented a serious risk of improper infringement of executive branch autonomy.[116]

The courts faced a separation of powers issue regarding Congress as well, as they would be deciding which of two statutes should be enforced and which should be ignored.[117] Congress authorized both the framework and statutory deadlines for Medicare claims and appeals and the creation of the RAC program.[118] Any significant curtailment of the RAC program would frustrate Congress' intent in creating it, and as noted above, the RAC program has been remarkably successful in its mission of recovering misspent funds.[119] But enforcing the RAC program would force the agency to violate statutory deadlines. In sum, the courts ultimately were going to disrupt the will of Congress whether or not they chose to grant the plaintiff relief.[120] If the courts dismissed the case, the statutory framework for these

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(showing how this case is about an agency caught between two congressionally assigned tasks).

113. *See id.* (describing that absent further congressional action the Secretary would have to drastically curtail the RAC program to comply with such an order, and that the political branches are endeavoring to address the issue).

114. *See id.* (explaining how ordering the affairs of an executive agency would probably require the agency to make major changes to its operations, which could limit the scope of a statutorily mandated program).

115. *Id.*

116. *Id.*

117. *See id.* (highlighting other issues with the Congress ordering the affairs of an executive agency).

118. *See id.* (showing how Congress is caught in the middle because it gave the court power to enforce the framework and deadlines for Medicare claims, but also authorized the creation of the program itself).

119. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 56 (D.D.C. 2014) (explaining how RACs were introduced as a check on improper payments, and have been successful in their role, recouping $2.3 billion in 2012).

120. *See id.* at 45 (stating how no matter which way the courts held in the case, the intentions of Congress would be disrupted).

appeals would continue to be blatantly violated.[121] At the same time, if they granted relief, they would be displacing the will of Congress and intruding into the policy decisions of an executive agency.[122]

The courts that considered this issue were understandably confounded.[123] Ultimately, the crisis is not the fault of the courts or even of the Department.[124] The driver of this crisis is Congressional inaction, specifically, failure to provide necessary appropriations for additional Administrative Law Judges for the Department.

IV. American Hospital Association v. Burwell I

This section will discuss the first round of opinions in the *American Hospital* saga. Part A will discuss the D.C. District's opinion on first impression. Here, the court ruled for the Department, holding that the relief sought would have intruded impermissibly into the affairs of an executive agency. Part B will detail the D.C. Circuit's opinion that overruled the district court. In that opinion, the court held that the District Court indeed had jurisdiction and could provide relief to the hospitals if the political branches continued to fail to act.

A. Original Action in the D.C. District Court: The Court Refused to Grant Mandamus Jurisdiction or Relief.

On first impression, the D.C. District Court ruled for the Department, dismissing the case due to the thorny jurisdictional

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121. *See id.* (highlighting that Congress could violate the appeals process if it dismissed the case).

122. *See id.* (showing that if relief is granted, the will of Congress will be ignored).

123. *Compare* Cumberland Cty. Hosp. Sys. v. Burwell, 816 F.3d 48, 50 (4th Cir. 2016) (holding that mandamus jurisdiction was not warranted to address the backlog), *with* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 188 (D.C. Cir. 2016) (holding that mandamus jurisdiction was warranted).

124. *See* Am. Hosp. Assoc. v. Burwell, 812 F.3d 183, 188–89 (D.C. Cir. 2016) (explaining how the District Court hoped the Secretary and Congress would work together to solve how OMHA could receive more resources).

environment.[125] The Plaintiff Hospitals had sought a writ of mandamus that would force the Secretary to adjudicate their pending administrative appeals in a timely fashion.[126] The Court noted the size and scale of the backlog and that it "sympathizes with the Plaintiffs' plight" but found that the Department's delay "while far from ideal, is not so egregious as to warrant intervention."[127]

The district court's inquiry was focused largely on the "extraordinary" nature of the mandamus remedy.[128] "Mandamus is 'drastic,' 'it is available only in extraordinary situations,' and 'it is hardly every granted."[129] To be entitled to mandamus relief, Plaintiffs must show that (1) they have a clear and indisputable right to relief, (2) that the agency has a clear duty to act, and (3) that there is no other adequate remedy available to them.[130] Further, the party seeking mandamus carries the burden of showing that its right to issuance of the writ is clear and indisputable.[131] Beyond these necessary requirements, "even if the plaintiff overcomes all these hurdles, whether mandamus relief should issue is discretionary."[132]

Mandamus involves both a jurisdictional and a merits inquiry that is said to "merge."[133] This is because a court's jurisdiction to compel a government official or agency to act is limited to specific circumstances in which a "clear and compelling duty is owed to the plaintiff."[134] For that reason, courts must consider the merits to

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

126. *Id.* at 48.

127. *Id.* at 45.

128. *Id.* at 49.

129. *Id.*

130. *Id.* (quoting United States v. Monzel, 641 F.3d 528, 532 (D.C. Cir. 2011) (citing Power v. Barnhart, 292 F.3d 781, 784 (D.C. Cir. 2002))).

131. *Id.* (quoting N. States Power Co. v. U.S. Dep't of Energy, 128 F.3d 754, 758 (D.C. Cir. 1997) (quoting Gulfstream Aerospace Corp. v. Mayacamas Corp., 485 U.S. 271, 289 (1988))).

132. *See In re* Cheney, 406 F.3d 723, 729 (D.C. Cir. 2005) (stating the standard of review for the court to follow when deciding whether the plaintiff should receive a mandamus relief).

133. *See id.* ("To this extent, mandamus jurisdiction under § 1361 merges with the merits.").

134. Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 50 (D.D.C. 2014) (quoting Auburn Reg'l Med. Ctr. v. Sebelius, 686 F. Supp. 2d 55, 62 (D.D.C. 2010), *rev'd on*

decide whether they have jurisdiction to provide relief. If no "clear and compelling duty" exists, then the court has no jurisdiction and must dismiss the case."[135] As both ends of the issue contribute to the other, the court in *American Hospital Association v. Burwell*[136] had to examine the merits despite its reservations.[137]

American Hospital did not concern an agency's refusal to act; rather, the issue was agency delay which worked against the plaintiff hospitals.[138] In actions regarding agency delay, the issue is whether the delay is "so egregious" as to warrant relief, a heightened standard.[139] No hard and fast rule exists as to how long a court must wait for agency action.[140] Rather, courts analyze each case according to its unique circumstances[141] and look to the six "TRAC factors" to provide "useful guidance in assessing claims of agency delay.[142]

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other grounds and remanded, 642 F.3d 1145 (D.C.Cir.2011)).

135. *See id.* (quoting *In re* Cheney, 406 F.3d 723, 729 (D.C. Cir. 2005); *In re* Medicare Reimbursement Litig., 309 F. Supp. 2d 89, 95, n.4 (D.D.C.2004)).

136. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43 (D.D.C. 2014) (holding the the Secretary of Health and Human Servies delay in granting Medicare claims was not egregious enough for the Court to step in and grant mandamus relief).

137. *Id.* at 50.

138. *See id.* (showing that the issue against the hospitals was the agency delay).

139. *See id.* at 45 (discussing egregiousness with the heightened standard).

140. *Id.*

141. *See id.* at 51 (explaining how a Court must evaluate and determine the nature of the agency delay).

142. *See id.* at 51–52 (listing the "TRAC factors" to use when evaluating agency delay). The TRAC factors are:

> [T]he time agencies take to make decisions must be governed by a rule of reason; (2) where Congress has provided a timetable or other indication of the speed with which it expects the agency to proceed in the enabling statute, that statutory scheme may supply content for this rule of reason; (3) delays that might be reasonable in the sphere of economic regulation are less tolerable when human health and welfare are at stake; (4) the court should consider the effect of expediting delayed action on agency activities of a higher or competing priority; (5) the court should also take into account the nature and extent of the interests prejudiced by delay; and (6) the court need not find any impropriety lurking behind agency lassitude in order to hold that agency action is unreasonably delayed.

Id. (quoting Telecomms. Research & Action Ctr. v. FCC, 750 F.2d 70, 79 (D.C. Cir.

The court found that the first two factors militated strongly in the plaintiff hospitals' favor.[143] These two factors go hand in hand. The first asks whether the agency's timeline of action is governed by a rule of reason.[144] The second provides that the rule of reason may be found in a "timetable or other indication . . . in the enabling statute."[145] The Department admitted that the ninety day time table provided by the statute supplied the "rule of reason," and admitted that the ALJs violated the statute.[146] It was also noted that these two factors have been called the "most important" factors and that while there is no *per se* rule for agency delay, a reasonable time for agency action "is typically counted in weeks or months, not years."[147]

The other TRAC factors did not support a finding that the agency's delay was "so egregious" as to warrant mandamus relief.[148] The third TRAC factor, for example, looks to the potential impact on the public. Agency delays that impact human health and welfare are given greater weight than simply economic injury.[149] The hospitals argued that this factor was met, as they had necessary assets tied up in the appeals process, and one hospital had its bond rating at risk.[150] There was a real impact on human health and welfare as these hospitals were forced to scale back on services.[151]

As noted, granting mandamus relief is a discretionary even when all the TRAC factors are present. Here, the threat to human

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1984)).

143. *See id.* (discussing the first two temporal factors of the test).

144. *Id.* at 51.

145. *Id.*

146. *See id.* ("The Secretary concedes that the 90-day statutory 'timetable supplies the applicable rule of reason' in this case, and she does not deny that ALJs are in violation of this rule.")

147. *In re* Am. Rivers & Idaho Rivers United, 372 F.3d 413, 419 (D.C. Cir. 2004).

148. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 51 (D.D.C. 2014) (citing *In re* Barr Labs., Inc., 930 F.2d 72, 75 (D.C.Cir.1991)) ("Although the Court agrees that HHS has violated its statutory framework, this conclusion 'does not, alone, justify judicial intervention.'").

149. *Id.* at 52.

150. *Id.*

151. *Id.*

health and welfare was deemed insufficient to grant relief.[152] The court distinguished this case with others in which more specific and immediate threats to public health were at play.[153] For example, in *Public Citizen v. Heckler*,[154] the secretary was compelled to act on a petition asking her department to ban sales of raw milk, because "[o]fficials at the highest levels of [the agency] have concluded that certified raw milk poses a serious threat to public health."[155] The court regarded the plaintiff's claim as compelling, but did not pose a severe and imminent threat to public health.[156]

Given the murky TRAC inquiry, the separation of powers issue loomed large. Mandamus relief does not necessarily follow a finding of a violation: "respect for the autonomy and comparative institutional advantage of the executive branch has traditionally made courts slow to assume command over an agency's choice of priorities."[157] Courts do not have generally have authority to reorder agency priorities.[158] Rather, agencies are granted powers by Congress, and are best positioned to allocate resources toward their objectives:

> Such budget flexibility as Congress allowed the agency is not for [the Court] to hijack."[159] In the event that Congress did not appropriate proper funding for a program or agency, "[p]erhaps . . . Congress should earmark more funds specifically to the . . . program, but that is a problem for the political branches to work out.[160]

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152. *Id.*

153. *Id.*

154. *See* Pub. Citizen v. Heckler, 602 F. Supp. 611 (D.D.C.1985) (holding that the Secretary of Health and Human Services was obligated to act on the petition banning all domestic sales of raw milk and raw milk products).

155. *Id.* at 613.

156. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 53 (D.D.C. 2014) (noting that the Department's entire caseload is related to human health and welfare, and that the consequences of agency delay in this case did not reach the standard of previous cases where the threat required urgent action).

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.*

Ultimately, the court concluded that equitable grounds did not exist for mandamus relief.[161] Although a clear statutory violation occurred, in cases of agency delay the delay must be "so egregious" as to warrant relief.[162] As of December 18, 2014, the court did not find that such circumstances existed.[163] The delay did not impact public health and welfare to a grave enough extent, and the court made it clear that "Congress is well aware of the problem, and Congress and the Secretary are the proper agents to solve it."[164] Further, "[i]n such situation[s]—where an agency is underfunded . . . the Court will not intervene."[165]

B. D.C. Circuit Appeal: The Court Reversed the District Court and Granted Mandamus Jurisdiction.

On appeal, the D.C. Circuit reversed the lower court and held that (1) the district court had jurisdiction to issue a writ of mandamus and (2) remand was warranted to determine whether the delays in processing appeals were compelling equitable grounds to issue the writ.[166] Like the lower court, the circuit court was highly cautious about intervening in the inner workings of an executive agency: "[p]erhaps counseling most heavily against mandamus is the writ's extraordinary and intrusive nature, which risks infringing on the authority and discretion of the executive branch."[167] Granting relief would "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 in incorrectly paid funds."[168]

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161. *Id.* at 55.

162. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016) ("[W]e reiterate that the district court has broad discretion in weighing the equities and deciding 'whether the agency's delay is so egregious as to warrant mandamus.'").

163. Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 55 (D.D.C. 2014).

164. *Id.*

165. *Id.*

166. *Am. Hosp. Ass'n*, 812 F.3d at 185.

167. *Id.*

168. *Id.* at 192.

The circuit court saw considerable factors in favor of mandamus.[169] There was a "real impact" on "human health and welfare," as the court gave considerable weight to the hospitals' claims of financial hardship.[170] Baxter Regional Medical Center, one of the plaintiff hospitals, alleged that money tied up in appeals made it difficult to replace ICU beds, make structural repairs, or replace outdated labs.[171] The court further noted "common sense suggests that lengthy payment delays will affect hospitals' willingness and ability to provide care."[172]

Congressional inaction played a major role in the decision as well.[173] The lower court's decision noted that the political branches are aware of the situation and are better positioned to handle the matter than the courts.[174] However, almost two years later at the circuit court, the political branches had done nothing: "[w]e reverse and remand with instructions to the district court to consider the problem as it now stands—worse, not better."[175]

If Congress fails to act or does not provide sufficient resources to comply with statutory obligations previously issued, the Circuit Court instructed the District Court that it could act if equitable grounds existed.[176] According to the Circuit Court "[f]ederal agencies must obey the law, and congressionally imposed mandates and prohibitions trump discretionary decisions."[177] The RAC program that catalyzed the backlog explosion was implemented by Congress.[178] But Congress neither provided the

169. *Id.* at 193.

170. *Id.*

171. *See id.* at 193 (detailing the hardships that the hospitals alleged, another hospital reported avoiding admitting certain types of patients who would likely trigger an audit).

172. *Id.*

173. *See id.* ("Congress is fully aware of both the backlog and its connection to the RAC program.").

174. Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 53 (D.D.C. 2014).

175. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016).

176. *See id.* at 192 ("On remand, the district court should determine whether 'compelling equitable grounds' now exist to issue a writ of mandamus.").

177. *Id.*

178. Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1395ddd(h) (2012).

means to implement it properly nor did it relieve the agency of its duty to process standard Medicare appeals.[179]

The D.C. Circuit held that the clear statutory language mandating an ALJ hearing within ninety days gave the district court the authority to issue a writ of mandamus.[180] However, even when a violation is proven, granting mandamus relief is a discretionary matter.[181] Therefore, the district court was instructed to determine whether compelling equitable grounds existed to issue the writ.[182]

V. Cumberland County Hospital Association v. Burwell*: The Fourth Circuit Split With the D.C. Circuit and Refused to Grant Mandamus Jurisdiction or Relief*

Less than a month after *American Hospital Association* was decided by the D.C. Circuit, the Fourth Circuit was faced with the same issue involving a different set of hospitals in *Cumberland County Hospital System, Inc. v. Burwell*.[183] The Fourth Circuit split with the D.C. Circuit, holding that mandamus jurisdiction did not lie.[184] Unlike the D.C. Circuit, the Fourth Circuit found that the statute at issue did not guarantee a hearing within ninety days that could be enforceable through mandamus.[185] Instead, the statute provided an alternative remedy, the "escalation" process that is outlined above.[186] In the eyes of the Fourth Circuit, the

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179. *Am. Hosp. Ass'n*, 812 F.3d at 193.

180. *See id.* ("Congress fails to act, either by providing the Secretary sufficient resources to comply with the clear statutory deadlines it has already enacted or by relieving her of the obligation to do so.").

181. *See id.* (explaining how District Court has broad discretion when determining equity and whether a party's conduct deserves a warrant mandamus).

182. *See id.* at 194 (remanding the case back to the lower court to reassess the issue according to the opinion).

183. *See* Cumberland Cty. Hosp. Sys. v. Burwell, 816 F.3d 48, 49 (4th Cir. 2016) (holding that the Medicare Act grant the right for a health system to have a hearing on claims for Medicare reimbursement within ninety days).

184. *Id.*

185. *Id.*

186. *Id.* at 54.

political branches were better equipped to address the issue and refused to grant mandamus jurisdiction.[187]

For the Fourth Circuit, the presence of an alternative remedy was enough to defeat the plaintiff's claims.[188] Mandamus requires a "clear and indisputable right" to be court enforceable.[189] Here, the plaintiffs possessed a clear and indisputable right to the administrative process laid out by statute.[190] Because the process allowed "escalation" from the ALJ level of appeal to the DAB level, there was not a clear and indisputable right to an adjudication of its appeals before an ALJ within ninety days.[191] The counterargument to the escalation issue is outlined above, and centers on the fact that the plaintiff hospitals view ALJ hearings are crucial for evidentiary purposes.[192]

The Fourth Circuit acknowledged that the appeals backlog is "incontrovertibly grotesque" and "its administrative process is in grave condition."[193] However, the court denied mandamus jurisdiction.[194]

Federalism concerns figured prominently in the Fourth Circuit's decision.[195] It first noted that mandamus is a drastic remedy that is reserved only for extraordinary situations[196] involving the performance of official acts or duties. "Mandamus is [ ] 'drastic'" because of its invasive nature.[197] "[W]ere we to

187. *See id.* at 50 ("[T]hat the political branches, rather than the courts, are best suited to address the backlog in the administrative process. We affirm.").

188. *See id.* (explaining how a healthcare provider must go through the administration process before turning to the Court).

189. *Id.* at 52.

190. *See id.* at 56 ("While the Act gives the hospital System the clear and indisputable right to this administrative process, it does not give it a clear and indisputable right to adjudication of its appeals before an ALJ within 90 days.").

191. *Id.*

192. *See id.* at 55–56 (describing the advantages of creating a full administrative record with an ALJ hearing).

193. *Id.* at 50, 57.

194. *See id.* at 57 ("[W]e affirm the district court's decision to dismiss the Hospital System's claim for a writ of mandamus.").

195. *See id.* at 56 ("[W]ere we to interfere at the ALJ stage, as the Hospital System would have us do, we would be undermining important separation-of-powers principles.").

196. *Id.* at 52.

197. *Id.* (quoting Kerr v. U.S. Dist. Court for the N. Dist. Of Cal., 426 U.S. 394, 402 (1976)).

interfere at the ALJ stage . . . we would be undermining important separation-of-powers principles."[198] Both executive and legislative powers would be infringed by granting jurisdiction:

> Even if the backlog were fully attributable to the Secretary's mismanagement, as the Hospital System maintains, our "respect for the autonomy and comparative institutional advantage of the executive branch" must make us mighty "slow to assume command over an agency's choice of priorities." In re Barr Labs., Inc., 930 F.2d 72, 74 (D.C.Cir.1991). And if the backlog were attributable to Congress' failure to fund the program more fully or otherwise to provide a legislative solution, it would likewise be a problem for Congress, not the courts, to address.[199]

The court also expressed skepticism that judicial intervention would improve the situation; granting timely relief would require simply putting these plaintiffs' claims at the top of the queue, hardly an equitable solution given the scale of the backlog and number of providers that have pending claims.[200] The court concluded: "[w]e thus share the district court's belief that the political branches are best-suited to alleviate OMHA's crippling delays."[201]

VI. American Hospital Association v. Burwell II

This section will discuss the second round of opinions after the D.C. Circuit remanded the *American Hospital*[202] matter back to the district level. Part A will examine the D.C. District's second opinion which was an about face from its original holding. In line with the circuit court's instructions, the district court granted mandamus relief by ordering the Department to resolve the

198. *Id.* at 56.

199. *Id.*

200. *See id.* ("[W]e have no reason to believe that any judicial intervention into HHS's administrative process, as urged by the Hospital System, would improve anything.").

201. *Id.*

202. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183 (D.C. Cir. 2016) (holding that the case needed to be remanded in order to determine whether the grounds of the case, such as the delays in processes, warranted a writ of mandamus to be used).

backlog by a specified date. Part B will discuss the appeal of that ruling; the D.C. Circuit found that the proposed remedy was impracticable and remanded the matter once again to consider alternatives.

A. On Remand, the D.C. District Court Granted Mandamus Relief to the Plaintiff Hospitals, Deepening the Split with the Fourth Circuit

The D.C. Circuit ruled that the threshold requirements for mandamus jurisdiction were met and remanded the case to the district Court to determine whether compelling equitable grounds now existed to issue a writ.[203] The district Court was given considerable discretion to grant relief because of the failure of the political branches to solve the problem.[204] This political paralysis was crucial to granting mandamus jurisdiction: "The record on appeal makes clear that the situation has worsened . . . although courts must respect the political branches and hesitate to intrude on their resolution of conflicting priorities, our ultimate obligation is to enforce the law as Congress has written it."[205] In the D.C. Circuit's view, the ninety day statutory time frame was a clear statutory duty created by Congress.[206] Its provisions were to be followed, and therefore a writ of mandamus compelling HHS to comply would be necessary if the political branches remained unable or unwilling to address the issue.[207]

The court then weighed the TRAC factors again, taking into account the current procedural posture and lack of meaningful

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203. *See id.* at 192 ("Because the Association has demonstrated that the threshold requirements for mandamus jurisdiction are met, and because the Secretary's other jurisdictional arguments fail, we reverse the district court's dismissal for lack of jurisdiction.").

204. *See id.* at 193 ("[W]e reiterate that the district court has broad discretion in weighing the equities and deciding whether the agency's delay is so egregious as to warrant mandamus.").

205. *Id.* at 192.

206. *See id.* ("[T]the statute imposes a clear duty on the Secretary to comply with the statutory deadlines.").

207. *See id.* at 193 ("[T]he clarity of the statutory duty will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time—say, the close of the next full appropriations cycle.").

action by Congress and the Department.[208] The main factor against mandamus is the "extraordinary and intrusive" nature of the remedy.[209] In other words, the court believed that granting the writ would require serious changes to the agency's operations and allocation of resources.[210] It would specifically impact the mechanics of the RAC program, which while problematic, had also been authorized by Congress.[211] In addition, the Secretary had made good faith efforts to comply with the statute, and implemented new initiatives to target the backlog.[212] Availability of "escalation" as a remedy also weighed against mandamus, but noted that escalation "may offer less than full relief."[213]

There were several factors in favor of mandamus.[214] The delays had a real impact on human health and welfare; hospitals are "deeply out of pocket due to denied claims."[215] High success rates of appeals were also noted by the court as weighing strongly in the plaintiff hospitals' favor.[216] In many cases, the majority of

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208. *See* Am. Hosp. Ass'n v. Burwell, 209 F. Supp. 3d 221, 225 (D.D.C. 2016) ("Whatever this Court originally thought of the merits of this case, it must, of course, follow the Court of Appeals' direction on remand. In its opinion, that court set out several considerations weighing for and against mandamus, each of which this Court addresses in the subsections that follow.").

209. *Id.*

210. *See id.* ("Granting the writ in this case would almost surely require the Secretary to significantly alter the agency's priorities and operations, particularly as to the RAC Program.").

211. *See id.* at 226 ("[T]he substantial discretion granted to the Secretary by Congress 'to implement [the Recovery Audit Program] and determine its scope'—including to curtail it as necessary to meet the statutory deadlines—favors granting the writ.").

212. *See id.* at 225 (quoting Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.D.C. 2016)) ("[T]he Court must consider 'the Secretary's good faith efforts to reduce the delays within the constraints she faces.'").

213. *Id.* at 226 (quoting Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.D.C. 2016)).

214. *Id.* (quoting Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 193 (D.D.C. 2016)).

215. *Id.* (quoting Am. Hosp. Ass'n v. Burwell, 2, 52 (D.D.C. 2014)).

216. *See id.* (describing how the high rate of appeals are causing severe financial impact on hospitals). The court explained:

> 21.5% of the rehabilitation hospitals that participate in Medicare—together had pending appeals worth $135 million. Id. at 4–5. Rehabilitation hospitals, moreover, win 80% of their reimbursement claims on appeal. That figure is even higher—87%— when the win rate is calculated using the value, rather than number, of the claims,

appeals were successful for a certain type of service, meaning that hospitals had millions of dollars tied up in this process for years that was rightfully theirs.[217] Also, the because of the financial burden of the backlog, "some providers are 'forced . . . to reduce costs, eliminate jobs, forgo services, and substantially scale back,' all of which affects the quality and quantity of patient care."[218] The court also noted that without legislative intervention these problems are likely only to get worse.[219]

While the Department proposed some solutions that were being implemented without Congressional assistance, the scale of the problem was shown to far exceed the department's resources.[220] Assuming each of the Secretary's solutions worked as planned, the OMHA backlog would "still grow every year from fiscal year 2016 to fiscal year 2020—from 757,090 to 1,003,444 appeals."[221] This was not the "progress toward a solution" that was sought after by the Court of Appeals.[222]

Legislative fixes were also considered, including the Audit & Appeal Fairness, Integrity, and Reforms in Medicare Act of 2015 (AFIRM Act), which if passed would provide the resources necessary to address the backlog.[223] As noted above, the AFIRM

> suggesting the vast majority of that $135 million rightfully belongs with the hospitals. But as long as the claims are tied up in the appeals process, they cannot access those funds.

Id.

217. *See id.* ("That figure is even higher—87%— when the win rate is calculated using the value, rather than number, of the claims, suggesting the vast majority of that $135 million rightfully belongs with the hospitals.").

218. *Id.* (quoting Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 52 (D.D.C. 2014)).

219. *See id.* ("These problems likely will worsen in the coming years because, as discussed below, the backlog is projected to grow considerably absent legislative intervention.").

220. *See id.* at 227 ("Yet there is one more consideration critical to the Court's ultimate decision: whether the administrative and legislative fixes offered in the Secretary's briefing constitute progress sufficient to warrant pausing this litigation until September 30, 2017. Unfortunately, the Court must conclude that they do not.").

221. *Id.* at 228.

222. *Id.*

223. *See id.* at 229 ("Combining the administrative measures and the legislative fixes [in the AFIRM Act] would reduce the number of pending OMHA cases to 50,000 by FY2020 and totally eliminate the backlog of pending OMHA cases older than 90 days by FY2021.").

Act has stalled with seemingly no prospects for renewed action.[224] The district court stated that "it has been seven months since the Court of Appeals issued its decision, and Congress has taken no action."[225] In addition, the plaintiff hospitals were very skeptical that a new Congress and President would move quickly on the issue.[226]

Considering the continued growth of the backlog, along with complete inaction by Congress, the district court issued the first of two opinions in favor of the plaintiff hospitals.[227] The first was issued September 19, 2016, and was an order denying the Department's motion to stay proceedings.[228] The department sought a stay of proceedings to give it time to resolve the crisis in cooperation with Congress according to its own timetable.[229] Finally on December 5, 2016, the district court granted summary judgment in favor of the plaintiff hospitals.[230] The court issued a writ of mandamus compelling the Secretary to clear the administrative appeals backlog by January 1, 2021.[231]

In crafting its remedy, the court utilized input from the parties, recognizing that it could not simply order the appeals to be resolved by the statutory deadline.[232] The plaintiffs first proposed a broad effort to settle claims, deferring repayment while accruing interest on pending claims, and imposing financial

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224. *See id.* at 230 ("[I[t has been 21 months since the AFIRM Act was reported by the Senate Finance Committee to the full Senate on December 8, 2015. No debate or vote has been scheduled, and the Secretary offers no evidence that any legislative action is imminent.").

225. *Id.*

226. *See id.* ("No debate or vote has been scheduled, and the Secretary offers no evidence that any legislative action is imminent, that the bill has support in the House of Representatives, or that the President would sign it.").

227. *Id.* at 222.

228. *See generally id.*

229. *See generally id.*

230. *See generally* Am. Hosp. Ass'n v. Burwell, No. 14-851, 2016 WL 7076983 (D.D.C. Dec. 5, 2016).

231. *See id.* at *1 ("Two and a half years ago, the American Hospital Association and affiliated entities asked this court to issue a writ of mandamus. . . . the court can finally grant Plaintiffs a remedy.").

232. *See id.* ("Recognizing, though, that it could not practicably order HHS to resolve each of the pending appeals by the statutorily prescribed deadlines, the Court asked the parties to address in briefing the specific forms mandamus relief should take . . . [t]hey have now done so.").

penalties on RAC contractors who clog the appeals system with high reversal rates by ALJs.[233] However, the court was concerned with this approach because it believed that it "should intrude as little as possible on the Secretary's specific decision making processes and operations."[234] Instead, a timetable approach was adopted, by which the Secretary would meet yearly benchmarks in reducing the backlog, and eliminating it entirely by 2021.[235]

The plaintiffs originally sought any claims outstanding as of January 1, 2021 to be summarily paid by the department.[236] This stance could have created a "perverse incentive" to clog the system with unmeritorious appeals, which would have to be paid by the target date.[237] The court sided with the department and mandated only that the Secretary provide periodic reports every ninety days.[238] The Court explained that "[t]he reports should communicate HHS's progress in reducing the backlog and should include updated figures for the current and projected backlog, as well as a description of any significant administrative and legislative actions that will affect the backlog."[239]

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233. *See id.* at *2 (explaining the plaintiff's proposed settlements to the Secretary). The Court's opinion states:

> Plaintiffs suggest that the Secretary should: (1) offer reasonable settlements to certain broad groups of Medicare providers and suppliers; (2) for some subset of disputed Medicare claims, alleviate the financial strain on providers by deferring their duty to repay the Secretary and tolling the accrual of interest on those claims for waiting times beyond the statutory deadlines; and (3) impose financial penalties on Recovery Audit Contractors for high reversal rates by Administrative Law Judges.

Id.

234. *Id.* at *3.

235. *See id.* (describing the obligations of the Department to resolve the claims by 2021, and that if the claims were not resolved by then, plaintiffs could move for default judgment or some other means to enforce the writ of mandamus).

236. *See id.* ("[T[he last bullet point in Plaintiffs' timetable: the suggestion that, as of January 1, 2021, default judgment be entered in favor of all claimants whose appeals have been pending at the ALJ level without a hearing for more than one calendar year.").

237. *See id.* ("Requiring default judgment in all such pending appeals if the benchmarks are not met, the Secretary contends, would 'create perverse incentives for providers and suppliers to appeal non-meritorious claims.'").

238. *See id.* ("The Secretary believes quarterly reports—every 90 days—would be appropriate . . . . The Court will thus adopt the Secretary's timeline.").

239. *Id.*

B. Second Appeal to the D.C. Circuit

Unfortunately, neither the backlog nor the thorny legal questions it presented were solved by the district court's ruling. The case went before the D.C. Circuit again after the Department appealed the lower court's ruling commanding it to resolve the backlog.[240] In a two to one ruling, the D.C. Circuit court reversed the lower court for a second time.[241] The reasoning was that the district court did not address the Department's argument that complying with the prescribed timetable would be impossible.[242] A court cannot compel an official or government agency to do something that cannot be lawfully accomplished.[243]

Here, the Department argued that it would be forced to break the law whether it chose to comply with the district court's ruling or not.[244] The district court ordered the Department to clear the backlog entirely by 2021.[245] In order to do so, the Department argued, it would have settle claims en masse, which would breach the Medicare statute.[246] The Department is required to ensure that any settlement amount bear a reasonable relation to the amount of the claim, as well as, *inter alia*, the likelihood that the Department would prevail or obtain a recovery.[247] *En masse* settlement would breach these criteria as there would be no

240. Am. Hosp. Ass'n v. Price, 867 F.3d 160 (D.C. Cir. 2017).

241. *See id.* at 170 ("[W]e vacate the mandamus order and the order denying reconsideration, and remand to the District Court to evaluate the merits of the Secretary's claim that lawful compliance would be impossible.").

242. *See id.* at 162 (D.C. Cir. 2017) ("[T]he Court commanded the Secretary to perform an act—clear the backlog by certain deadlines—without evaluating whether performance was *possible*.").

243. *See id.* at 167–68 ("The reasoning is simple and intuitive: it is not appropriate for a court—contemplating the equities—to order a party to jump higher, run faster, or lift more than she is physically capable.").

244. *See id.* at 167 (describing the Department's position "between a rock and a hard place," either settle claims en masse without regard for merit, or violate the court ordered deadlines).

245. Am. Hosp. Ass'n v. Burwell, No. 14-851, 2016 WL 7076983, at *2 (D.D.C. Dec. 5, 2016), *vacated*, 867 F.3d 160 (D.C. Cir. 2017).

246. *See* 42 C.F.R. § 401.613(a), (c) (2004) (listing the circumstances under which the Department may settle administrative claims).

247. *Id.*

appraisal of the Department's legal position regarding the claims.[248]

Alternatively, if the Department failed to clear the backlog by 2021, it would be in violation of the district court's order.[249] The D.C. Circuit found that the district court failed to properly consider the Department's contentions.[250] Before granting the relief sought, the district court was ordered to ensure that that relief was legally possible.[251] As noted above, the Department simply lacks the resources to clear the backlog in a reasonable timeframe.[252] Even with the department's proposed and implemented measures to address the backlog, there will still be approximately 800,000 claims pending before an ALJ by the end of FY 2020.[253] Without those measures, there would be approximately 2,000,000 claims.[254]

The D.C. Circuit remanded the case back to the district court.[255] The district court was ordered to determine if equitable relief was possible given the circumstances.[256] The original remedy granted did not take into account the Department's argument of impossibility.[257] The issues that supported that remedy remain, primarily the clear statutory deadlines and lack of congressional action.[258] It is unlikely that any satisfying conclusion will come out

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248. *See generally id.*

249. *See* Am. Hosp. Ass'n v. Price, 867 F.3d 160, 167 (D.C. Cir. 2017) (noting the Department's position that if it used only legal means, it could not meet the court's prescribed timeline).

250. *See id.* at 168 ("[W]here a party insists that resource constraints render lawful compliance with a court's order impossible, an equity court must examine that claim and, prior to issuing the order, find that lawful compliance is indeed possible.").

251. *Id.*

252. *See id.* at 173 ("We acknowledged HHS's argument that it 'lacks the resources to render decisions within the statutory time frames.'").

253. *Id.*

254. *Id.*

255. *Id.* at 160.

256. *Id.* at 170.

257. *See id.* at 169 ("There is nothing mystical or punctilious about the judiciary giving due consideration to an executive agency's central argument—made repeatedly and emphatically across three sets of motions, not solely with allegations but with proffers of evidence—before issuing extraordinary relief with multi-billion-dollar stakes.").

258. *See id.* at 164 (noting that if Congress remains silent, the equities start to tip in favor of the petitioners given the statutory framework).

of the subsequent district court opinion. The likely outcomes are either no remedy at all or a longer but more realistic timeframe for the department to clear the backlog. Neither reaches the root cause of this crisis, which is that Congress must address the issue.

VII. Analysis

The D.C. Circuit's Approach was Preferable to the Fourth Circuit's, but Should Have Paid More Attention to the Underlying Problem, Congressional Inaction.

The Fourth and D.C. Circuits took diverging approaches to the issues presented here. The Fourth Circuit, in Cumberland viewed the issue as essentially non-justiciable, as it would be intruding on its co-equal branches if it provided the remedy sought.[259] The D.C. Circuit in American Hospital recognized that a separation of powers issue would occur either way the court ruled.[260] Either the RAC program or the administrative appeals system were going to be disrupted and would not function in accordance with their statutory framework.[261]

The D.C. Circuit's approach was more nuanced compared with the Fourth's. The D.C. Circuit adapted to Congress' failure to act on the problem for over two years.[262] As noted above, this case was dismissed when it first appeared before the D.C. District Court.[263] That court's reasoning was very similar to that of the Fourth Circuit in Cumberland County.[264] However, the petitioners were successful on appeal, as the D.C. Circuit was moved considerably by the fact that Congress was aware of the issue but took no action.[265] The original action was decided on December 18, 2014

259. Cumberland Cty. Hosp. Sys. v. Burwell, 816 F.3d 48, 50 (4th Cir. 2016).

260. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 184–88 (D.C. Cir. 2016).

261. *See id.* (explaining the various issues the court assessed between the RAC program and the administrative appeals process).

262. *See id.* at 184. (noting that as the case then stood, on appeal, Congress was aware of the issue for nearly two years without taking meaningful action, which made mandamus jurisdiction a plausible option for the court).

263. *Id.*

264. *See* Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 44 (D.D.C. 2014), *rev'd*, 812 F.3d 183 (D.C. Cir. 2016) ("HHS' delay was not so egregious as to warrant mandamus relief.").

265. *See* Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 184 (D.C. Cir. 2016)

and the ultimate opinion granting mandamus relief was not issued until almost two years later on December 5, 2016.[266] This delay gave the political branches the opportunity to resolve the issue on their own. In doing so, the court demonstrated that it was not simply barreling into the policy decisions of an executive agency. Rather, the court was highly conscious of the hazardous territory, and was careful in balancing the wide array of legitimate interests at issue. Allowing Congress and the Department this opportunity was prudent given the separation of powers issue. However, it was also prudent to grant mandamus jurisdiction when it became clear that the Department was unable, and Congress unwilling, to solve the crisis.

The D.C. District Court's order was flawed in that it was almost exclusively directed at the Department, while the real underlying cause of backlog is Congressional inaction.[267] The Department has only so much flexibility. Unless sufficient resources are allocated to fulfill both Congressional mandates (both standard Medicare and RAC appeals), the separation of powers issue will surface again. The court has stated that the plaintiffs have a "clear and indisputable" right to have their claims resolved.[268] Either this right, or the functioning of another congressional mandate will suffer, and the court will be responsible for making that decision.

To be clear, the court cannot simply order or compel Congress to act in a certain manner.[269] However, given Congress' centrality to the issue, the court should have done more to pressure that body to act. At the very least, the court could have made clear to Congress that the other two branches were in desperate need of its

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(noting that as the case then stood, on appeal, Congress was aware of the issue for nearly two years without taking meaningful action, which made mandamus jurisdiction a plausible option for the court).

266. *See* Am. Hosp. Ass'n v. Burwell, No. 14-851, 2016 WL 7076983, at *1 (D.D.C. Dec. 5, 2016), *vacated*, 867 F.3d 160 (D.C. Cir. 2017) (granting mandamus relief).

267. *See generally id.* (granting mandamus relief but not mentioning Congress beyond noting that it is "unlikely to play the role of the cavalry here").

268. *See Am. Hosp. Ass'n*, 812 F.3d at 188 (stating that to show entitlement to mandamus, a plaintiff must demonstrate a "clear and indisputable right" to relief).

269. *Id.*

assistance.[270] As Congress is currently debating another round of healthcare reform, now is a fitting time for such a warning.[271] The creation of this backlog was a result of good intentioned policy that sought to recover misspent funds for important and costly social programs.[272] However, the execution of that policy created an entirely new problem, which a gridlocked Congress has proven unable to solve. The longer it takes for Congress to address the issue, the deeper the quagmire will become for the courts. Nowhere is this more apparent than in the fact that nearly four years after this litigation began, it is headed to the district court for a third time. The prospects for a proper resolution, for the reasons noted above, are dim.[273]

VIII. Conclusion

Congressional inaction has placed the courts in an untenable position. The issue brought before the court in *American Hospital* would have created a clear a violation of statutory authority no matter what the outcome was.[274] The D.C. District and Circuit courts should be commended for carefully balancing the interests at play, showing reluctance to intervene, but also showing a willingness to take action when it was clear that Congress was

270. *Id.*

271. *See* Trent Gillies, *Obamacare was 'Flawed', but Here's What Health Care Should Look Like After Reform: Ex-Aetna CEO*, CNBC (Feb. 21, 2017), http://www.cnbc.com/2017/02/19/obamacare-was-flawed-but-heres-what-health-care-should- look-like-after-reform-ex-aetna-ceo.html (describing the ongoing attempts to reform the country's healthcare system) (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

272. *See generally* Am. Hosp. Assoc. v. Burwell, 812 F.3d 183, 185–88 (D.C. Cir. 2016).

273. *See generally* Am. Hosp. Ass'n v. Burwell, 867 F.3d 160, 169–70 (D.C. Cir. 2017) ("[T]he District Court was assigned an exceptionally difficult project . . . . [T]he Court needed to craft workable relief while negotiating both the on-the-ground realities and the guidance offered in our past decision. An unenviable task.").

274. *Am. Hosp. Ass'n*, 812 F.3d at 184.

silent.[275] However, the remedy crafted was flawed as it did not truly speak to the root of the problem, Congressional inaction.[276]

While there has been much debate in Congress recently regarding healthcare reform, there is no indication that these elements of Medicare will be changed.[277] The Medicare appeals system will continue to generate an enormous number of claims. The RAC program, with its success in preventing waste, fraud, and abuse, is unlikely to be scrapped by any movement to lower healthcare costs.[278] This issue will continue to plague service providers and confound courts until Congress either revamps the RAC program or allocates the necessary resources to the Department to resolve this issue.

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275. *See generally* Am. Hosp. Ass'n v. Burwell, No. 14-851, 2016 WL 7076983, at *1–*3 (D.D.C. Dec. 5, 2016), *vacated*, 867 F.3d 160 (D.C. Cir. 2017) (granting mandamus relief but not mentioning Congress beyond noting that it is "unlikely to play the role of the cavalry here").

276. *See generally id.*

277. Rebecca Savransky, *Priebus: Trump Doesn't Want to 'Meddle With Medicare or Social Security'*, HILL (Jan. 8, 2017), http://thehill.com/policy/healthcare/313223-priebus-trump-doesnt-want-to-meddle-with-medicare-or-social-security (on file with the Washington & Lee Journal of Civil Rights & Social Justice).

278. *See* Am. Hosp. Assoc. v. Burwell, 812 F.3d 183, 187 (D.C. Cir. 2016) (describing the successes of the RAC program.