Healing Medicare: Enforcing Administrative Law Deadlines in Medicare Appeals*

INTRODUCTION

The United States health-care system revolves around a small number of powerful actors, including insurers, providers, and patients. To date, many attempts at health-care reform have merely shifted costs from one group to another. One such attempt occurred in 2010, when the Center for Medicare and Medicaid Services ("CMS") in the Department of Health and Human Services ("HHS) implemented the Recovery Audit Contractor ("RAC") program.[1] While the program successfully reduced overpayments to hospitals paid by Medicare,[2] it also led to an unprecedented rise in appeals of Medicare payment decisions by health-care providers.[3] Because of this rise in appeals, there is a significant backlog at the Office of Medicare Hearings and Appeals ("OMHA").[4] As of 2015, it would take ten years for OMHA to adjudicate every case currently before it and the appeals backlog is only growing larger.[5]

Frustrated with this delay, some providers have filed motions in the U.S. Court of Appeals for the Fourth Circuit[6] and the U.S. Court of

1. Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Announces New Recovery Audit Contract to Help Identify Improper Medicare Payments (Oct. 6, 2008), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2008-Fact-Sheets-Items/2008-10-06.html [http://perma.cc/J48L-5ZFZ]. *See generally* Mary Squire, Comment, *RAC: A Program in Distress*, 2015 B.Y.U. L. REV. 291 (2015) (providing more information on the history and the initial negative consequences of the RAC program).

2. CTRS. FOR MEDICARE & MEDICAID SERVS., RECOVERY AUDITING IN MEDICARE FEE-FOR-SERVICE FOR FISCAL YEAR 2015, at 14 (2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2015-Medicare-FFS-RAC-Report-to-Congress.pdf [http://perma.cc/NU69-P55G] (reporting that the RAC program corrected $1.6 billion in overpayments in the 2014 fiscal year and $141 million in the 2015 fiscal year).

3. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS PRIMER: THE MEDICARE APPEALS PROCESS 3 (2015), https://www.hhs.gov/dab/medicare-appeals-backlog.pdf [http://perma.cc/BMN3-BGPP].

4. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 50–51 (4th Cir. 2016).

5. *Id.*

6. *Id.* at 57 (denying jurisdiction for a hospital's claim of mandamus to compel OMHA to hear its ongoing Medicare appeals).

Appeals for the District of Columbia[7] seeking to compel OMHA to hear their appeals. The two circuits reached divergent conclusions due to different views on the enforceability of agency deadlines when alternative remedies are present, such as the option to escalate the claim to the next level of appeal.[8] The Fourth Circuit viewed the appeals as part of a "coherent regulatory scheme," and thus not independently enforceable by mandamus.[9] The D.C. Circuit concluded that escalation is not an "adequate alternative remedy[,]" so mandamus is available.[10] To answer the question of whether the courts should enforce OMHA's statutorily imposed ninety-day deadline to adjudicate each appeal, it is necessary to address Congress's rationale for providing intermediate deadlines in the Medicare appeals system and to evaluate possible solutions to the current backlog.

The D.C. Circuit's decision to recognize the jurisdictional grounds for mandamus is essential to solving the problem, despite potentially significant consequences. Congress is pulling CMS in two separate directions by requiring CMS to implement the RAC program, yet failing to allocate funds necessary for OMHA to meet statutory appeals deadlines. Unless Congress increases funding, OMHA will have to implement one or more of the following changes: (1) significantly changing the RAC program, (2) altering the procedural rights guaranteed through the appeals process, or (3) allowing the backlog to grow even larger. This Recent Development argues that the D.C. Circuit's decision to address the Medicare appeals process as a whole, instead of confining its analysis to just one hospital's rights, is necessary to effectuate the intent of the governing legislation and reduce the Medicare appeals backlog.

Analysis proceeds in three parts. Part I explains the factors that must be present to allow a court to enforce an agency deadline through mandamus. Part I then addresses the Fourth Circuit and D.C. Circuit decisions, *Cumberland County Hospital System, Inc. v. Burwell*[11] and *American Hospital Ass'n v. Burwell*.[12] Part II examines common reasons courts avoid granting mandamus in cases of agency inaction, and then concludes by piecing together when and how courts should enforce agency deadlines, particularly when remedies such as escalation are

7. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.C. Cir. 2016) (finding jurisdiction for the district court to address the equities of hospitals' claims for mandamus).

8. *See Cumberland Cty. Hosp. Sys.*, 816 F.3d at 55; *Am. Hosp. Ass'n*, 812 F.3d at 192.

9. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 56 (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 569 (1995)).

10. *Am. Hosp. Ass'n*, 812 F.3d at 192; *see infra* Section I.D.

11. 816 F.3d 48 (4th Cir. 2016).

12. 812 F.3d 183 (D.C. Cir. 2016).

available. Part III recommends steps each branch should take to resolve this issue and discusses the possible consequences from taking such actions.

I. PETITIONS FOR MANDAMUS RELIEF FROM THE MEDICARE APPEALS BACKLOG

Mandamus relief compels a government agency or official to act when the claimant demonstrates a "clear and indisputable right to relief[.]"[13] Both *Cumberland County* and *American Hospital Ass'n* involved hospital systems seeking to compel OMHA to abide by the statutorily imposed Medicare appeals deadlines.[14] This Part provides a brief overview of the mandamus remedy, an outline of the multi-level Medicare appeals framework, and an introduction of the facts and legal reasoning behind both *Cumberland County* and *American Hospital Ass'n*.

A. Factors Courts Consider When Evaluating Mandamus Claims

Mandamus is a drastic remedy, "invoked only in extraordinary circumstances."[15] For a district court to have jurisdiction over a mandamus claim, the "plaintiff[] 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."[16] Once those threshold requirements are met, the merits of mandamus are judged by the six *TRAC* factors, so-called because they were first articulated in *Telecommunications Research & Action Center v. FCC (TRAC)*.[17] The *TRAC* factors include considering the effects of mandamus on other agency activities and a timetable for agency action that is "governed by a 'rule of reason[.]' "[18] When applied, the

13. *Id.* at 189 (citing United States v. Monzel, 641 F.3d 528, 532 (D.C. Cir. 2011)).

14. *Id.* at 185; *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 49.

15. *Am. Hosp. Ass'n*, 812 F.3d at 189 (quoting Power v. Barnhart, 292 F.3d 781, 784 (D.C. Cir. 2002)).

16. *Id.* (citing United States v. Monzel, 641 F.3d 528, 532 (D.C. Cir. 2011)); *see* United States *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 511 (4th Cir. 1999).

17. 750 F.2d 70, 80 (D.C. Cir. 1984).

18. *Id.* at 80 (quoting Potomac Elec. Power Co. v. ICC, 702 F.2d 1026, 1034 (D.C. Cir. 1983)). The full list of *TRAC* factors are as follows:

> (1) the 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

jurisdictional and equitable inquiries essentially merge, and the district court considers both questions at the same time.[19] However, upon appeal, the circuit court may only address the jurisdictional issue de novo, while reviewing the equitable holdings for abuse of discretion.[20]

B. The Medicare Appeals Process

Medicare is the United States' federally controlled and funded, single-payer health insurance plan for people age sixty-five or older, or people under age sixty-five with certain disabilities.[21] Through Medicare, certified health-care providers such as hospitals and clinics apply for reimbursement for providing services to qualifying patients for qualifying procedures.[22] When a provider sees a Medicare patient and performs a billable test or procedure, the health-care provider then submits a reimbursement claim to a Medicare Administrative Contractor ("MAC").[23] RACs review the claims initially granted by a MAC and revoke the claims if the test or procedure does not meet Medicare's "coding or medical necessity policies."[24] If a MAC or RAC

> 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. (citations omitted) (first quoting Potomac Elec. Power Co. v. ICC, 702 F.2d 1026, 1034 (D.C. Cir. 1983); then quoting Pub. Citizen Health Research Grp. v. FDA, 740 F.2d 21, 34 (D.C. Cir. 1984)).

19. Auburn Reg'l Med. Ctr. v. Sebelius, 686 F. Supp. 2d 55, 62 (D.D.C. 2010), *rev'd on other grounds and remanded*, 642 F.3d 1145 (D.C. Cir. 2011).

20. *See, e.g.*, *In re* Medicare Reimbursement Litig., 414 F.3d 7, 10 (D.C. Cir. 2005).

21. *Medicare Program—General Information*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 25, 2014), https://www.cms.gov/Medicare/Medicare-General-Information/MedicareGenInfo/index.html [https://perma.cc/X9GK-H39T].

22. *See Survey & Certification—Certification & Compliance*, CTRS. FOR MEDICARE & MEDICAID SERVS. (July 23, 2012), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html?redirect=/certificationandcomplianc/02_ascs.asp [https://perma.cc/892N-453A].

23. *See* 42 U.S.C. §§ 1395f(a), 1395h(a) (2015) (detailing procedures for filing for Part A of Medicare, which covers hospital expenses); *see also id.* §§ 1395n(a), 1395u(a) (detailing procedures for Medicare Part B, which provides medical insurance).

24. Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 1. Each procedure must be "reasonable and necessary for the diagnosis or treatment of an illness or injury[.]" § 1395y(a)(1)(A). The controversial "Two Midnight Rule" provides an example of when providers can run afoul of Medicare's coding policies, with some providers having claims denied for filing them under Medicare Part A for inpatient care, when CMS decided they should be classified as Medicare Part B for outpatient care. Elizabeth Weeks Leonard, *CMS' Proposed Changes to the Two-Midnight Rule: Partial Restoration of Medical Judgment*, HEALTH AFF.: BLOG (Sept. 1, 2015), http://healthaffairs.org/blog/2015/09/01/cms-proposed-changes-to-the-two-midnight-rule-partial-restoration-of-medical-judgment/ [https://perma.cc/NDU4-EHZF].

denies the provider's claim then the provider can ask for a redetermination by the same MAC.[25] Following a second denial, the provider may then appeal to a Qualified Independent Contractor ("QIC") for redetermination.[26] The QIC must then issue a decision within sixty days of the appeal.[27] If still unsatisfied, the health-care provider may then appeal to a third level of review by requesting a hearing from an Administrative Law Judge ("ALJ").[28] ALJs must render a decision within ninety days of the date that the provider requested a hearing.[29] The provider may then seek a fourth level of review before the Departmental Appeals Board ("DAB"); the law also requires the DAB to either return a decision or remand the case back to an ALJ within ninety days.[30] Similar to many final administrative actions, DAB decisions may be appealed to a federal district court for review of relevant questions of law,[31] or the provider may escalate its claim to the district court level if the DAB misses its deadline.[32] At every appellate stage, if HHS does not meet a deadline the provider may escalate its claim to the next appellate level.[33]

C. Cumberland County Hospital System v. Burwell

Neither *Cumberland County* nor *American Hospital Ass'n* concerned appeals to the federal courts from denied payment claims.[34] Instead, these cases involved hospital systems filing suit in federal district court to compel the secretary of HHS to adjudicate its appeals for Medicare reimbursement claims.[35] In *Cumberland County*, the hospital system had 750 outstanding appeals worth $12.3 million, some

25. § 1395ff(a)(3)(A) (2014).
26. *Id.* § 1395ff(c)(1).
27. *Id.* § 1395ff(c)(3)(C)(i).
28. *Id.* § 1395ff(d)(1)(A).
29. *Id.*
30. *Id.* § 1395ff(d)(2)(A).
31. *Id.* § 1395ff.
32. *Id.* § 1395ff(d)(3)(B). Only after an appeal to the DAB can providers seek judicial review in Article III courts, and only if the amount in controversy is over $1,000. *Id.* § 1395ff(b)(2)(C), (b)(1)(E).
33. *Id.* § 1395ff(c)(3)(C)(ii), (d)(3)(A)–(B); 42 C.F.R. §§ 405.1104, 405.1108(d), 405.1132(b) (2016). To echo Judge Tatel's apology to the reader, "We apologize to our readers for all of the acronyms, but this is, after all, a Medicare case, and acronyms seem integral to the parties' native language." Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 186 (D.C. Cir. 2016).
34. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 49 (4th Cir. 2016); *Am. Hosp. Ass'n*, 812 F.3d at 185.
35. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 49; *Am. Hosp. Ass'n*, 812 F.3d at 185.

of which had been awaiting assignment to an ALJ for two years.[36] In a unanimous Fourth Circuit panel opinion authored by Judge Niemeyer, the court affirmed the district court's denial of mandamus for lack of jurisdiction because the Medicare statute did not grant the plaintiff a "clear and indisputable right to the relief sought[.]"[37] The court reasoned that when faced with a potentially long delay at the ALJ level, a health-care provider may either escalate the claim to the DAB level or simply wait it out.[38] The court further found that the option for escalation following a missed deadline indicated that Congress indeed "anticipated that the [ninety]-day deadline might not be met."[39] The hospital system argued that escalating its claim without receiving an ALJ hearing would act as a "waive[r of] its right to due process."[40] The hospital's grievance focused on both DAB's policy of denying a hearing unless the appeal presented "extraordinary question[s] of law, policy or fact[]" and on DAB's remanding of each claim to the "back of [an] ever-growing ALJ line."[41] Nevertheless, the Fourth Circuit held that the hospital system did not have a "clear and indisputable right" to a hearing within ninety days and that either CMS or Congress should rectify the unfortunate appeals backlog.[42]

D. American Hospital Association v. Burwell

In *American Hospital Ass'n*, the plaintiffs also sought mandamus to compel HHS to comply with the ninety-day deadline for ALJ review of their appeals.[43] Appellants argued that escalation does not serve as an

36. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 50 (noting that the hospital's claims had already easily surpassed the ninety-day ALJ deadline). The plaintiffs have stated that most of the $12.3 million in denied claims came from their inpatient rehabilitation facility, which already takes a much higher percentage of Medicare patients than a normal hospital. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, No. 5:14-CV-508-BR, 2015 WL 1249959, at *3 (E.D.N.C. Mar. 18, 2015); *What We Do*, CAPE FEAR VALLEY HEALTH FOUND., http://www.cfvfoundation.org/whatwedo.html [http://perma.cc/AXL4-ERCK]. The $12.3 million amount is roughly equal to one year of revenue from that rehabilitation facility. *Cumberland Cty. Hosp. Sys.*, 2015 WL 1249959, at *3.

37. *See Cumberland Cty. Hosp. Sys.*, 816 F.3d at 52 (quoting United States *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 511 (4th Cir. 1999)); *see also* discussion *infra* Section II.A.

38. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 55.

39. *Id.*

40. *See id.*

41. Brief for Appellant at 6, *Cumberland Cty. Hosp. Sys.*, 816 F.3d 48 (No. 5:14-CV-508-BR).

42. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 52, 57 (quoting United States *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 511 (4th Cir. 1999)).

43. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 185 (D.C. Cir. 2016); Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 48 (D.D.C. 2014), *rev'd and remanded*, 812 F.3d 183 (D.C. Cir. 2016).

adequate remedy given the rarity of DAB hearings and the large backlog of appeals.[44] Like the district court in *Cumberland County*,[45] the U.S. District Court for the District of Columbia denied the plaintiffs' claim.[46] However, on appeal, a unanimous D.C. Circuit panel reversed and remanded.[47] The D.C. Circuit agreed with plaintiffs' argument and held that escalation is not an adequate remedy to the missed deadlines, because DAB hearings are rare and have their own large backlogs of appeals as well.[48] After concluding that "the statute imposes a clear duty on the secretary to comply with the statutory deadlines," the D.C. Circuit remanded the case to the district court to balance the equities on whether to grant mandamus relief.[49] The district court then granted mandamus for the plaintiffs, requiring HHS to formulate and comply with a plan to completely eliminate the appeals backlog by the end of 2020, with yearly percentage benchmarks that the agency must meet along the way.[50] If, by January 1, 2021, there are still claims that have been pending before ALJs for longer than one year, those claimants can then petition a federal court for a declaratory judgment in their favor.[51]

Essentially, the two circuits disagreed on whether escalation was an "adequate alternative remedy" for a mandamus claim.[52] The Fourth Circuit determined that mandamus relief was precluded by the availability of escalation,[53] whereas the D.C. Circuit concluded that escalation was not an adequate remedy for missed deadlines.[54] While courts may treat the equities of enforcing agency deadlines differently, escalation should not be considered an adequate alternative remedy in the Medicare appeals context.[55]

44. *See Am. Hosp. Ass'n*, 812 F.3d at 191.

45. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, No. 5:14-CV-508-BR, 2015 WL 1249959, at *10 (E.D.N.C. Mar. 18, 2015)

46. *Am. Hosp. Ass'n*, 76 F. Supp. 3d at 56.

47. *Am. Hosp. Ass'n*, 812 F.3d at 183.

48. *Id.* at 191.

49. *Id.* at 192.

50. Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 7076983, at *3 (D.D.C. Dec. 5, 2016).

51. *Id.* Although the consequence for failure to reach this 2021 goal is rather significant, there are no apparent consequences if HHS fails to meet the yearly percentage goals. *Id.*

52. *Am. Hosp. Ass'n*, 812 F.3d at 192; *see* Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 56 (4th Cir. 2016).

53. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 56.

54. *Am. Hosp. Ass'n*, 812 F.3d at 192.

55. *See infra* Section II.B.

II. TESTS AND REASONS BEHIND JUDICIAL ENFORCEMENT OF ADMINISTRATIVE DEADLINES

As stated before, mandamus is a drastic remedy, "invoked only in extraordinary circumstances."[56] Even when a plaintiff proves mandamus jurisdiction, courts have been reluctant to grant mandamus relief.[57] Typically, they do not want to interfere with an agency's prioritization of limited resources or simply move one petitioner to the front of the line—at the expense of others.[58] Section A describes how courts have treated mandamus claims in the agency delay context. Section B concludes that mandamus is appropriate for hospitals awaiting their appeals, because of the "systemic failure" of the Medicare appeals system.

A. Justifications Courts Use to Enforce or Decline to Enforce Agency Deadlines via Mandamus

Courts justify refusal to compel agency action because they are generally unwilling to interfere with an agency's prioritization of its limited resources.[59] If a plaintiff overcomes the jurisdictional bar to mandamus, courts will often still find judicial enforcement of a deadline to be inequitable.[60] For instance, in *In re Barr Laboratories, Inc.*,[61] Barr, a drug manufacturer, sought to compel the Food and Drug

56. *Am. Hosp. Ass'n*, 812 F.3d at 189 (quoting Power v. Barnhart, 292 F.3d 781, 784 (D.C. Cir. 2002)).

57. *See infra* Section II.A.

58. *See infra* Section II.A.

59. *See* Mashpee Wampanoag Tribal Council, Inc. v. Norton, 336 F.3d 1094, 1101 (D.C. Cir. 2003) ("[T]he district court erred by disregarding the importance of there being 'competing priorities' for limited resources."); *In re* Barr Labs., Inc., 930 F.2d 72, 76 (D.C. Cir. 1991).

60. *See, e.g.*, *Mashpee Wampanoag Tribal Council*, 336 F.3d at 1101–02; *In re Barr Labs.*, 930 F.2d at 76; *In re* Monroe Commc'ns Corp., 840 F.2d 942, 946 (D.C. Cir. 1988). The court in *Cumberland County* cited a Fourth Circuit case for the mandamus relief standard. *See* Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 52 (4th Cir. 2016) (citing United States *ex rel.* Rahman v. Oncology Assocs., P.C., 198 F.3d 502, 511 (4th Cir. 1999)). Notably, the court in *Cumberland County* relied on *In re Barr Laboratories* from the D.C. Circuit. *See id.* at 56 (citing *In re Barr Labs.*, 930 F.2d at 74–75). The D.C. Circuit occupies a uniquely important place in administrative law, because most federal agencies are located within its jurisdiction. *See generally* Eric M. Fraser et al., *The Jurisdiction of the D.C. Circuit*, 23 CORNELL J. L. & PUB. POL'Y 131 (2013) (examining the different causes for the D.C. Circuit's unique caseload, such as special treatment by Congress and geographic factors); John G. Roberts, Jr., Lecture, *What Makes the D.C. Circuit Different? A Historical View*, 92 VA. L. REV. 375 (2006) (summarizing the history of the D.C. Circuit); Patricia M. Wald et al., *The Contribution of the D.C. Circuit to Administrative Law*, 40 ADMIN. L. REV. 507 (1988) (chronicling the many instances throughout history when the D.C. Circuit substantially affected the state of administrative law).

61. 930 F.2d 72 (D.C. Cir. 1991).

Administration ("FDA") to comply with a 180-day deadline for approving Barr's generic drug application.[62] Although FDA admittedly violated the statutory deadline, the D.C. Circuit refused to grant mandamus.[63] The court reasoned that granting mandamus would place Barr "at the head of the queue[,] simply mov[ing] all others back one space and produc[ing] no net gain."[64] Instead of a judicial order, the court suggested legislative or administrative action: Congress could earmark more funds for FDA or FDA could simplify the review process.[65]

In another D.C. Circuit case, the court chose to afford the Federal Communications Commission ("FCC") "great latitude" despite ongoing delay.[66] *In re Monroe Communications Corp.*[67] involved a competing television licensee applicant attempting to compel the FCC to decide whether the current licensee had broadcast obscene material.[68] Recognizing the FCC's authority to set its own agenda, the court refused to address arguments that the FCC had resolved other actions sooner than the petitioner's.[69] The court further found that the issue was "a delicate one, requiring the FCC to balance policy and constitutional concerns," which contributed to the court's reluctance to compel agency adjudication.[70] Therefore, courts refuse to grant mandamus for agency delay on either separation-of-powers grounds[71] or due to an unwillingness to rush particularly complex agency decisions.[72]

62. *Id.* at 73–74. To put the deadline violation in context, FDA took roughly double the allotted time for most applications, and up to quadruple the allotted time for certain applications. *Id.* at 74. In contrast, the most recent HHS report showed an average wait time of 877 days for an ALJ hearing, almost ten times the statutory deadline. *See Average Processing Time by Fiscal Year*, DEP'T HEALTH & HUM. SERVS. (Nov. 18, 2016), https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html [http://perma.cc/8QCU-Z349].

63. *In re Barr Labs.*, 930 F.2d at 76.

64. *Id.* at 75. For another case justifying a denial of mandamus in order to thwart line-jumping, see *Mashpee Wampanoag Tribal Council*, 336 F.3d at 1101.

65. *In re Barr Labs.*, 930 F.2d at 76.

66. *In re* Monroe Commc'ns Corp., 840 F.2d 942, 946 (D.C. Cir. 1988). Although the FCC was not subject to any firm deadlines, the proceedings had well eclipsed the suggested timelines given in the statute and Senate reports. *Id.* at 945.

67. 840 F.2d 942 (D.C. Cir. 1988).

68. *Id.* at 943–44.

69. *Id.* at 946 ("Further, we must give agencies great latitude in determining their agendas . . . ."); *see also* Med. Comm. For Human Rights v. SEC, 432 F.2d 659, 674–75 (D.C. Cir. 1970) (giving the SEC substantial deference for setting its agenda), *vacated*, 404 U.S. 403 (1972).

70. *In re Monroe Commc'ns*, 840 F.2d at 946.

71. *See* Mashpee Wampanoag Tribal Council, Inc. v. Norton, 336 F.3d 1094, 1101 (D.C. Cir. 2003); *In re* Barr Labs., Inc., 930 F.2d 72, 76 (D.C. Cir. 1991).

72. *See In re Monroe Commc'ns*, 840 F.2d at 946; Orion Reserves Ltd. P'ship v. Kempthorne, 516 F. Supp. 2d 8, 15–17 (D.D.C. 2007) (ruling that the Bureau of Land

Courts have, however, granted mandamus in some circumstances, but each case involves a very fact-intensive inquiry. If there is a showing of bias or impropriety, then courts are more willing to grant mandamus.[73] Absent any bias in the administrative delay, courts are reluctant to intervene unless the administrative systems are significantly failing to function as Congress intended[74] or are failing to follow a previous court order.[75]

For example, in *Air Line Pilots Ass'n v. Civil Aeronautics Board*,[76] the D.C. Circuit mandated that the Civil Aeronautics Board ("CAB") hear cases that had been pending before it for five years.[77] The Airline Deregulation Act of 1978 required CAB to provide unemployment benefits to airline employees who were laid off as a result of the major regulatory changes CAB enacted.[78] In the Act's five-year history, CAB held only one hearing and did not issue any dispositions.[79] The court decided that this delay was unreasonable and required CAB to "report to [the D.C. Circuit] on its progress in these cases every [thirty] days[.]"[80]

Management's nine-year delay in processing Orion's oil shale mining claims was not unreasonable, given the substantial amount of work required to process each claim); *see also* Eric Biber, *The Importance of Resource Allocation in Administrative Law*, 60 ADMIN. L. REV. 1, 19 (2008) ("[C]ourts might well conclude that . . . they are just not well suited to the task of regularly supervising and monitoring large organizations.").

73. *See, e.g.*, Sandoz, Inc. v. Leavitt, 427 F. Supp. 2d 29, 39–40 (D.D.C. 2006). In a factual pattern almost identical to that in *In re Barr Labs.*, the court granted mandamus for a generic drug application because plaintiff drug manufacturer showed that the agency may have singled them out and that expediting their application would not adversely affect any other drug applications. *Id.*; *see In re Barr Labs.*, 930 F.2d at 76 ("Where the agency has manifested bad faith, as by singling someone out for bad treatment or asserting utter indifference to a congressional deadline, the agency will have a hard time claiming legitimacy for its priorities.").

74. *See* Air Line Pilots Ass'n Int'l v. Civil Aeronautics Bd., 750 F.2d 81, 85–86 (D.C. Cir. 1984) (holding that "claims of unreasonable delay fall within a narrow class of interlocutory appeals from agency action over which we appropriately should exercise our jurisdiction" and requiring the agency report its progress in reviewing a backlog of wrongful termination complaints to the court every thirty days).

75. *See In re* People's Mojahedin Org. of Iran, 680 F.3d 832, 838 (D.C. Cir. 2012) (holding it will grant mandamus if the Secretary of State did not issue the reasoning behind a decision, which the D.C. Circuit had ordered two years prior, within four months); *In re* Core Commc'ns, 531 F.3d 849, 861–62 (D.C. Cir. 2008) (granting mandamus for the FCC's seven-year delay in responding to a court order, requiring the agency to rescind and replace an old rule).

76. 750 F.2d 81 (D.C. Cir. 1984).

77. *Id.* at 86–87.

78. *See* Airline Deregulation Act, Pub. L. No. 95-504, § 43, 92 Stat. 1705, 1750–53 (1978) (codified as amended at 49 U.S.C. § 1371) (requiring the CAB to provide benefits to employees whose employment was terminated due to the other regulatory changes enacted in the Airline Deregulation Act).

79. *Air Line Pilots Ass'n Int'l*, 750 F.2d at 85.

80. *Id.* at 88–89.

Here, the court focused on the unreasonable delays felt by *all claimants*, and not just the delays felt by the plaintiff, as the *Barr Laboratories* court did.[81] In shifting its focus from one claimant to the whole system, the court disregarded the common line-jumping or resource allocation arguments. In effect, the court's mandamus order simply addressed the unreasonable delays felt by all of the potential parties with claims under the Act in question. In doing so, the court avoided the separation of powers and complex agency decisions issues highlighted above.

B. Applying Mandamus to Agency Deadlines

The escalation provision, which is unique to Medicare appeals, separates this system from those involved in the bulk of other mandamus cases regarding agency delay.[82] In the absence of an escalation provision, a person or organization delayed beyond an agency deadline has no formal recourse; the only recourse is to wait.[83] However, in the Medicare appeals context, statutes permit providers to escalate their claim to the next level.[84] The Fourth Circuit and D.C. Circuit disagreed on the role that the escalation option plays in the mandamus analysis: the Fourth Circuit viewed escalation as part of a "coherent regulatory scheme" that must be interpreted in context;[85] the D.C. Circuit held that escalation is an "inadequate" alternative remedy.[86] Nonetheless, neither opinion sufficiently explains what makes a remedy adequate, or what effect a "coherent regulatory scheme" has on the availability of mandamus relief.[87]

These two opinions reflect the state of federal mandamus jurisprudence. Federal courts have denied mandamus jurisdiction in cases where there was a clear alternative method available to accomplish

81. *Id.*; *In re* Barr Labs., Inc., 930 F.2d 72, 74 (D.C. Cir. 1991).

82. *See, e.g.*, *In re* Core Commc'ns, 531 F.3d 849, 858–60 (D.C. Cir. 2008) (granting mandamus to compel the FCC to comply with a previous mandamus order granted seven years prior); *In re* United Mine Workers of Am. Int'l Union, 190 F.3d 545, 550 (D.C. Cir. 1999) (remarking that the Mine Safety and Health Administration had a rule pending final decision for eight years after the comment period ended); *In re Barr Labs.*, 930 F.2d at 74 (noting that FDA simply has a 180-day deadline to issue a decision for drug applications, without giving applicants any other recourse).

83. *See In re Barr Labs.*, 930 F.2d at 74.

84. *See supra* Section I.B.

85. *See* Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 52, 56 (4th Cir. 2016) (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 569 (1995)).

86. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.C. Cir. 2016). The court does note that, although the availability of escalation does not preclude mandamus jurisdiction, it could weigh against mandamus when addressing the equities. *Id.*

87. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 56 (quoting Gustafson v. Alloyd Co., 513 U.S. 561, 569 (1995)).

the same result sought by mandamus.[88] The Supreme Court has held that even "costly and inconvenient" alternative remedies can preclude mandamus relief.[89] If the substantive right sought by the mandamus action is available through an alternative means, then mandamus is generally unavailable.[90] Federal courts have not substantially developed the "adequate" prong of the phrase "adequate alternative remed[ies]";[91] indeed, they seem more focused on whether the remedy actually safeguards the substantive right instead of worrying whether any procedural rights were lost as a result of the alternative remedy.[92]

In the Medicare appeals context, the option to escalate a claim presents a unique problem for the "adequate alternative remedy" analysis.[93] *American Hospital Ass'n* turned on the "systemic failure" of the Medicare appeals system that "causes virtually all appeals to be decided well after the statutory deadlines."[94] Judge Tatel acknowledged that "in isolated or occasional cases," escalation could serve as an adequate alternative remedy, and that its inclusion "indicate[d] that Congress anticipated that [delay] might occur with some measure of regularity."[95] However, the opinion concluded that escalating to the DAB would be an inadequate remedy in this situation, due to the DAB's own significant backlog and its discretionary review of cases.[96]

88. Mukand Int'l, Ltd. v. United States, 502 F.3d 1366, 1369 (Fed. Cir. 2007) (noting that the plaintiff could have sought "similar injunctive relief"); Power v. Barnhart, 292 F.3d 781, 784 (D.C. Cir. 2002) (noting that the fee petition process was an adequate alternative method for seeking remedy); Barnhart v. Devine, 771 F.2d 1515, 1524 (D.C. Cir. 1985) (noting that appellants "should have sought recourse through the Office of Special Counsel").

89. Roche v. Evaporated Milk Ass'n, 319 U.S. 21, 30 (1943) (holding that mandamus could not be used to require a district court judge to reinstate a plea in abatement, even though the petitioners would have to complete the underlying trial before being able to appeal the abatement).

90. *See In re* al-Nashiri, 791 F.3d 71, 78 (D.C. Cir. 2015); *Power*, 292 F.3d at 787.

91. *Am. Hosp. Ass'n*, 812 F.3d at 189.

92. *See* United States *ex rel.* Girard Tr. Co. v. Helvering, 301 U.S. 540, 544 (1937) ("[T]he writ of mandamus may not be employed to secure the adjudication of a disputed right for which an ordinary suit affords a remedy equally adequate, and complete."); Carter v. Seamans, 411 F.2d 767, 773 (5th Cir. 1969) ("[T]he alternative remedy must be adequate, i.e., capable of affording full relief as to the very subject matter in question."). State mandamus jurisprudence has provided more robust guarantees in procedural rights through mandamus. *See* Southern LNG, Inc. v. MacGinnitie, 755 S.E.2d 683, 685 (Ga. 2014) ("[The] alternative legal remedy must be 'equally convenient, complete and beneficial' to the petitioner." (quoting N. Fulton Med. Ctr., Inc. v. Roach, 453 S.E.2d 463, 466 (Ga. 1995))); *In re* Prudential Ins. Co. of Am., 148 S.W.3d 124, 136 (Tex. 2004) (granting mandamus when necessary to "preserve important substantive and procedural rights from impairment or loss").

93. *Am. Hosp. Ass'n*, 812 F.3d at 189.

94. *Id.* at 191.

95. *Id.*

96. *Id.* at 192.

This line of reasoning introduces a seemingly equitable consideration into a decision that is supposed to be strictly legal in nature.[97]

Mandamus relief is an "extraordinary remedy[.]"[98] While courts are reluctant to grant mandamus for agency inaction in cases involving an agency's resource allocation decisions or particularly difficult questions, courts have found mandamus jurisdiction in cases involving a "systemic failure" of the agency to operate as Congress intended.[99] This systemic failure occurs when insufficient funding completely overburdens the alternative remedies otherwise available.[100] If a "systemic failure" occurs, fixing that failure requires much more than a judicial writ; it requires two, or all three, branches of the government to work to solve the problem at hand.[101]

III. POSSIBLE SOLUTIONS TO THE MEDICARE APPEALS BACKLOG

All parties involved in *Cumberland County*[102] and *American Hospital Ass'n*[103] agree that the Medicare appeals backlog problem poses a "heavy financial burden" for providers[104] and places "the administrative process" in "grave condition."[105] To fix such a wide-reaching problem, multiple branches of the federal government must play significant roles in restructuring the overburdened administrative system. This Part identifies steps available to each branch of government for reducing backlogged Medicare appeals and considers their potential consequences.

Section A explains that Congress is in the best position to fix the backlog, through providing more funding for OMHA or by restructuring

97. *Id.* at 189–90; *see supra* Section I.A. This reasoning, of course, passes over the important question of how to identify a "systemic failure[.]" *Am. Hosp. Ass'n*, 812 F.3d at 191. It is fair to assume, for the purposes of this problem, that an average delay of almost ten times the statutory deadline constitutes a "systemic failure[.]" *Id.*

98. *In re* People's Mojahedin Org. of Iran, 680 F.3d 832, 836 (D.C. Cir. 2012) (quoting *In re* Core Commc'ns, 531 F.3d 849, 855 (D.C. Cir. 2008)); Telecomms. Research & Action Ctr. v. FCC, 750 F.2d 70, 78 (D.C. Cir. 1984); *see* Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 52 (4th Cir. 2016); *Am. Hosp. Ass'n*, 812 F.3d at 189.

99. *See supra* Section II.B.

100. *Am. Hosp. Ass'n*, 812 F.3d at 191.

101. *See* Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 5106997, at *8 (D.D.C. Sept. 19, 2016) ("The Court, however, does not possess a magic wand that, when waved, will eliminate the backlog.").

102. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, No. 5:14-CV-508-BR, 2015 WL 1249959 (E.D.N.C. Mar. 18, 2015).

103. Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 5106997 (D.D.C. Sept. 19, 2016).

104. *Cumberland Cty.*, 2015 WL 1249959, at *10; *see Am. Hosp. Ass'n*, 2016 WL 5106997, at *4.

105. *Cumberland Cty. Hosp. Sys.*, 816 F.3d at 57.

the appeals framework. Congressional action may be ineffectual, however, due to the political pressures that may slow its response. Section B addresses HHS's role in the backlog and concludes that the agency cannot entirely fix the backlog on its own. Section C addresses the role of the judiciary: mandamus should only be granted in the most egregious circumstances of agency delay. This Part concludes that the D.C. district court was correct in granting mandamus, because Congress demonstrated its inability or unwillingness to act and HHS failed to uphold the Medicare appeals system as envisioned by Congress.[106]

A. Legislative Action

To ensure providers' procedural rights are enforced through the appeals process without diminishing the scope or effectiveness of the RAC program, Congress should increase funding for OMHA and ALJ appeals. Congress contributed to this problem by requiring CMS to implement the RAC program without significantly increasing OMHA funding, and Congress is therefore in a good position to remedy the shortfall.[107] With increased funding, OMHA could hire more ALJs to decrease the backlog at a much faster rate. If Congress fails to increase OMHA funding, HHS will have to take drastic action, significantly altering both its appeals process and the RAC program.[108] Alternatively, Congress could alleviate the appeals backlog by altering the nature of the appeals process or the RAC program itself.

Even though congressional action is the most desirable solution, significant legislative reform seems unlikely.[109] In September 2016, the D.C. district court denied the government's motion for a stay due to its serious doubts that any legislative fix was forthcoming.[110] HHS argued that the President's proposed budget for fiscal year ("FY") 2017, along with the proposed Audit & Appeals Fairness, Integrity, and Reforms in

106. *See infra* Section III.C.

107. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 3, at 6. OMHA's appropriations have increased from $72 million to $82 million from fiscal year ("FY") 2012 to FY 2014, while the number of appeals have increased from 117,068 in FY 2012 to 474,063 in FY 2014. *Id.* The amount of overpayments collected by RACs, and concurrently the number of appeals, decreased significantly in FY 2015, largely due to HHS's decision to temporarily prohibit RACs from performing inpatient hospital patient status reviews, where the RAC reviews whether a patient should be considered inpatient or outpatient. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 2, at v. Even with this sharp reduction, the ALJ level of appeals still received twice as many appeals as it processed in FY 2015. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 3, at 4.

108. *See infra* Section III.B.

109. *See* Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 5106997, at *7 (D.D.C. Sept. 19, 2016).

110. *Id.* at *8.

Medicare Act ("AFIRM Act"), would alleviate much of the backlog without any drastic agency action necessary.[111] However, the court declined to give the possibility of any legislation much weight in its analysis.[112] In Congress's FY 2017 proposed budget, the Senate version would increase OMHA's budget by $5 million—only a 5% increase from the previous year—even though OMHA requested a $143 million increase in order to combat the backlog.[113] Similarly, the budget proposal from the House of Representatives did not include any increase in OMHA funding.[114] The AFIRM Act, which would have created a new class of "Medicare Magistrates" to assist appeals, did not move beyond the Senate Finance Committee after it was introduced in December 2015.[115]

All of this underscores the unreliability of depending on congressional action to solve serious agency problems. Relying on legislative funding to honor administrative deadlines can be difficult because the coalition that passed the legislation to begin with may be stripped of power or otherwise dissolved over time.[116] For a relatively nonpartisan issue like Medicare appeals, this may not appear to pose a threat to congressional enforcement. However, the RAC program's implementation and the exponential rise in appeals also coincidentally occurred during what, by some metrics, were two of the most unproductive congressional sessions in this country's recent history.[117] In both district court cases for *Cumberland County* and *American Hospital*

111. *Id.* at *7; *see* Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, S. 2368, 114th Cong., at 1 (2015) (stating that the purpose of the bill is "to improve the efficiency of the Medicare appeals process"); OFFICE OF MGMT. & BUDGET, EXEC. OFFICE OF THE PRESIDENT, BUDGET OF THE U.S. GOVERNMENT: FISCAL YEAR 2017, at 138 (2016), https://obamawhitehouse.archives.gov/sites/default/files/omb/budget/fy2017/assets/budget.pdf [https://perma.cc/DA9A-5ZKN].

112. *Am. Hosp. Ass'n*, 2016 WL 5106997, at *7–8.

113. *See* S. 3040, 114th Cong., at 82 (2016); *HHS FY 2017 Budget in Brief—OMHA*, U.S. DEP'T HEALTH & HUM. SERVS., http://www.hhs.gov/about/budget/fy2017/budget-in-brief/omha/index.html [http://perma.cc/6XSE-38ZW].

114. *See* H.R. 5926, 114th Cong., at 82 (2016).

115. *See* Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015, S. 2368, 114th Cong., at 4 (2015); *Audit & Appeals Fairness, Integrity, and Reforms in Medicare Act of 2015: Introduction to S. 2368 Before the S. Fin. Comm.*, 114th Cong. (Dec. 8, 2015).

116. *See* Mathew D. McCubbins, Roger G. Noll & Barry R. Weingast, *Administrative Procedures as Instruments of Political Control*, 3 J.L. ECON. & ORG. 243, 245 (1983).

117. *See* Cristina Marcos & Ramsey Cox, *Historically Unproductive Congress Ends*, HILL (Dec. 16, 2014), http://thehill.com/blogs/floor-action/senate/227365-historically-unproductive-congress-ends [http://perma.cc/XA8S-ZRNL]. *But see* Glenn Kessler, *Harry Reid's Claim That the Current Senate Is "the Most Unproductive" in U.S. History*, WASH. POST: FACT CHECKER (Dec. 8, 2015), https://www.washingtonpost.com/news/fact-checker/wp/2015/12/08/harry-reids-claim-that-the-current-senate-is-the-most-unproductive-in-u-s-history/ [http://perma.cc/J7WD-26J2].

Ass'n, which addressed the appeals backlog from late 2014 and early 2015, the courts recognized that Congress was aware of the problem and was working to address it.[118] In the two years since the first opinion, Congress has yet to increase funding or to alter the structure of the Medicare appeals process in any way.[119] Clearly, Congress failed to adequately respond to backlogged Medicare appeals. Because of congressional inaction, OMHA remains "in an untenable position" created by the confluence of increased appeals and stagnant funding.[120]

B. Agency Action

If Congress will not act, then HHS must take corrective measures to comply with the statutory framework. To HHS's credit, the agency implemented several steps to address the backlog during the course of the *American Hospital Ass'n* litigation, such as offering to settle any pending appeals for sixty-six percent of the amount of the claims[121] and proposing a system to evaluate and incentivize each RAC based on an accuracy score.[122] However, in the D.C. district court's denial of HHS's motion for a year-long stay, Judge Boasberg determined that the proposed administrative changes would not make any "significant progress toward a solution."[123] Although the proposed increase in settlements, introduction of alternative adjudicatory procedures, and alterations to the RAC program would result in fifty percent fewer backlogged OMHA appeals by FY 2020 than if HHS had taken no action, these changes would not affect the hundreds of thousands of appeals that are already backlogged.[124] Moreover, one of the proposed changes, requiring prior authorization for certain items or services, would actually impose new procedural hurdles for providers.[125]

HHS's inability to propose meaningful and significant changes underscores the primary limitation of relying on only agency action: the constraints placed on the agency by Congress restrict its ability to make drastic and wholesale changes in agency procedure. Although HHS's

118. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, No. 5:14-CV-508-BR, 2015 WL 1249959, at *9 (E.D.N.C. Mar. 18, 2015); Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 55 (D.D.C. 2014), *rev'd and remanded*, 812 F.3d 183 (D.C. Cir. 2016).

119. *See* Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 5106997, at *7 (D.D.C. Sept. 19, 2016).

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

121. Supplemental Declaration of Ellen Murray at 8, Am. Hosp. Ass'n v. Burwell, __ F. Supp. 3d __ (D.D.C. Nov. 7, 2016) (No. 1:14-CV-00851), 2016 WL 5106997.

122. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 2, at 10.

123. *Am. Hosp. Ass'n*, 2016 WL 5106997, at *6.

124. *Id.*

125. *See id.*

proposed changes did not extend to the outer boundaries of its statutory constraints,[126] any further changes may compromise the integrity of the appeals process or RAC program and would likely contravene the congressional intent of curbing Medicare overpayments.[127]

HHS argues that it is unable to satisfy these two competing interests: guaranteeing certain procedural rights for providers' appeals on one hand[128] and implementing the RAC program to reduce Medicare overpayments on the other.[129] Although it would be preferable from a principal-agent perspective for the agency to wait to receive guidance from Congress on how to balance those competing priorities,[130] HHS may be able to infer congressional intent based on the amount of procedural requirements in place under both statutory mandates. While Congress has provided explicit procedural rights by including deadlines for each level of appeal,[131] the RAC statute provides HHS with much more discretion to determine its scope.[132] Therefore, in this context, HHS should ensure that the Medicare appeals process meets its

126. *See* 42 U.S.C. § 1395ddd(h) (2015); *Am. Hosp. Ass'n*, 2016 WL 5106997, at *7. The American Hospital Association, in its motion for summary judgment, proposed that the secretary implement harsher penalties on RACs with high reversal rates and shortening the "lookback period" during which RACs can review payments. Plaintiff's Motion for Summary Judgment & Memorandum of Points & Authorities in Support at 10–11, Am. Hosp. Ass'n v. Burwell, __ F. Supp. 3d __ (D.D.C. Oct. 14, 2016) (No. 1:14-CV-00851), 2016 WL 5106997. Both of those proposals would fit within the statutory constraints of the RAC program. *See* § 1395ddd(h)(1) (mandating that the secretary "enter into contracts" with RACs under the Medicare Integrity Program); § 13955ddd(h)(4) (limiting the lookback period to no more than four years prior).

127. *See* § 1395ddd(h)(1) (instructing the HHS secretary to enter into contracts with recovery audit contractors to "recoup[] overpayments" made for all Medicare programs).

128. *See supra* Section I.B. In its briefs throughout the entire litigation against American Hospital Association, HHS has stressed the difficulty of its task to reduce the backlog without congressional support. *See, e.g.*, Brief for the Appellee at 17, Am. Hosp. Ass'n v. Burwell, 812 F.3d 183 (D.C. Cir. 2016) (No. 15-5015) ("Congress has not provided the resources needed to adjudicate claims within the timetable contemplated by the Medicare statute. Several members of Congress have explicitly recognized that this is the case, and plaintiffs do not seriously contend otherwise."). The agency raised an argument of impossibility in its motion for the D.C. district court to reconsider granting mandamus. Defendant's Motion for Reconsideration & Memorandum of Points & Authorities in Support at 2, Am. Hosp. Ass'n v. Burwell, __ F. Supp. 3d __ (D.D.C. Dec. 15, 2016) (No. 1:14-CV-00851), 2016 WL 5106997.

129. *See* § 1395ddd(h)(1); *Am. Hosp. Ass'n*, 812 F.3d at 186.

130. *See generally* Michael D. Sant'Ambrogio, *Agency Delays: How A Principal-Agent Approach Can Inform Judicial and Executive Branch Review of Agency Foot-Dragging*, 79 GEO. WASH. L. REV. 1381 (2011) (examining the treatment of agency delay by the judicial and executive branches from a principal-agent approach).

131. § 1395ff(a)(2), (c)(3)(C), (d)(1)(A), (d)(2)(A).

132. *See id.* § 1395ddd(h)(1) ("[T]he Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments . . . .").

statutory minimum requirements before HHS continues to operate the RAC program beyond its legally required minimum.

However, although HHS has more clear responsibilities regarding the appeals process, there are also clearer opportunities for enforcement of those responsibilities, as seen in the recent litigation.[133] Judicial review of deadlines is much easier to obtain than substantive review of the scope of an agency's adoption of a certain program.[134] A plaintiff who wished to challenge the underimplementation of the RAC program would likely face standing problems in federal court.[135] Therefore, the only possible protection for the RAC program would be congressional action, which can be unreliable given the current political state.[136] Although extrapolating congressional intent from the constraints put on agency discretion can be a useful tool, Congress clearly intended the RAC program to encompass more than just a token collection of contractors to meet the statutory minimum requirements.[137] Therefore, given the difficulty of enforcing congressional intent for the RAC program, it is important to maintain the efficacy of the RAC program as much as possible while emphasizing the statutory guarantees afforded to providers through the Medicare appeals system.

C. Judicial Action

The most crucial step for a mandamus claim against agency inaction is deciding whether to address the rights of only the plaintiffs or the rights of all participants in the administrative system. The Fourth Circuit focused on the resource allocation problem, reasoning that this problem would best be solved by "the political branches[,]" and therefore denied

133. *See supra* Section II.B.

134. *See* Jacob E. Gersen & Anne Joseph O'Connell, *Deadlines in Administrative Law*, 156 U. PA. L. REV. 923, 932 (2008).

135. *See* Warth v. Seldin, 422 U.S. 490, 500–01 (1975). A plaintiff challenging the underimplementation of the RAC program would not likely satisfy standing requirements for a "distinct and palpable injury[.]" *See id.* at 501. The only group of possible litigants who could be injured by the underimplementation of the RAC program would be health-care providers, since RACs are tasked with finding *under*payments as well as overpayments. § 1395ddd(h)(1). Given the unpopularity of the RAC program among most health-care providers, it is highly unlikely that any provider would actually file suit. *See* Bob Herman, *RACs Recouped $3B for Medicare in 2013*, MODERN HEALTHCARE (Sept. 29, 2014), http://www.modernhealthcare.com/article/20140929/NEWS/309299939 [https://perma.cc/9LMJ-TBZX] (reporting the high overturn rates for RACs in 2013).

136. *See supra* Section III.A.

137. *See* Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 1 (announcing Congress's expansion of the three-year, six-state RAC pilot program to all fifty states).

mandamus to the hospital plaintiff.[138] In contrast, the D.C. Circuit treated this case as a suit against the Medicare appeals process in general, rather than one in favor of just one or a few hospitals, as the Fourth Circuit did.[139] This shift in focus allowed the D.C. Circuit, and the district court on remand, to concentrate on the statutory obligations of HHS as a whole rather than confining their analyses to the status of one hospital's appeals.

Courts should allow Congress the opportunity to fix systemic Medicare appeals backlogs, especially if Congress has indicated its intent to do so.[140] Courts recognize that Congress is much better equipped than the judiciary to reshape an entire administrative procedural system, such as the Medicare appeals process, and therefore courts aim to give Congress proper deference.[141] The district court for the District of Columbia afforded Congress an appropriate amount of deference: in its 2014 denial of mandamus, the court viewed the possibility of congressional action as a factor weighing against mandamus.[142] Two years later, the court more pessimistically noted that "Congress is unlikely to play the role of the cavalry here, riding to the rescue of the Secretary's besieged program."[143] The prospect of congressional action only remains a compelling factor for mandamus as long as Congress appears willing and able to address the underlying problem.[144] However, once Congress is clearly unwilling or unable to make corrective changes, courts should affirmatively enforce statutory rights.[145]

Although judicial enforcement can be a powerful force when utilized, it sometimes suffers from procedural delays typically

138. Cumberland Cty. Hosp. Sys., Inc. v. Burwell, 816 F.3d 48, 57 (4th Cir. 2016) (quoting Cumberland Cty. Hosp. Sys., Inc. v. Burwell, No. 5:14-CV-508-BR, 2015 WL 1249959, at *10 (E.D.N.C. Mar. 18, 2015)); *see supra* Section I.C.

139. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.C. Cir. 2016) ("[T]he complaint also requests the broader relief of 'requiring HHS to otherwise comply with its statutory obligations in administering the appeals process for all hospitals.' ")

140. *See, e.g.*, Am. Hosp. Ass'n v. Burwell, 76 F. Supp. 3d 43, 55 (D.D.C. 2014) (noting that "Congress is aware of the inundation of appeals"), *rev'd and remanded*, 812 F.3d 183 (D.C. Cir. 2016).

141. *See* Sant'Ambrogio, *supra* note 130, at 1431.

142. *Am. Hosp. Ass'n*, 76 F. Supp. 3d at 55.

143. Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 5106997, at *8 (D.D.C. Sept. 19, 2016).

144. *See Am. Hosp. Ass'n*, 812 F.3d at 193 ("[T]he clarity of the statutory duty likely will require issuance of the writ if the political branches have failed to make meaningful progress within a reasonable period of time . . . ."); *Am. Hosp. Ass'n*, 2016 WL 5106997, at *4 ("[T]he force of Congress's knowledge and ability to act as a reason to deny mandamus diminishes with the passage of time absent meaningful legislative action, particularly as the backlog and delays have worsened.").

145. *See* Marbury v. Madison, 5 U.S. (1 Cranch) 137, 147 (1803) ("[E]very right, when withheld, must have a remedy . . . .").

experienced by the other political branches.[146] As noted by commentators, "[t]he [federal] judiciary is not known for its expeditious decisionmaking[,]"[147] even though it is generally insulated from political pressures that can delay the other two branches.[148] In *American Hospital Ass'n*, for example, the D.C. district court granted mandamus in December 2016, two and a half years after the plaintiffs filed their complaint.[149] Waiting two and a half years for relief would not be considered particularly expedient, especially considering some hospitals had approximately one year's worth of revenues tied up in the appeals process.[150] However, because the court was separated from the even-slower Congress, Judge Boasberg was able to grant mandamus to begin to quell the Medicare appeals backlog.[151]

In addition to some procedural slowness, the remedies available to the courts are much more limited than those available to the other branches of government.[152] Courts can issue writs of mandamus, prescribe new judicial deadlines, or simply order that an agency "act expeditiously."[153] In its mandamus order, the D.C. district court imposed a timetable that requires HHS to decrease the backlog by a certain percentage each year.[154] Although the court will be able to enter default judgments for claims still significantly backlogged after 2020, there are no penalties if HHS does not meet each yearly goal.[155] This serves as a perfect example of the courts' role in enforcing administrative deadlines: after years of hard-fought litigation, the final judicial order is only a part of the overall solution. The judicial branch may not have the flexibility or responsiveness of the political branches, but it serves as a vital backstop to enforce administrative deadlines and guarantee procedural rights to those interacting with the administrative state.

146. Professor Sant'Ambrogio views judicial enforcement of an agency's statutory responsibilities as "[a] core responsibility of the judiciary." *See* Sant'Ambrogio, *supra* note 130, at 1431.

147. Sant'Ambrogio, *supra* note 130, at 1430. Nationwide, fourteen percent of civil district court cases have been pending for at least three years. *See* ADMIN. OFFICE OF THE U.S. COURTS, UNITED STATES DISTRICT COURTS—FEDERAL COURT MANAGEMENT STATISTICS 1 (June 30, 2016), http://www.uscourts.gov/file/20172/download [http://perma.cc/8S5T-STS9].

148. Sant'Ambrogio, *supra* note 130, at 1430.

149. Am. Hosp. Ass'n v. Burwell, No. 1:14-CV-00851, 2016 WL 7076983, at *1 (D.D.C. Dec. 5, 2016).

150. *See supra* Section I.C.

151. *See Am. Hosp. Ass'n*, 2016 WL 7076983, at *3.

152. Sant'Ambrogio, *supra* note 130, at 1431.

153. Gersen & O'Connell, *supra* note 134, at 964–66.

154. *Am. Hosp. Ass'n*, 2016 WL 7076983, at *3.

155. *Id.*

CONCLUSION

Administrative procedure is viewed by scholars as a way for congressional coalitions to exert lasting power over agency action.[156] The coalition that enacted the Medicare appeals framework included deadlines to guarantee providers a baseline for procedural rights. However, just as a competing congressional mandate's effects were beginning to impact those procedural rights, Congress became simultaneously mired in one of the most divisive and unproductive periods in history.[157] Because the coalition that originally enacted the Medicare appeals process has long dissolved, the duty to enforce those procedural rights falls to HHS and the courts. Given that an efficient administrative state is faithful to the intent of the enacting coalition, the D.C. Circuit was correct in finding mandamus jurisdiction. By addressing the Medicare appeals process as a whole instead of just the rights of one provider, and accurately viewing the escalation provision as a non-viable "alternative remedy,"[158] the D.C. Circuit served the important role of protecting statutorily granted procedural rights, ensuring that the costs of health-care reform are not distributed disproportionately—a result that would be counter to the intent of the legislation.

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156. *See* Sant'Ambrogio, *supra* note 130, at 1388–89; Gersen & O'Connell, *supra* note 134, at 932–33.

157. *See supra* Section III.A.

158. Am. Hosp. Ass'n v. Burwell, 812 F.3d 183, 192 (D.C. Cir. 2016).

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