Articles + Publications | September 21, 2021

DC Circuit Revives Medicare Advantage Overpayment Rule

WRITTEN BY

Virginia Bell Flynn | Judith L. O'Grady | Sara B. Richman | Barak A. Bassman | Leah Greenberg Katz | Marlee (Waxelbaum) Santos

This article was republished in the December 2021 edition of Pratt's Government Contracting Law Report.

On August 13, the D.C. Circuit revived the CMS 2014 Medicare Advantage Overpayment Rule in deciding *UnitedHealthcare Ins. Co. v. Becerra*, a ruling that could have broad implications for Medicare Advantage (MA) insurers. *See UnitedHealthcare Ins. Co. v. Becerra*, No. 18-5326, 2021 WL 3573766 (D.C. Cir. Aug. 13, 2021).

The Affordable Care Act requires MA insurers to report and return any overpayments identified by the insurer to CMS within 60 days. Failure to do so can trigger liability under the False Claims Act. In 2014, CMS promulgated the Overpayment Rule to implement these statutory requirements and further specified that a "diagnosis that has been submitted [by a Medicare Advantage insurer] for payment but is found to be invalid because it does not have supporting medical record documentation would result in an overpayment." *Becerra*, 2021 WL 3573766, at *10. For purposes of the rule, overpayments are "identified" when actually identified or when they should have been identified by the insurer "through the exercise of reasonable diligence." "Reasonable diligence" is defined as "proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments." 42 C.F.R. § 422.326 at 29,921.

Documentation of a reported medical diagnosis is relevant here because of the way CMS pays MA insurers. Unlike traditional fee-for-service (FFS) Medicare payments, MA insurers receive pre-established monthly lump sum payments for each beneficiary they insure. The monthly payment amounts are intended to reflect the relative risk and cost of insuring any particular member. To that end, the Medicare statute requires a monthly payment adjustment to reflect "such risk factors as age, disability status, gender, institutional status, and … health status … , so as to ensure actuarial equivalence" between traditional Medicare and Medicare Advantage. MA insurers are then paid larger amounts for covering higher risk, costlier individuals. 42 U.S.C. § 1395w-23(a)(1)(C)(i).

CMS uses the Hierarchical Condition Category risk adjustment model to convert diagnosis data into expected costs for MA beneficiaries. The model uses data from individuals covered under the traditional Medicare program to determine medical costs associated with certain diagnosis and demographic information. CMS then uses this data to predict the cost of care for MA beneficiaries based on their demographics and diagnoses.

Since errors may occur in reporting diagnosis codes, CMS has implemented mechanisms, including the Overpayment Rule, to validate reported diagnoses. Another validation mechanism is the Risk Adjustment Data

Validation audit through which CMS audits a sample of medical records for any unsupported diagnoses that may have resulted in an overpayment. CMS then extrapolates this sample's error rate across all beneficiaries. At one point, CMS considered adding, but ultimately did not, an FFS adjuster to achieve actuarial equivalence in the RADV program. The FFS adjuster would be applied to any overpayment amounts to ensure that MA insurers were only liable for repayments that exceeded any payment errors under the traditional Medicare program. The FFS adjuster was at issue in the challenge to the Overpayment Rule before the D.C. Circuit.

DC District Court Vacates Overpayment Rule in 2018

A group of MA insurers sued to challenge the Overpayment Rule in 2016. The MA insurers argued, among other things, that the Overpayment Rule: (1) ran afoul of the Medicare statute's actuarial equivalence requirement; (2) is inconsistent with CMS' earlier announcement that an FFS adjuster would be applied to RADV audits; and (3) applies a negligence standard to False Claims Act liability, which contradicts the FCA's standards.

The District Court granted the insurers' motion for summary judgment and vacated the Overpayment Rule, holding that it violated the Medicare statute's actuarial equivalence requirement. The court held that because "payments for care under traditional Medicare and Medicare Advantage are both set annually based on costs from unaudited traditional Medicare records," but the Overpayment Rule measures overpayments on audited records, there was an actuarial distinction. *Becerra*, 2021 WL 3573766, at *10. The court found there could be no actuarial equivalence between payments under traditional Medicare and Medicare Advantage when CMS pays for "all diagnostic codes, erroneous or not, submitted to traditional Medicare," but would require repayment for erroneous diagnoses submitted by MA insurers. *UnitedHealthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 187 (D.D.C. 2018).

The court further held that CMS' prior statements regarding the inclusion of an FFS adjuster in its RADV audits for purposes of actuarial equivalence constituted an agency decision or policy from which CMS unlawfully departed in enacting the Overpayment Rule. *Id*. at 189-90.

Finally, the court held that the Overpayment Rule's "reasonable diligence" requirement went "far beyond the False Claims Act," and "CMS has no legislative authority to apply more stringent standards to impose FCA consequences through regulation." *Id*. at 191.

DC Circuit Court Revives Overpayment Rule

CMS appealed the District Court's order in late 2018 and prevailed in August. In reversing the District Court's order, the Circuit Court primarily focused on whether the Medicare statute's actuarial equivalence requirement even applied to the Overpayment Rule. The court answered that question in the negative: "[A]ctuarial equivalence does not apply to the Overpayment Rule or the statutory overpayment-refund obligation under which it was promulgated. Reference to actuarial equivalence appears in a different statutory subchapter … and neither provision cross-references the other." *Becerra*, 2021 WL 3573766, at *2. It further explained that "[a]ctuarial equivalence is a directive to CMS. It describes the goal of the risk-adjustment model Congress directed CMS to develop. It does not separately apply to the requirement that Medicare Advantage insurers avoid known error in their payment requests." *Id*.

Because the court held that the actuarial equivalence requirement does not even apply to the Overpayment Rule,

it ruled that the agency had no obligation to consider an FFS adjuster as it did in the context of RADV audits.

Notably, CMS did not appeal the District Court's holding on the Overpayment Rule's reasonable diligence requirement as it pertains to False Claims Act liability. Accordingly, the District Court's holding that the reasonable diligence requirement was overreaching remains intact. Although the Circuit Court was not charged with reviewing the reasonable diligence requirement, it did, in the context of evaluating the actuarial equivalence requirement, reject the insurers' argument that the Overpayment Rule "creates a sweeping obligation that effectively requires Medicare Advantage insurers to self-audit all their data." *Id*. at *13. The court explained that "nothing in the Overpayment Rule obligates insurers to audit their reported data … the Rule only requires" refunds for any *known* overpayments, *i.e.,* "payments [insurers] *are aware* lack support in a beneficiary's medical records."

Implications

With this opinion, the D.C. Circuit disfavored arguments advanced by Medicare Advantage insurers and the District Court, largely reinstating the Overpayment Rule and shoring up CMS' authority to implement fraud prevention and cost containment measures in a variety of forms. Importantly though, this opinion did not disturb the significant victory Medicare Advantage insurers enjoyed at the District Court concerning the reasonable diligence requirement, which the court ruled could not be applied to lower the standard for False Claims Act Liability. Even so, Medicare Advantage insurers must remain diligent in their compliance procedures. As the Circuit Court made clear, CMS has several tools in its arsenal — including certification obligations, RADV audits, and the Overpayment Rule — to identify and recoup overpayments and to potentially impose substantial liability for erroneous coding submissions.

RELATED INDUSTRIES + PRACTICES

- Business Litigation
- Consumer Financial Services
- Fraud + Abuse Litigation + Investigations
- Health Care + Life Sciences
- Insurance + Reinsurance