Published on *The National Law Review* https://natlawreview.com

D.C. Circuit Gives New Life to CMS Overpayment Rule

Article By:

Christine M. Clements

Erica J. Kraus

Michael W. Paddock

Paul A. Werner

On August 13, 2021, the D.C. Circuit Court of Appeals reversed a district court opinion vacating CMS' Overpayment Rule, 42 C.F.R. 422.326, for Medicare Advantage organizations ("MAOs"). UnitedHealthcare Insurance Co. et al. v. Becerra et al., case number 18-5326. As a result of this decision, CMS can once again rely on the Overpayment Rule to impose voluntary refund obligations for MAOs. MAOs – already subject to significant government enforcement related to their risk adjustment coding practices – should carefully consider the implications of this decision for their coding and auditing practices.

I. The Overpayment Rule

The Overpayment Rule, promulgated in 2014 as part of the Affordable Care Act, requires an MAO to "report and return any overpayment it received no later than 60 days after the date on which it identified it received an overpayment" and defines an overpayment as "identified" when the MAO "has determined, or should have determined through the exercise of reasonable diligence that the MA organization has received an overpayment." 42 C.F.R. 422.326(d), (c). UnitedHealth challenged this rule in January 2016, arguing that (i) it violated the statutory requirement of actuarial equivalence between payments to MAOs and traditional Medicare expenditures, (ii) it was arbitrary and capricious because it did not incorporate an adjustment factor similar to the adjuster included in CMS' RADV audit rules, and (iii) its incorporation of a negligence standard through the definition of an identified overpayment to include overpayments that "should have [been] determined through the exercise of reasonable diligence" conflicted with the knowledge standard in the False Claims Act and violated the Administrative Procedure Act ("APA").

II. The District Court Decision Vacating the Overpayment Rule

The district court agreed with UnitedHealth and vacated the Overpayment Rule. Focusing on indications of a high error rate in diagnosis codes recorded for traditional Medicare beneficiaries,

which codes are not used to determine payment and therefore not subject to "reasonable diligence review" for potential accuracy or overpayments, but which are used to set capitated payment rates for Medicare Advantage plans, the district court found that "the 2014 Overpayment Rule systematically devalues payments to Medicare Advantage insurers by measuring 'overpayments' based on audited patient records." *UnitedHealthcare Ins. Co. v. Azar*, 330 F. Supp. 3d 173, 184 (D.D.C. 2018). The court concluded that this systematic devaluation violated the requirement of actuarial equivalence between expected payments under traditional Medicare and capitated payments to MAOs, as well as the requirement to compute and publish average risk factors for traditional Medicare beneficiaries using the "same methodology" expected to be used to calculate MAO payments. It also concluded that the rule departed from the prior policy embodied in CMS' proposal of a "FFS Adjuster" for RADV audits, which did not penalize MAO diagnosis coding error rates below a set level based on CMS' finding that similar error rates existed in diagnosis coding for traditional Medicare beneficiaries. Finally, it agreed with UnitedHealth that the Overpayment Rule's incorporation of a negligence standard violated the APA.

III. Reversal of the District Court Decision by the Court of Appeals

CMS appealed the district court's holdings with respect to actuarial equivalence, same methodology, and the capriciousness of the departure from the proposed FFS Adjuster, but did not challenge the district court's findings with respect to the negligence standard. The Court of Appeals reversed each of the challenged holdings. With respect to the actuarial equivalence holding, the Court found that, based on the text of the statutory mandate, the actuarial equivalence requirement in the Medicare Advantage statute applies to the way in which CMS determines payments to MAOs, and has no application to the Overpayment Rule. In particular, nothing in the text of either the actuarial equivalence requirement or the Overpayment Rule explicitly indicates that actuarial equivalence could be "a defense against the obligation to refund any individual, known overpayment." The Court reasoned that the actuarial equivalence requirement is intended to establish a methodology that will tend to equalize CMS' payments for Medicare Advantage beneficiaries at the population level with its payments for traditional Medicare beneficiaries, whereas the Overpayment Rule is meant to correct "particular mistaken payments to Medicare Advantage insurers" – namely, that "if a [MAO] has received a payment increment for a beneficiary's diagnoses and discovers that there is no basis for that payment in the underlying medical records, that is an overpayment that the insurer must correct by reporting it to CMS…."

Further, the Court concluded that, even if the actuarial equivalence requirement were interpreted to disallow an overpayment recovery mechanism that would result in lower net payments to MAOs, UnitedHealth had failed to show empirically that — the Overpayment Rule was such a mechanism. The Court explained that "UnitedHealth identifies no reason why the traditional Medicare data that goes into the risk-adjustment model would suffer systematically from unsupported codes like those that the Overpayment Rule targets…[n]or has UnitedHealth established another premise of its position – that the unsupported codes it posits in traditional Medicare would both be materially analogous to those the Overpayment Rule targets, and would cause UnitedHealth to be underpaid." The Court noted that a CMS study released after the district court's decision "found that errors in [traditional Medicare] claims data do not have any systematic effect on the risk scores calculated by the CMS-HCC risk adjustment model, and therefore do not have any systematic effect on the payments made to [MAOs]."[1] The Court reversed the district court's "same methodology" holding for similar reasons, finding that the "'same methodology' requirement plays a specific role in the computation and publication of data to aid in the [MAO] bidding process" and is not implicated by the separate provision under which the Overpayment Rule was promulgated.

The Court's reasoning with respect to the actuarial equivalence and same methodology requirements also drove its conclusion that CMS did not act arbitrarily and capriciously when it did not consider a FFS Adjuster or similar correction in the context of its Overpayment Rule. Again, the Court emphasized the distinction between CMS' process for setting MAO payments, and for auditing these payment levels via the RADV process, and the separate requirement that MAOs report and return particular known overpayments. The Court explained that RADV audits, which search for all unsupported codes in a MAO's data "are an error-correction mechanism that is materially distinct from the Overpayment Rule…which requires only that an insurer report and return to CMS known errors in its beneficiaries' diagnoses that it submitted as grounds for upward adjustment of its monthly capitation payments."

IV. Status of Any Proactive Diligence Requirement Unclear

Because CMS did not appeal the district court's finding that CMS' adoption of a negligence standard in defining an overpayment as "identified" violated the APA, the Court did not address that ruling. CMS decision to not appeal this finding appears to have undercut the strength of UnitedHealth's argument, which the court characterized as based on the assumption that "the Overpayment Rule creates a sweeping obligation that effectively requires [MAOs] to self-audit all their data." The court dismissed this assumption, stating that "[n]othing in the Overpayment Rule obligates [MAOs] to audit their reported data. As the district court held, … and CMS does not here dispute, the Rule only requires [MAOs] to refund amounts they *know* were overpayments, *i.e.*, payments they *are aware* lack support in a beneficiary's medical records. That limited scope does not impose a self-auditing mandate" (emphasis in original). Unconvinced that MAOs have a responsibility to self-audit that equates them to subjects of RADV audits, the Court reversed and remanded the case "with orders to enter judgment in favor of Appellants" – allowing the Overpayment Rule to stand.

However, CMS' decision to not appeal and the D.C. Circuit's decision to leave unperturbed the district court's holding (*i.e.*, that CMS' adoption of a negligence standard in the Overpayment Rule violated the APA) leave in doubt the status of any purported requirement that MAOs engage in proactive, "reasonable diligence" to self-audit or otherwise identify overpayments lest they risk liability under the Overpayment Rule and potentially the False Claims Act. Despite reversing the district court's vacatur of the Overpayment Rule, the Court stated that the Overpayment Rule imposes no obligation to self-audit, but rather only requires refunds of amounts "known" to be overpayments, *i.e.*, when the recipient is "aware" that there is no support for the payment. Albeit dicta, these statements suggest that liability for retained overpayments may be limited to those of which MAOs (and potentially providers and suppliers subject to a similar CMS overpayment rule) are actually aware.

With the Court's decision, CMS could begin to process the backlog of risk adjustment-related recoupments that MAOs submitted pursuant to the Overpayment Rule, but which CMS put on hold while it awaited the outcome of the litigation.

FOOTNOTES

[1] CMS' study has been widely criticized and CMS has yet to issue a final rule on the FFS Adjuster. *E.g.*, Rob Pipich, *Medicare Advantage RADV FFS Adjuster: White Paper*, Milliman (Aug. 23, 2019) (*available* here).

National Law Review, Volume XI, Number 229