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# The Supreme Court Denies Petition Challenging CMS's Overpayment Rule

**Health Care Law Brief Blog** on **June 26, 2022**

This past week, the Supreme Court of the United States (Supreme Court) denied UnitedHealthcare Insurance Company's (UnitedHealthcare) petition for a writ of certiorari (Petition) challenging, in part, the Centers for Medicare & Medicaid Services's (CMS) Overpayment Rule, which requires Medicare Advantage (MA) plans, such as UnitedHealthcare, to return identified "overpayments" to CMS within 60 days. With this denial, the Overpayment Rule remains in full force and effect, and UnitedHealthcare, among other MA plans, must comply or potentially face False Claims Act (FCA) liability.

## CMS's Payments to MA Plans

Under the traditional, or fee-for-service (FFS), Medicare program, CMS directly pays providers a predetermined rate for the items and services furnished to patients under Medicare Parts A and B. In the MA, or Part C, context, CMS contracts with private plans who enroll patients and contract with providers to furnish items and services to the patients that enroll in an MA plan. CMS pays MA plans a predetermined, or per-capita, premium in exchange for the MA plan covering all of the mandated health care benefits to the enrollees, regardless of the items and services actually received by each enrollee. In turn, an MA plan pays providers a negotiated rate for the items and services they render to enrollees.

When it created MA, Congress required CMS to pay MA plans an *actuarially equivalent* amount to what CMS would have paid to insure the same beneficiary in FFS Medicare. To account for health and costliness and, in part, to prevent MA plans from enrolling the healthiest (and less costly) patients, CMS was mandated under the Social Security Act to create a risk adjustment methodology. Specifically, Congress directed CMS to adjust the payment amount for certain "risk factors," including demographic characteristics and medical conditions, to ensure "actuarial equivalence." See 42 U.S.C. § 1395w-23(a)(1)(C)(i). Congress also required CMS to use the "same methodology" to calculate the costliness of insuring a beneficiary in the MA program and in FFS Medicare. See id. at § 1395w-23(b)(4)(D). In response, CMS created a model using FFS Medicare data to create a "risk score" that predicts how much FFS Medicare will spend on a particular beneficiary in the subsequent year, relative to the average beneficiary. And, then, using this "risk score" as a baseline, CMS factors in the applicable geographic area to create an "adjuster" in the premium to determine how much it will pay MA plans for each enrollee.

To determine how much it will pay MA plans, CMS requires MA plans to submit certain information about its enrollees, including diagnosis codes that support the items and services furnished. Whether a risk score increases and, thus, whether the premium is adjusted upward, depends on the diagnosis code(s) used for a particular enrollee. An increased risk score means an increased payment to MA plans for that particular enrollee because, e.g., the enrollee is less healthy than another enrollee and would, per CMS's prospective calculation methodology, cost more.

The Overpayment Rule

In its normal course, CMS audits diagnosis codes submitted by MA plans to determine whether they are supported by the medical record. If an unsupported diagnosis code is found, MA plans are obligated to return payments made by CMS based on such diagnosis code—e.g., the risk adjusted portion of the MA premium. The Overpayment Rule, set forth at 42 U.S.C. § 1320a-7k(d), codifies an MA plan's obligation to return any overpayment it identifies to CMS within 60 days. If an MA plan knows of an overpayment and fails to return it, then the MA plan is subject to FCA liability. The preamble to the Overpayment Rule provides that "a risk adjustment diagnosis that has been submitted for payment but is found to be invalid because it does not have supporting medical documentation would result in an overpayment." 79 Fed. Reg. 29844, 29921 (May 23, 2014). As is ultimately explained by CMS in its pleadings to the Supreme Court (see below), while the Overpayment Rule broadly incorporates by reference the Medicare statute, the Overpayment Rule's obligations upon MA plans are separate and distinct from CMS's risk adjustment payment methodology to MA plans based on actuarial equivalence.

UnitedHealthcare's Contentions and Legal Proceedings

Shortly after CMS implemented the Overpayment Rule, UnitedHealthcare, and other plaintiffs, filed suit against CMS in 2016, arguing that the Overpayment Rule violated the Social Security Act's "actuarial equivalence" and "same methodology" mandates, and was arbitrary and capricious under the Administrative Procedure Act because the Overpayment Rule was an unexplained departure from CMS's prior position with respect to paying the same amount to an MA plan as CMS would have paid to insure the same beneficiary in FFS Medicare using the same methodology.

In 2018, the United States District Court for the District of Columbia (District Court) agreed, entering judgment for UnitedHealthcare and vacating the Overpayment Rule as it relates to MA plans. See UnitedHealthcare Insurance Co. v. Azar, Civil Case No. 16-157 (RMC), 330 F. Supp. 3d 173 (Sep. 7, 2018), reconsideration denied Jan. 27, 2020. The District Court judge specifically noted that, "[t]he effect of the 2014 [O]verpayment [R]ule, without some kind of adjustment, is that [MA plans] will be paid less to provide the same health care coverage to their beneficiaries than [FFS Medicare] pays for comparable patients." In essence, this is a likely result because FFS Medicare pays based on all diagnosis codes—erroneous or not—and CMS will pay less to MA if MA plans are obligated to return payments based on erroneous codes.

CMS appealed. And, in 2021, a three-judge panel from the United States Court of Appeals for the District of Columbia Circuit (Appellate Court) unanimously reversed the District Court's holding. See UnitedHealthcare Insurance Co. v. Becerra, No. 18-5326, 16 F.4th 867 (Nov. 1, 2021), rehearing denied Nov. 1, 2021. In its opinion, the Appellate Court found that "actuarial equivalence does not apply to the [O]verpayment [R]ule or the statutory overpayment-refund obligation under which it was promulgated. … [N]othing in the Medicare statute's text, structure or logic applies actuarial equivalence to its separate overpayment-refund obligation, and thus the [O]verpayment [R]ule does not violate actuarial equivalence." Additionally, the Appellate Court rejected UnitedHealthcare's assertion that the Overpayment Rule is inconsistent with and breaches CMS's duty to use the "same methodology" for MA and FFS Medicare, reiterating that CMS's duty "does not bear on the overpayment-refund obligation." Lastly, the Appellate Court held that the Overpayment Rule was not arbitrary and capricious but rather clarified the procedures to return overpayments given that the underlying obligation has always been for MA plans to return payments based on diagnosis codes that are not supported by the medical record.

Within a matter of months of receiving the Appellate Court's decision, and about six years after first filing in District Court, UnitedHealthcare submitted its Petition to the Supreme Court in February, 2022. UnitedHealthcare drew the Supreme Court's attention to the fact that "the Medicare statute explicitly links these provisions"—i.e., the definition of an "overpayment" incorporates by reference "subchapter XVIII," which "includes the actuarial-equivalence requirement." Multiple amici from the healthcare industry were filed—both in support of UnitedHealthcare's efforts and in defense of CMS's position.

Last month, CMS opposed UnitedHealthcare's Petition, articulating, in summary:

"Nothing in the Medicare Act suggests that before CMS can collect known overpayments from a [MA plan]—mistaken payments that the [MA plan] *knows* were not supported by medical-record documentation—CMS must engage in unprecedented auditing or make use of an adjuster to eliminate a supposed bias in traditional [FFS] Medicare data. The [Appellate Court's decision] does not conflict with any decision of [the Supreme Court] or any other court of appeals, and [UnitedHealthcare's] claims about the consequences for the Part C program are without merit."

UnitedHealthcare filed its reply, noting that CMS had "largely ignore[d] the amici … explaining that the decision will severely damage the [MA] program to the detriment of the millions of Americans who depend on it for high-quality, lost cost care." Notably, in 2022, 45% of Medicare beneficiaries have an MA plan.

This past week, the Supreme Court denied UnitedHealthcare's Petition, ending its efforts to reinstate the District Court's decision vacating the Overpayment Rule.

Takeaways

With the Supreme Court's denial of UnitedHealthcare's Petition, the Overpayment Rule remains in full force and effect. If an MA plan knows of an overpayment, it must return it within 60 days. A consequence of failing to return an identified overpayment includes potential FCA liability—liability that includes civil monetary penalties, damages, and/or administrative enforcement actions, including exclusion by or integrity obligations with OIG. This is not dissimilar to a FFS provider's obligation to return identified overpayments within 60 days under the same Overpayment Rule.[1]

The Firm is experienced with providing advice and guidance relating to the Overpayment Rule as it relates to MA plans, FFS Medicare, and providers.

[1] We note that application of the Overpayment Rule to providers who are overpaid by MA plans is uncertain.

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