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District Court Vacates 2014 Medicare Advantage Overpayment Final Rule Citing Failure to Satisfy Actuarial Equivalence Requirement

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The United States District Court for the District of Columbia issued an order vacating the Centers for Medicare and Medicaid Services' (CMS) 2014 Overpayment Final Rule ("Final Rule") and opined that the Final Rule failed to satisfy the statutory mandate of actuarial equivalence for CMS payments.

Background

Medicare Advantage plans contract annually with CMS to provide health care benefits to members who otherwise qualify for traditional Medicare but who elect coverage by a Medicare Advantage plan. CMS reimburses Medicare Advantage plans for assuming the risk of providing health benefits to Medicare beneficiaries on a capitated, or per-member, per-month basis. Under congressional mandate, CMS must determine this monthly payment in a manner that ensures actuarial equivalence to ensure that plans are fairly and appropriately compensated and that Medicare Advantage plans do not cherry-pick healthier-than-average members.

CMS ensures actuarial equivalence by assessing the health status of traditional and Medicare Advantage members separately but using the same information: diagnostic codes obtained from claims data. This raw data – without adjustment for information in the patient's medical records or based on treatment rendered – is the primary

measurement for determining the capitated CMS reimbursement for Medicare Advantage plans.

CMS also ensures actuarial equivalence in determining the appropriate CMS payment to Medicare Advantage plans by conducting retrospective annual Risk Adjustment Data Valuation (RADV) audits. RADV audits require CMS to audit a sample of its own claims data by comparing a sample of the diagnostic codes that are submitted by Medicare-enrolled providers with those associated beneficiaries' underlying medical charts to determine an error rate. CMS completes the same sample set analysis for a selected Medicare Advantage plan. CMS then determines whether a Medicare Advantage plan's payment error rate exceeds CMS' own corresponding error rate, which is largely based on the percentage of diagnostic codes that were not adequately supported by their corresponding medical records. If a Medicare Advantage plan's payment error rate is lower than or equal to that of CMS, the result of CMS' RADV audit is that the Medicare Advantage plan's diagnostic codes appropriately measure the health of its members, and the plan has not been overpaid. If, however, the Medicare Advantage plan's payment error rate exceeds that of CMS, the Medicare Advantage plan would have to repay the difference between its error rate and CMS' rate.

Final Rule Undermines Actuarial Equivalence and Results in Lower Payments to Medicare Advantage Plans

The Patient Protection and Affordable Care Act imposes an obligation on Medicare Advantage plans, among others, to report and repay overpayments to CMS by the later of 60 days after the date on which the overpayment was identified or the date that any corresponding cost report was due. Repayment after the deadline results in risk of a finding of liability under the False Claims Act (FCA). FCA violation can result in treble damages, civil penalties and exclusion from participation in federal health care programs.

Under a proposed rule that CMS introduced in 2014, an "overpayment" was identified as when a Medicare Advantage plan had "actual knowledge of the existence of the overpayment or act[ed] in reckless disregard or deliberate ignorance of the existence of the overpayment." However, CMS modified that definition in the Final Rule without providing proper notice and comment under the Administrative Procedure Act. Under the Final Rule, an overpayment would be "identified" by a Medicare Advantage plan when it has determined, or should have determined through the exercise of reasonable diligence, that it received an overpayment. CMS further indicated that "reasonable diligence" would include proactive compliance activities that are conducted in good faith by qualified individuals to monitor for receipt of overpayments. As a result of the Final Rule, failure to conduct such proactive compliance activities could subject a Medicare Advantage plan to liability under the FCA.

In this case, plaintiffs, UnitedHealthcare Insurance, argued, and the court agreed, that the Final Rule, as written, obliges plans to withdraw previously submitted codes when a plan has determined or should have determined through reasonable diligence that a diagnostic code was not adequately documented in the underlying medical record. CMS imposed this requirement on Medicare Advantage plans

notwithstanding the fact that CMS calculates the plan's payment on the basis of the average health status of a CMS beneficiary as determined by diagnosis codes obtained from claims data, which CMS conclusively treats as valid without confirmation through review of documentation in the beneficiaries' records. By imposing validation criteria on Medicare Advantage plans that CMS does not utilize itself when it calculates the risk scores of its own beneficiaries, the Final Rule artificially makes a plan's beneficiaries appear to have fewer conditions than identical CMS beneficiaries, which therefore leads to underpayment of Medicare Advantage plans.

Impact

Although the Final Rule has been vacated and formal CMS guidance on how to interpret the ACA overpayment requirement is unavailable, the requirement to return and repay all overpayments under the ACA and FCA still stands. Medicare Advantage plans must continue to monitor their payment activity and diligently report any overpayments to CMS.

CMS is considering whether to appeal this summary judgment finding.