In a ruling that may portend a significant uptick in False Claims Act (FCA) whistleblower cases, last week the U.S. Court of Appeals for the District of Columbia Circuit reversed a 2018 decision that vacated Medicare's “Overpayment Rule” for Medicare Advantage organizations (MAOs). As a result, CMS can once again impose obligations on MAOs to proactively return identified overpayments within 60 days. We discuss *UnitedHealth v. Becerra* and its likely impact below.
The Overpayment Rule

Adopted in 2014 as part of the Affordable Care Act, the Overpayment Rule requires MAOs to report and return any overpayment within 60 days after the payment is “identified.” An overpayment is “identified” when the MAO “has determined, or should have determined through the exercise of reasonable diligence” that the MAO received an overpayment. UnitedHealth challenged this rule in January 2016, arguing that it improperly lowered the FCA’s well-established “knowingly” knowledge standard to one of mere negligence. UnitedHealth also argued that the Overpayment Rule violated the statutory requirement of “actuarial equivalence,” which, broadly speaking, is meant to ensure that Medicare Advantage providers receive equivalent pay for services as compared to their traditional fee-for-service Medicare counterparts.

The D.C. District Court agreed with UnitedHealth’s argument in both respects, holding that the Overpayment Rule not only conflicted with the FCA’s knowledge requirement, but also violated actuarial equivalence in that it imposed repayment obligations on Medicare Advantage providers that were not imposed on traditional Medicare providers. The court reasoned that although payments under traditional Medicare and Medicare Advantage are both set annually based on costs from unaudited Medicare records, only Medicare Advantage insurers are required to return overpayments based on audited patient records. This, according to the district court, systemically devalues payments to Medicare Advantage insurers in violation of the Medicare statute.

Circuit Court Ruling

On appeal, the D.C. Circuit overruled the lower court, concluding that the Overpayment Rule “does not violate, or even implicate, actuarial equivalence”. Looking to the construction and logic of the Rule, the court reasoned that “[t]he actuarial-equivalence requirement and the overpayment-refund obligation apply to different actors, target distinct issues arising at different times, and work at different levels of generality.” In that context, the court noted that the Medicare law only directs CMS to reimburse Medicare Advantage plans at approximately the same rates as traditional Medicare providers; it doesn’t refer to the overpayment obligation. The court also noted that even if actuarial equivalence did implicate the Overpayment Rule, UnitedHealth did not directly challenge CMS’ risk adjustment model, nor did it provide evidence that the model resulted in unequal payments between Medicare and Medicare Advantage providers.

"Even if actuarial equivalence applied as UnitedHealth suggests, it would be UnitedHealth’s burden to show the systematically skewed inaccuracies on which its theory depends, which it has not done. Also fatal to UnitedHealth’s claim is that it never challenged the values CMS assigned to the risk factors it identified or the level of the capitation payments resulting from CMS's risk-adjustment model... It cannot belatedly do so in the guise of a challenge to the Overpayment Rule."

Industry Implications

This ruling undoubtedly contributes to the already heightened risk environment
facing MAOs – a trend brought into particular focus last December when Deputy Assistant Attorney General Michael Granston singled out Medicare Advantage fraud as an “important priority” for DOJ enforcement moving forward. That said, it is notable that CMS elected not to appeal the district court’s finding that the Overpayment Rule effectively imposed an impermissible negligence standard in certain FCA cases. As such, the D.C. Circuit did not directly rule on whether, moving forward, CMS can mandate that MAOs engage in proactive self-auditing or other “reasonable diligence” in order to comply with the Overpayment Rule. However, the court did comment:

“Nothing in the Overpayment Rule obligates insurers to audit their reported data. As the district court held... the Rule only requires insurers 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.”

Although the court’s comments were somewhat gratuitous, they raise the question of whether they might undermine DOJ’s current position in other notable pending matters. For example, just weeks ago the government intervened in six complaints against the Kaiser Permanente consortium, and the Anthem suit remains pending in the Southern District of New York. Both of these matters are premised on the theory that MAOs have an obligation to proactively audit their data before submitting to Medicare – particularly on “red flag” codes and when they are in risk-sharing agreements that give providers an incentive to overcode. It is critical that MAOs operating in this environment continue to be conscious of the risk around their coding and billing practices. This is particularly true for audit and monitoring functions, given the recent aggressive uptick in “one-way auditing” qui tams, and the fact that courts across the country have not universally agreed with the D.C. District Court’s opinion of the impact of the Overpayment Rule on FCA scienter.

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