Federal Court Overturns CMS Overpayment Rule

By Niraj Rath, Associate

A recent ruling by a federal district court could have a significant impact on how certain health insurers, specifically those providing coverage pursuant to Medicare Parts C (i.e., Medicare Advantage insurers) and D (i.e., prescription drug coverage), treat overpayments by Medicare.

The U.S. District Court for the District of Columbia vacated the Center for Medicare and Medicaid Service's ("CMS") 60-day overpayment rule ("60 Day Rule"). The 60-Day Rule originated from the Affordable Care Act, which mandates that all Medicare Advantage insurers that identified any overpayments from Medicare must return those payments back to the government within 60 days of discovery. CMS then further refined this rule in 2014, specifying that *any* incorrectly documented diagnostic code in a medical chart results in an overpayment. The rule also held insurers liable for overpayments that they *should* have found. In vacating the rule, the court determined that CMS:

- Failed to use the same type of Medicare records (e.g., audited, unaudited) between itself and Medicare Advantage insurers in calculating an overpayment;
- Used different methodology concerning unverified diagnosis code than the one statutorily prescribed for Medicare when making payments to Medicare Advantage insurers;
- Departed from a mandatory method for calculating overpayments involving a policy of using fee-for-service adjustment procedure;
- Improperly imposed a standard that Medicare Advantage insurers were responsible for proactively recognizing overpayments

As background, Medicare Part C allows private insurance companies to offer Medicare coverage provided such companies offer an equivalent level of benefits as found in Medicare. Medicare Advantage insurers are paid at a pre-determined rate for each person treated as calculated by CMS. The rate calculation is complex and factors in certain risk adjustments such as age, disability status, geography, and diagnosis code (a metric to track what kind of disease is treated). Given the inexact nature of this calculation, Medicare Advantage insurers were required by the Affordable Care Act to return any overpayments (i.e., instances in which the insurer was paid more than for what was treated) by Medicare within 60 days. In 2014, CMS then put forth a rule (explained briefly above) to help insurers calculate and track these overpayments that one Medicaid Advantage insurer, UnitedHealth, sought to challenge by bringing forward this suit.

The ruling is positive for Medicare Advantage insurers (as well as prescription drug plan sponsors under Medicare Part D) that were required to proactively identify and report every overpayment to CMS. Additionally, while this decision does not directly impact the overpayment rule as related to Medicare Part A and Part B providers, it may have opened the door to future challenges on behalf of these providers.

It is important to remember, however, that while CMS's rule has been vacated, the ACA still imposes a 60-day standard for overpayments. Moreover, it is unclear whether CMS will revise their rules for overpayment recovery from Medicare Advantage and Part D plans in light of the court's ruling or appeal the decision

altogether. Thus, it is critical that both insurers and drug plan sponsors analyze payments closely and report any overpayments when possible until CMS takes further action.

Identifying and refunding Medicare payment is complex. If you participate in the Medicare program, we encourage you to contact one of the listed Roetzel attorneys to discuss your responsibilities.

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