

FCA Implications for Recent UnitedHealth Overpayment Ruling

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UnitedHealthcare Insurance Co. recently secured a significant victory with potentially far-reaching consequences when the United States District Court for the District of Columbia vacated the 60-Day Overpayment Rule applicable to Medicare Advantage plans (the “Overpayment Rule”). The court’s decision could potentially impact traditional Medicare providers as well since the language at issue in the case tracks the separate but similar 60-day overpayment rule applicable to traditional Medicare.

Overpayment Rule

The Centers for Medicare & Medicaid Services (“CMS”) promulgated the Overpayment Rule in 2014 to implement and clarify the Affordable Care Act’s (“ACA”) 60-day repayment obligation. The ACA states that “[a]n overpayment must be reported and returned” within “60 days after the date on which the overpayment was identified.”¹ Failure to timely return an overpayment constitutes a violation of the federal False Claims Act (“FCA”).² The Overpayment Rule states that a Medicare Advantage organization has “identified” an overpayment “when it has determined, or should have determined through the exercise of reasonable diligence,” that it received an overpayment.³ CMS explained in the preamble that such diligence would require “at a minimum . . . proactive compliance activities conducted in good faith by qualified individuals to monitor for the receipt of overpayments.”⁴ Thus, under the Overpayment Rule, as written by CMS, failure to conduct reasonable diligence arguably could result in False Claims Act liability.

District Court Opinion

UnitedHealthcare Insurance Co. (“United”) filed suit against the government in D.C. district court challenging the Overpayment Rule on several bases, including that it impermissibly expands the scope of liability under the FCA.⁵ The FCA only imposes liability for false claims that are submitted “knowingly.” The FCA defines “knowingly” as (i) actual knowledge of the information, or (ii) deliberate ignorance of the truth or falsity of the information, or (iii) acting in reckless disregard of the truth or falsity of the information.⁶ In other words, the FCA does not premise liability on negligence alone. In contrast, the Overpayment Rule’s definition of “identified” could subject Medicare Advantage plans to potential FCA liability based on merely negligent inaction (*i.e.*, failing to proactively search for and find overpayments). United argued this was inconsistent with the FCA’s knowledge standard.

The district court agreed, adding that Congress had no intention to turn the FCA, which was enacted to combat fraud, into a vehicle for punishing honest mistakes or incorrect claims submitted through mere negligence. Because the court concluded that the definition of “identified” in the Overpayment Rule was inconsistent with the definition of “identified” in the FCA, the court vacated the Overpayment Rule.⁷

Impact on Medicare Advantage Plans

Plans watched closely last year when the DOJ for the first time intervened in FCA whistleblower suits alleging Medicare Advantage fraud. The first intervened suit was voluntarily dismissed late last year after the judge found the complaint too vague. The second intervened suit, *United States ex rel. Poehling v. UnitedHealth Group, Inc.*, survived a motion to dismiss and remains pending in California.⁸ Just last week, the DOJ intervened in yet another suit, *United States ex rel. Ormsby v. Sutter Health et al.*,⁹ in which the relator alleged that Sutter Health knowingly submitted inaccurate risk adjustment data and knowingly retained overpayments it received based on that inaccurate or false data.¹⁰ The DOJ has not yet filed its own complaint, so it remains to be seen whether the DOJ will directly address the *UnitedHealthcare Ins. Co.* case's impact on the Overpayment Rule. In any event, this intervention demonstrates that the DOJ continues to be focused on FCA litigation involving Medicare Advantage plans.

Impact on Traditional Medicare Providers

Also interesting is the impact the *UnitedHealthcare Ins. Co.* decision will have *outside* of the Medicare Advantage context. In 2016, CMS promulgated a separate but similar overpayment rule applicable to traditional Medicare providers. The "identified" definition in that rule also includes a "reasonable diligence" standard. Traditional Medicare providers facing allegations that they failed to exercise "reasonable diligence" to identify an overpayment may now argue that the 2016 60-day overpayment rule, like the Overpayment Rule applicable to Medicare Advantage providers vacated in *UnitedHealth Ins. Co.*, also impermissibly broadens the knowledge standard articulated by the FCA. Given the similarity of the two rules, it is likely that a court will have to address this issue as to traditional Medicare providers in the near future. The ultimate impact of *UnitedHealthcare Ins. Co.* could be far-reaching and remains to be seen.

¹ 42 U.S.C. § 132a-7k(d)(2).

² 42 U.S.C. § 132a-7k(d)(3).

³ 42 C.F.R. § 422.326(c).

⁴ 79 Fed. Reg. at 29,923.

⁵ *UnitedHealthcare Ins. Co. v. Azar*, No. 1:16-cv-00157 (RMC), 2018 WL 4275991 (D.D.C. Sept. 7, 2018).

⁶ 31 U.S.C. § 3729(b)(1). Note that CMS filed a Motion for Reconsideration on November 5, 2018 and a Notice of Appeal on November 6, 2018.

⁷ While this article focuses on the FCA issue, the court's decision was also based on two other findings: (1) the Overpayment Rule violated the statutory mandate of actuarial equivalence between CMS payments for coverage under traditional Medicare and Medicare Advantage, and (2) the Overpayment Rule's definition of "identified" was finalized without adequate notice as required by the Administrative Procedure Act.

⁸ No. 2:16-cv-08697, 2018 WL 1363487 (C.D. Cal. Feb. 12, 2018).

⁹ No. 15-cv-01062 (N.D. Cal.).

¹⁰ See Compl. at 12.