October 1, 2018

Reimbursement Issues Worth Noting: Administrative Law and False Claims Act Implications

By Stuart M. Gerson

News of two distantly related reimbursement issues with administrative law and False Claims Act ("FCA") implications is worth noting.

I. OIG Study Raises Concerns About Claim Denials by Medicare Advantage Plans

The Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services ("DHHS") has just published a study revealing that Medicare Advantage plans overturn 75 percent of their own claim denials. The OIG found high overturn rates for prior authorization and claim denials in the plans, indicating possible improper payment and care denials. Using Medicare Advantage data on denials, appeals, and appeal outcomes from 2014 to 2016, the federal watchdog found that Medicare Advantage organizations ("MAOs") overturned 75 percent of their own prior authorization and claim denials during those years.

"The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided," the OIG stated. "This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment. During 2014-16, beneficiaries and providers appealed only one percent of denials to the first level of appeal."

Medicare pays MAOs a risk-adjusted capitated payment each month for every beneficiary enrolled in the health plan. MAOs are to use the capitated payments to pay for all the medically necessary care for the enrolled beneficiary as long as the services are within Medicare's

benefits package. There is a concern that this capitated payment model may incentivize MAOs to inappropriately deny claims and prior authorization requests to maximize their profits.

There are more than 20 million Medicare Advantage subscribers, and so the impact of this report and any ongoing action by the OIG will affect both the revenue cycle management space and provide meat to potential FCA relators.

II. U.S. Supreme Court Will Examine Medicare's Rulemaking Duties

Today is the first day of October, the opening day of the new term of the U.S. Supreme Court, which begins with only eight seats occupied. Though the date for oral argument has not yet been set, it is worth noting that the Court last week granted the government's cert petition in *Azar v. Allina Health Services et al.,* No. 17-1484. The dispute centers on DHHS's decision to group Medicare Advantage beneficiaries with traditional Medicare beneficiaries when calculating disproportionate share hospital payments. Because Medicare Advantage patients tend to have higher incomes, a hospital treating them will get lower reimbursement.

The Court will be concerned with whether full-blown Administrative Procedure Act notice-and-comment rulemaking is required, or whether DHHS may use so-called "interpretive rules" that instruct contractors on changes to Medicare reimbursement. The Administrative Procedure Act contains a rulemaking exception for interpretive rules, but the U.S. Court of Appeals for the D.C. Circuit held that the Medicare Act doesn't incorporate that exception.

The Supreme Court will opine on whether formal rulemaking is required when reimbursement instructions are not a "logical outgrowth" of prior reimbursement policy. The D.C. Circuit had held that formal rulemaking is required but that DHHS failed to engage in such rulemaking. Interestingly, the D.C. Circuit opinion in *Allina Health* was written by U.S. Supreme Court nominee Judge Brett Kavanaugh.

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For additional information about the issues discussed above, please contact the Epstein Becker Green attorney or EBG Advisors consultant who regularly assists you, or the author of this advisory:

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