No. 21-1140

IN THE

Supreme Court of the United States

UNITEDHEALTHCARE INSURANCE COMPANY, ET AL.,

Petitioners,

v.

XAVIER BECERRA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The District of Columbia Circuit

MOTION FOR LEAVE TO FILE AND BRIEF OF AMERICA'S PHYSICIAN GROUPS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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MOTION OF AMERICA'S PHYSICIAN GROUPS FOR LEAVE TO FILE BRIEF AS *AMICUS CURIAE* IN SUPPORT OF UNITEDHEALTHCARE INSURANCE COMPANY

Pursuant to this Court's Rule 37.2, America's Physician Groups ("APG") respectfully moves this Court for leave to file the attached brief as *amicus curiae* in support of the petition for a writ of certiorari to review the judgment of the Court of Appeals for the District of Columbia Circuit in *UnitedHealthcare Insurance Co. v. Becerra,* 9 F.4th 868 (D.C. Cir. 2021).

Counsel for APG notified counsel of record for the parties to this case of APG's intention to file this brief on March 10, 2022. Both parties have consented to the filing of this brief. Although the parties received notice eight days in advance of this brief's due date, two days less than the ten days required under this Court's Rule 37.2(a), neither party was prejudiced—as shown by the fact that both parties have consented to the filing of this brief. Additionally, respondent on February 18, 2022, sought an extension of time to file a brief in opposition to April 18, 2022, and this Court granted the request on February 22, 2022. Thus, respondent will have ample time to respond to the points raised in APG's brief.

As detailed below, APG is a national association representing more than 335 physician groups with approximately 170,000 physicians. APG is the nation's largest trade organization that explicitly promotes alternatives—known as "value-based" or "risk-sharing" arrangements—to fee-for-service as the insurance payment model for its members. Medicare Advantage ("MA") relies on a textbook value-based payment model, and its payment model for healthcare

plans provides incentives for plans to enter into subsequent risk-sharing arrangements with providers. APG requests the opportunity to present an *amicus curiae* brief in this case because its members are keenly interested in the possible negative ramifications of the D.C. Circuit's decision, which will harm not only MA plans, but also providers and provider organizations, like APG's members, who contract with those plans to provide healthcare services for MA enrollees on a risk-sharing basis. APG believes its perspectives on the practical realities of value-based payment models will aid the Court in its consideration of the questions presented.

Accordingly, APG respectfully requests that the Court grant this motion for leave to file a brief as *amicus curiae*.

Respectfully submitted,

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae America's Physician Groups ("APG") is a national association representing more than 335 physician groups with approximately 170,000 physicians. APG is the nation's largest trade organization that explicitly promotes alternatives—known as "value-based" or "risk-sharing" arrangements—to fee-for-service as the insurance payment model for its members. Value-based payment models produce significantly better health outcomes for patients by promoting coordinated care that focuses holistically on the patient, rather than on reimbursing physicians for specific treatments or procedures. APG's mission is to lead the coordinated care movement across the nation. And Medicare Advantage ("MA"), which relies on a textbook value-based payment model, plays an integral role in promoting coordinated care.

In this case, Petitioners seek review from the D.C. Circuit's decision upholding the Centers for Medicare and Medicaid Services's "Overpayment Rule," which imposes additional (and unjustified) payment obligations on MA plans. APG submits this brief to underscore that the D.C. Circuit's decision—and the Rule it upholds—is harmful not only to MA plans, but also to *providers*, like APG's members, who contract with those plans to provide healthcare services for MA enrollees on a risk-sharing basis. The Overpayment

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[1] Pursuant to Supreme Court Rule 37.6, counsel for *amicus curiae* states that no counsel for a party authored this brief in whole or in part, and no party or counsel for a party, or any other person other than *amicus curiae* or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. All parties have consented in writing to the filing of this brief.

Rule will not only discourage risk-sharing arrangements, but will also undermine the equitable distribution of services by creating disincentives for plans and providers to treat the least healthy patients. The Rule will therefore undermine key features of the MA program and the risk-sharing and value-based models it has engendered. In the end, patients will suffer the consequences—costlier healthcare and reduced access to quality services.

APG therefore has a substantial interest in the proper operation and vitality of the MA program. APG believes its perspectives on the practical realities of value-based payment models will aid the Court in its consideration of the questions presented.

BACKGROUND

This case concerns a thriving alternative to traditional Medicare known as Medicare Advantage ("MA").

The core difference between traditional Medicare and MA lies in their payment models. Traditional Medicare is based on a "fee-for-service" model in which the federal government directly compensates healthcare providers for each service they provide to Medicare enrollees. *See* 42 U.S.C. §§ 1395c–1395i-6, 1395j–1395w-6. MA, by contrast, permits enrollees to receive their Medicare benefits through private health plans that the federal government pays on a "capitated" basis—that is, a monthly payment per enrollee—to bear the risk of insuring Medicare beneficiaries. *Id.* § 1395w-23. If cost of care is below the capitation payment, the plan keeps the surplus. But plans also bear the losses if cost of care exceeds the capitation. *See* Pet. App. 9a.

An MA plan, in turn, can pay healthcare providers either on a fee-for-service basis, as the government does when it acts as direct insurer in traditional Medicare, or on a capitated basis, as the plans themselves are paid. Many of APG's members contract with insurers on a capitated basis, with the plan paying providers a percentage of the premium paid to it by the federal government. Sandra Newman, *Fundamental Concepts for Managing Risk and Understanding the Total Cost of Care* 3, California Quality Collaborative (Spring 2019), https://bit.ly/3HQklR7 (describing this as a "common model" in Medicare Advantage). In exchange, the provider agrees to bear the risk of providing care to patients. Again, if cost of care comes in below the capitation, the providers share in the profits, but the providers also bear a share of the losses when costs exceed the capitation. Ksenia Whittal, *Provider Payment: What Does Risk Adjustment Have to Do with It?* 1, Milliman (Mar. 2016), https://bit.ly/3MoHo9f.

An essential element of any successful capitation scheme is risk adjustment. If an MA plan or its contracted providers are paid the same amount regardless of how healthy its beneficiaries are, they have structural incentives to enroll only the healthiest patients in order to keep down the costs of care. *See* Pet. App. 11a (citing Gregory C. Pope *et al.*, *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model* 119-20, Health Care Fin. Rev., (Summer 2004)). Risk adjustment corrects that incentive. It involves adjusting payments to plans and providers based on the specific health risks posed by a plan's beneficiary population. *Id.* Plans and providers are therefore paid more to take on beneficiaries with higher expected healthcare costs.

In Medicare Advantage, the federal government adjusts risk by comparing reported diagnoses from an MA plan to reported diagnoses from traditional Medicare. *See* Gregory C. Pope *et al.*, *Evaluation of the CMS-HCC Risk Adjustment Model: Final Report* 8 (Mar. 2011), https://go.cms.gov/3pPuMyc. The diagnosis codes submitted in traditional Medicare are used to create a model to determine the relative costs of treating various conditions. *Id.* After MA plans submit the diagnosis codes of their own beneficiaries, the government applies its model to project the costs of treating patients enrolled in the MA plans. *Id.* MA plans that contract with providers on a capitated basis can, in turn, build risk adjustment into their own contractual arrangement. *See* Whittal, *supra*, at 1. This arrangement is common for APG's members because it further aligns the incentives of plans and providers to provide the highest quality care to all patient populations at an affordable cost.

To ensure these goals, the Medicare statute directs the Secretary of Health and Human Services to "adjust" the payment amount made to MA plans for "risk factors" like health status "so as to ensure actuarial equivalence" with traditional Medicare. 42 U.S.C. § 1395w-23(a)(1)(C)(i). In a nutshell, this actuarial equivalence requirement seeks to ensure that MA plans are fully compensated for *all* the risk they take on in insuring beneficiaries, on equal terms as the federal government in insuring traditional Medicare beneficiaries. Two plans are actuarially equivalent if they would produce the same payments under the same set of assumptions. *Stephens v. U.S. Airways Grp., Inc.*, 644 F.3d 437, 440 (D.C. Cir. 2011).

Of course, in both traditional Medicare and in Medicare Advantage, providers sometimes make

mistakes in coding patient diagnoses. *See* Pet. 9. For years, however, such mistakes generally posed no threat to accurately paying MA plans because coding errors in both programs were treated in an actuarially equivalent manner. Neither mistakes in traditional Medicare nor mistakes in Medicare Advantage were systematically corrected or treated as overpayments, so, in effect, any inaccuracies in coding the diagnoses for individual patients cancelled out. *See id.* at 10-12.

That changed with the Centers for Medicare and Medicaid Services's ("CMS") introduction of the Overpayment Rule in 2014. *See* Medicare Program; Policy and Technical Changes to Medicare Advantage, 79 Fed. Reg. 29,844 (May 23, 2014) (codified at 42 C.F.R. § 422.326). In the Overpayment Rule, the government changed only one side of the equation: It required MA plans to return any identified "overpayment" on pain of False Claims Act liability, and it defined an overpayment as *any* payment made by CMS for a diagnosis code unsupported by medical records. *Id.* at 29,951, 29,958. Medical record-keeping is rarely perfect, so unsupported diagnosis codes (and thus "overpayments," as defined in the preamble) could theoretically be found in numerous providers' offices throughout the United States.

The Overpayment Rule, however, treats unsupported codes as overpayments only if they involve MA enrollees. The Rule did not require CMS to audit the traditional Medicare diagnosis codes it uses to calculate its initial monthly payment to MA plans. This violates actuarial equivalence, because it results in CMS applying *different* assumptions for the accuracy of diagnosis codes in measuring the risks posed by traditional Medicare and MA beneficiary populations. And it undermines accuracy by grossly

undercalculating the total risk MA plans take on in insuring their beneficiaries, paying MA insurers less to provide the same healthcare coverage to their beneficiaries than CMS pays for comparable patients under traditional Medicare.

Petitioners challenged the Overpayment Rule in federal court as a violation of the statute's actuarial equivalence requirement. Pet. App. 54a. In the decision below, the D.C. Circuit rejected that challenge. *Id.* at 6a-7a. In the D.C. Circuit's view, even if the Overpayment Rule made risk adjustment less accurate, that did not matter because the actuarial equivalence requirement does not apply *at all* in determining what counts as an "overpayment" under the Overpayment Rule. *Id.* at 6a.

SUMMARY OF ARGUMENT

This Court should grant the petition for certiorari and reverse the D.C. Circuit's decision upholding the Overpayment Rule because the Rule threatens significant harm not only to MA plans, but to the providers with which they contract and the patients they serve. As Petitioners well explain, the D.C. Circuit's decision in this case imposes potentially billions of dollars in additional payment obligations on MA plans and rests on blatant statutory error. Pet. 17-22. APG submits this brief as *amicus curiae* to address the Rule's broader impact on providers, patients, and the vitality of the MA program. In particular, APG writes to underscore two additional consequences of the decision below for providers, provider organizations, and patients: It renders untenable the highly beneficial risk-sharing agreements between providers and MA plans that have spurred MA's success, and it jeopardizes

incentives that encourage equitable healthcare distribution.

The risk-adjusted capitation model that underlies MA has proved overwhelmingly successful, and the lynchpin of that success is accurate risk adjustment. *See* Medicare Program; Establishment of the Medicare Advantage Program, 70 Fed. Reg. 4588, 4657 (Jan. 28, 2005). The actuarial equivalence requirement serves a crucial role in ensuring accuracy. It rests on the premise that the best measure of the risk an MA plan takes on in insuring its enrollees is the risk that CMS itself takes on in insuring a comparable population of traditional Medicare enrollees. *See* Pet. 23. The decision below, however, discarded the actuarial equivalence requirement altogether for the Overpayment Rule. Pet. App. 6a-7a. As a result of that holding, MA plans will not be fully compensated for risk and will face significantly greater uncertainty about the scope of financial risks they must bear.

In contracting to share risks with providers, plans pass the same risks forward. Under these arrangements, the financial impact of "overpayments" likewise will be borne by risk-sharing providers—often in surprise audits or bills for massive lump sums received years after the services were rendered. Under threat of decreased payments and a cloud of uncertainty, providers will view such arrangements as significantly less attractive and will be less likely to enter such agreements. The D.C. Circuit's decision will thus gravely undermine the risk-sharing agreements between insurers and providers that have been a major driver in MA's success. The ultimate losers are patients, who will receive worse healthcare at higher costs.

Worse still, by undermining accurate risk adjustment, the D.C. Circuit's decision threatens the equitable distribution of healthcare. Strong empirical evidence shows that proper risk adjustment can not only correct structural incentives to take on healthier patients, but reverse them altogether. *See, e.g.*, Joseph P. Newhouse & Thomas G. McGuire, *How Successful Is Medicare Advantage?*, 92 Milbank Q. 351, 382-83 (2014); Anders Anell *et al.*, *Does Risk-Adjusted Payment Influence Primary Care Providers' Decision on Where to Set Up Practices?*, BMC Health Services Research 2, 10 (2018). In undercompensating plans and providers, the D.C. Circuit's decision restores the structural incentives that accurate risk adjustment is designed to correct.

The D.C. Circuit's decision cannot stand. The Court should grant the petition and reverse.

ARGUMENT

I. MEDICARE ADVANTAGE'S RISK-ADJUSTED CAPITATION PAYMENT MODEL HAS PROVED FAR SUPERIOR TO TRADITIONAL FEE-FOR-SERVICE PAYMENT MODELS

Due in large part to its capitated payment model, Medicare Advantage is a thriving and growing alternative to traditional Medicare.

On quality of care metrics, Medicare Advantage blows away traditional Medicare. "MA team care has brought down the number of congestive heart failure events—an area traditional Medicare has struggled with—by significant levels for many sites because plans make that condition a priority for improving care." George C. Halvorson, *Medicare Advantage Delivers Better Care and Saves Money: A Response to Gilfallan and Berwick*, Health Affairs (Jan. 7, 2022),

https://bit.ly/3vx8nJU. One study found that "Medicare Advantage contracts operating within three large, diverse states provided substantially higher quality of care than [traditional fee-for-service Medicare] for all 16 clinical quality measures" studied. Justin W. Timbie *et al.*, *Medicare Advantage and Fee-for-Service Clinical Quality and Patient Experience Measures: Comparisons from Three Large States*, 52 Health Servs. Res. 2038, 2054 (2017), https://bit.ly/3CbUouc. Another recent study concluded that, compared on a risk-adjusted basis to beneficiaries of traditional Medicare, MA plan enrollees have 33 percent fewer emergency department admissions and 23 percent fewer standard hospital admissions because of the superior care delivered by MA plans and providers. Avalere Health, *Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare* 4 (July 2018), https://bit.ly/3HEOMde. Accordingly, as two scholars recently concluded, there is every reason "to maintain the level of payment to MA plans at or above the level of [traditional Medicare]." Newhouse & McGuire, *supra*, at 383.

MA owes much of its success to its underlying payment model. "The downfall" of a traditional fee-for-service model is that it rewards quantity of service, not quality, and it "does not incentivize managing care or taking steps to reduce the use of high-cost, low-value services." Whittal, *supra*, at 1. By contrast, because MA plans are paid a fixed monthly amount per beneficiary, MA plans have strong incentives to focus on quality—to keep their enrollees healthy and slow disease progression. MA plans thus coordinate care through an integrated approach that ensures members receive streamlined

treatment. *See generally* Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for Medicare Beneficiaries: Hearing Before the H. Subcomm. on Health of the Comm. on Ways and Means, 115 Cong. 96 (2017) (statement of AHIP), https://bit.ly/3sWlFxH.

That payment model, in turn, has led to highly beneficial risk-sharing agreements between plans and providers. Having taken on a risk-adjusted capitation payment model themselves, MA plans often contract for the same with providers, thereby incentivizing providers also to focus on quality of care. Newman, *supra*, at 3. Far more than any other insurance program, government-run or otherwise, MA has promoted such risk-sharing agreements. Compared to the overall market for health insurance in 2018, in which only about 5% of insurer payments to providers were made through some form of risk-sharing arrangement, over 17% of payments made by MA plans deployed such an arrangement. *See* Rachel M. Werner *et al.*, *The Future of Value-Based Payment: A Road Map to 2030* 4, Penn LDI Leonard Davis Institute of Health Economics (Feb. 2021) (Table 2), https://bit.ly/3sZYy5z.

The basic benefit is the same as the benefit of a capitated payment model for insurance plans: Such arrangements "emphasize a shared responsibility in the care provided to members," and "aim to distribute the risk between health plans and providers equitably while better aligning insurer and provider incentives, thereby reducing health plan spending and increasing quality of care." Whittal, *supra*, at 1. These aligned incentives redound to the benefit of patients, as patients will less often be caught in between a

provider who believes a service is essential and an insurer who is unwilling to pay for it.

Experience shows that these insurer-provider risk-sharing agreements work. Take, for example, the pilot program launched by the California Public Employees' Retirement System ("CalPERS") in 2010 in collaboration with Blue Shield of California and two provider organizations in Sacramento. Bailit Health Purchasing, LLC, *Payment Matters: The ROI for Population-Based Payment* 1 (Feb. 2013), https://bit.ly/3IXca74. Blue Shield agreed to pay the providers a pre-determined amount to provide care to 41,500 CalPERS employees and dependents. *Id.* Over the first three years of the project, the providers saw a 15 percent reduction in inpatient readmissions, a 15 percent reduction in inpatient days, and a 13 percent reduction in surgeries—and CalPERS saw $32 million in aggregate savings. *Id.* Part of the savings was used to prevent an insurance rate hike on the CalPERS employees, and the remainder was divided among the three partners. *Id.* The risk-sharing arrangement gave "providers the opportunity to share in the savings for keeping patients healthy, rather than just paying them to provide services to the sick," and the providers therefore "successfully shifted the focus to population health management—targeting patients with chronic illnesses and medically complex conditions, and reducing unnecessary care." *Id.* at 1-2.

Another recent study by two University of California-Berkeley professors based on California's healthcare system also showed that providers who accept greater financial risk for the health outcomes of their patients dramatically improve quality of care and reduce costs. *See* Richard Sheffler & Stephen

Shortell, *California Dreamin': Integrating Health Care, Containing Costs, and Financing Universal Coverage* 31 (Feb. 8, 2019), https://bit.ly/3tnWRxI. Thus, the authors concluded, "proposals to encourage more Californians to receive their care from groups providing more integrated care through risk-based capitated payments would likely result in both lower costs and better quality of care." *Id.* In short, risk-sharing agreements between plans and providers are a major driver of MA's success.

II. THE D.C. CIRCUIT'S DECISION UNDERMINES ACCURATE RISK-ADJUSTMENT

The Overpayment Rule threatens these efficiencies, harming plans, providers, and ultimately patients. Under the Overpayment Rule, plans must report and return any "overpayment" they receive from CMS within sixty days of identifying it. The Rule defines "overpayment" as "any funds that [an MA plan] has received or retained under [MA] to which the [plan] … is not entitled." Overpayment Rule, 79 Fed. Reg. at 29,958. Seems simple enough. The problem, however, is that the Rule states that *every* unsupported diagnosis code identified by an MA plan counts as an overpayment: "[A] risk adjustment diagnosis that … does not have supporting medical record documentation would result in an overpayment." *Id.* at 29,921.

That requirement, however, is grounded on a different set of assumptions than the model used to adjust an MA plan's prospective monthly payment. CMS does not audit the data from traditional Medicare that it uses to establish its risk-adjustment model, and it therefore treats all beneficiaries in traditional Medicare who have a diagnosis code as actually having the condition, whether supported or

not. The Overpayment Rule, by contrast, assumes that only *supported* diagnosis codes represent true health conditions. The Rule thus violates the statute's actuarial equivalence requirement by deploying different assumptions about the accuracy of diagnosis codes in measuring the risks of traditional Medicare and MA populations.

The failure to ensure actuarial equivalence undermines accurate risk adjustment and will have the inevitable consequence of undercompensating MA plans and their providers. To take a simplified example, assume that a population of traditional Medicare beneficiaries includes 10 beneficiaries with a diagnosis code for depressive disorder, but one of the codes is unsupported. *See* Ursula Taylor, *Why Actuarial Equivalence Matters for Medicare Advantage*, Law360 (June 26, 2017), https://bit.ly/3I1IzIm (setting out this hypo). Assuming also that the true expected cost of treating a beneficiary for depressive disorder is $1,000 per beneficiary, CMS will observe the total expected cost to be $9,000 for actually treating beneficiaries for depressive disorder ($1,000 for each of the nine beneficiaries who was actually treated for depression, and $0 for the tenth beneficiary who was not). In the risk adjustment model, however, CMS will calculate a per-beneficiary cost of only $900—by dividing the observed $9,000 in total expenditures by *10 beneficiaries*, *i.e.*, the number of beneficiaries with a diagnosis code for depressive disorder, rather than by the 9 beneficiaries with the condition, because CMS does not audit diagnosis codes from traditional Medicare when crafting the risk adjustment model. In this example, had CMS done so, it would have calculated the true per-beneficiary cost of *$1,000* because it would have divided the total expenditures for depressive disorder

($9,000) by the total verified beneficiaries (only 9). CMS will therefore undercalculate the expected per-beneficiary cost of treating the condition. *See* C.A. App. 393 (comment of American Academy of Actuaries, explaining in related context that calculating a risk factor for a condition based on unaudited data will "understate[]" the factor "that would have resulted from using only substantiated diagnoses").[2]

Now take an MA plan with a similar population of 10 beneficiaries with a diagnosis code for depressive disorder, one of which is likewise unsupported. CMS will pay its calculated $900 per-beneficiary cost for each of the plan's 10 beneficiaries, for a total of $9,000, representing an accurate payment for the population. But the MA plan must repay one of those payments under the Overpayment Rule. So the plan will be left with only $8,100—$9,000 minus one of its $900 payments—and short of the true cost of coverage. Put differently, correcting diagnosis codes for the MA population would make it appear healthier than an identical population of traditional Medicare patients, so the plan would be paid less under MA than under traditional Medicare to treat the same population of patients. Thus, while the Overpayment Rule corrects the individual coding error, the MA plan is left underpaid overall because the methodology for calculating risk adjustment payment amounts using fee-for-service Medicare data is not subject to the

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[2] In practice, these calculations are more complicated. *See* Pope *et al.*, *Evaluation of the CMS-HCC Risk Adjustment Model*, *supra*, at 2; *see* Pet. App. 11a-13a (describing the model in detail). But this simplified example illustrates how unsupported codes inevitably lower payments for particular conditions.

same verification process required of the MA plans under the Overpayment Rule.

By upholding the Overpayment Rule, therefore, the D.C. Circuit's decision will dramatically undercompensate private health plans for the risks they take on in joining MA.

III. THE D.C. CIRCUIT'S DECISION RENDERS RISK-SHARING AGREEMENTS UNTENABLE AND UNDERMINES EQUITABLE HEALTHCARE DISTRIBUTION

By undermining the accuracy of risk adjustment and imposing unjustified financial obligations on MA plans, the D.C. Circuit's decision destroys incentives for insurers and providers to share financial risk and jeopardizes incentives that encourage equitable healthcare distribution. The consequence will be costlier healthcare and reduced access to quality services for patients.

A. The D.C. Circuit's Decision Destroys Incentives for Plans and Providers to Enter Into Highly Beneficial Risk-Sharing Arrangements

As explained, insurer-provider risk-sharing arrangements have contributed greatly to MA's success. But the uncertainty created by the D.C. Circuit's holding in this case renders these beneficial risk-sharing arrangements far less attractive. As interpreted by the D.C. Circuit, the Overpayment Rule saddles MA plans with a potentially vast additional (and unjustified) obligation to repay risk adjustment premiums for any unsupported diagnosis code. That dramatically increases the risks MA plans bear, as they cannot be assured that the federal

government will fully compensate them for the degree of risk they assume in covering the plan's beneficiaries. Through risk-sharing agreements between the MA plans and providers, these purported "overpayments" would reduce compensation to providers for the care they provide. And over time, providers that enter risk-sharing agreements would share the same risks and uncertainties.

That is not a tenable basis for entering into a risk-sharing agreement. "[P]rovid[ing] predictability to Medicare Advantage plans" is necessary "so they [can] invest in innovation and care improvements" and engage in "multi-year value-based contracting that includes multi-year goals regarding risk-assumption by the provider." Better Medicare Alliance, *Understanding Medicare Advantage Payment & Policy Recommendations* 13 (Sept. 2018), https://bit.ly/36ZOuAR. But plans operating under the Overpayment Rule "must prepare for unstable funding" and unforeseen clawbacks. *Cf. id.* If providers cannot be assured that CMS will provide sufficient capitation payments to plans to sustain them over the long term in Medicare Advantage, they will be "unsure of how to invest for optimal transformation and return on investment." *See* Werner *et al.*, *supra*, at 9. Patients, of course, will bear the ultimate cost when healthcare providers forgo investments in improving care. And because "[t]raditional fee-for-service remains alluringly profitable for providers," a provider weighing the tradeoffs may choose to stay with a suboptimal fee-for-service arrangement or, at minimum, adopt a wait-and-see approach. *Id.* at 8. In sum, providers will view such agreements as far less attractive when they must enter such agreements under a cloud of uncertainty about how much financial risk they must

actually bear. By discouraging risk-sharing arrangements between insurers and providers, the Overpayment Rule undermines a key component of MA's success.

B. Proper Risk Adjustment Is Key To A Well-Functioning Capitation-Based Payment Model

Even more fundamentally, a capitation-based payment model like MA can lead to more equitable health outcomes. But that is only possible with proper risk adjustment. Without it, plans and providers have structural incentives to select for risk by taking on only the healthiest patients. As the D.C. Circuit noted, "the *demographic- and health-adjusted*, capitated payment scheme is designed to blunt the incentives to enroll only the healthiest, and thus least expensive, beneficiaries while steering clear of the sickest and costliest—thereby rewarding Medicare Advantage [plans] to the extent that they achieve genuine efficiencies over traditional Medicare in addressing the same health conditions." Pet. App. 11a (emphasis added) (citing Pope *et al.*, *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*, *supra*, at 119-20).

For risk adjustment to work—and for the MA program to realize its goals—it needs to be done correctly. A capitation model that is not accurately adjusted for risk can cause treatment disparities: particular conditions (like diabetes, depression, and other chronic conditions that providers often do not write down in a record every time they see it) will be systematically undercompensated. Additionally, "individuals with lower socioeconomic status (SES) tend to live shorter, report worse self-assessed health and experience more chronic disease," so absent risk

adjustment, "a simple undifferentiated capitation payment may contribute to socioeconomic differences in health care utilization." Anell *et al.*, *supra*, at 1-2. But a well-calibrated risk-adjusted capitation model does just the opposite: It not only corrects for the underlying structural incentive for plans and providers to enroll healthy beneficiaries, but reverses it—leading to more equitable health care.

Early experience with MA confirms the point. "[T]he primitive risk adjustment in place in the 1990s … resulted in Medicare's paying more for the enrollees in MA than it would have paid for them in [traditional Medicare]." Newhouse & McGuire, *supra*, at 352. But today, after a series of changes to the risk adjustment model in the 2000s, "better risk adjustment appear[s] to have substantially reduced selection problems in MA." *Id.* at 382. Recent evidence shows that, with proper risk adjustment, "MA … may help close health inequalities for minority populations and others with significant social determinant barriers." Marc S. Ryan, *Medicare Advantage Helps with Healthcare Equity*, MHK (June 16, 2021), https://bit.ly/35CUUp8. Indeed, as of 2017, over 36% of MA beneficiaries had annual incomes of less than $20,000. Better Medicare Alliance, *Understanding Risk Adjustment in Medicare Advantage* 2 (June 2017), https://bit.ly/3vH31f0. And "[p]atients with low income … tend to report high levels of satisfaction with their plans." Halvorson, *supra*.

A study based on Sweden's experience with a risk-adjusted capitation system shows much the same. In an "empirical analys[i]s of the effects of risk-adjusted payment," the authors found that local county councils in Sweden that increased capitation to

primary care centers for taking on patients with a larger share of unfavorable socioeconomic and demographic characteristics significantly increased the number of primary care centers in areas of socioeconomic need. Anell *et al.*, *supra*, at 2, 10. A "risk-adjusted capitation payment," the authors concluded, can "contribute to a more equal supply of primary care." *Id.* at 10.

In deeming the actuarial equivalence requirement inapplicable to the Overpayment Rule, the D.C. Circuit's decision here seriously undermines the goals of proper risk adjustment. The actuarial equivalence requirement ensures that MA plans are compensated for risk on equal terms with the risk the government assumes in insuring a comparable beneficiary population under traditional Medicare. But under the D.C. Circuit's decision, so long as CMS adjusts risks to ensure actuarial equivalence with traditional Medicare *ex ante*, *i.e.*, in determining the amount of the monthly capitation to plans, it can ground decisions about what payments to claw back as overpayments on different actuarial assumptions. That cannot be right. Unless CMS undertakes an apples-to-apples comparison at *both* ends of the payment process, CMS could leave MA plans with a fraction of the actuarially equivalent payment to which they are "entitled," 42 U.S.C. § 1320a-7k(d)(4)(B).

Undercompensating MA plans and providers for risk "undermin[es] the purpose of the risk-adjustment system." Pet. App. 65a (quoting American Academy of Actuaries). In light of the D.C. Circuit's holding, MA plans and providers facing greater risks and a reduced capitation stream have strong incentives to seek out healthier beneficiary populations to make up

the difference. If plans cannot, they will be forced to reduce coverage, cut benefits, or raise premiums. That means patients will pay more for reduced access to healthcare. And ultimately, plans may be forced to leave MA altogether. *See* Lori Achman & Marsha Gold, The Commonwealth Fund, *Medicare+Choice 1999-2001: An Analysis of Managed Care Plan Withdrawals and Trends in Benefits and Premiums* 3-6 (2002) (describing withdrawals from MA after a change in the MA reimbursement formula in 1997).

In the end, the MA program and the risk-adjusted capitation payment model on which it is based have produced highly effective coordinated care for patients across the country, and especially for the least well-off. The D.C. Circuit's decision seriously undermines the basic levers of this important program.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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