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

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS CURIAE [1]

America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance provider community. AHIP's members provide health coverage and other financial health and wellness benefits through employer-sponsored coverage, the individual insurance market, and public programs such as the Medicare Advantage program at issue in this case.

AHIP's members include private insurance providers known as Medicare Advantage organizations ("MAOs") that contract with the U.S. Centers for Medicare & Medicaid Services ("CMS") to provide health care coverage to enrollees through the Medicare Advantage program, a public-private partnership that offers an alternative to the federally administered, original Medicare program. AHIP advocates for public policies that expand affordable health coverage for all Americans, including through Medicare Advantage. Sixty-four AHIP members offer Medicare Advantage plans. AHIP is thus well situated to explain how the CMS rule at issue in this case—and the D.C. Circuit decision substantially reinstating it—will severely damage the Medicare Advantage program to the detriment of the millions of Americans who depend on it for high-quality, low-cost health care.

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[1] No counsel for a party authored this brief in whole or in part, and no entity or person other than amicus curiae, its members, and its counsel made a monetary contribution intended to fund the preparation or submission of this brief. Sup. Ct. R. 37.6. All parties received timely notice and have consented to the filing of this brief. Sup. Ct. R. 37.2(a).

INTRODUCTION AND SUMMARY OF ARGUMENT

The Medicare Advantage program is a critical component of our nation's health care system and improves health outcomes for millions of Americans while promoting cost-saving practices. Medicare Advantage plans deliver numerous benefits compared to original Medicare, including reduced cost sharing and supplemental benefits such as dental or vision care not covered by original Medicare. As a result, enrollment in Medicare Advantage has steadily increased over the past 15 years. Today more than 28 million Americans, or approximately 45% of all Medicare beneficiaries, are enrolled in Medicare Advantage plans. The program is also highly valued by enrollees, with 93% reporting satisfaction with their plan.[2]

This case concerns a core payment provision of the Social Security Act (the "Act"). When Congress created Medicare Advantage in Part C of the Act's Medicare subchapter, it directed CMS to adjust the payments to participating insurance providers based on the demographic characteristics and health status of a given plan's enrollees, "so as to ensure actuarial equivalence" with the expected costs CMS would incur to provide benefits to that set of beneficiaries under original Medicare. 42 U.S.C. § 1395w-23(a)(1)(C)(i). "Actuarial equivalence" in this context means the application of actuarial principles to achieve equivalence between CMS's payments to an insurance provider for its enrolled population and the government's expected costs for the same population in original Medicare. This

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[2] *See* AHIP, *7 Things You Need to Know About Medicare Advantage* (Jan. 21, 2022).

actuarially based payment methodology, known as risk adjustment, is essential to Congress's goal in Part C of harnessing the power of private insurance markets. By mandating actuarial equivalence, Congress linked Medicare Advantage costs to original Medicare costs, guaranteeing that insurance providers would have the resources to provide the same coverage available under original Medicare to their enrolled populations. And by ensuring higher payments for higher-cost enrollees, it sought to eliminate structural incentives that could favor enrollment of younger and healthier individuals, so that Medicare Advantage plans would be available to all eligible Americans.

The Overpayment Rule here violates Congress's mandate by disregarding a key actuarial principle requiring data consistency. CMS has chosen to calibrate its Medicare Advantage payment model by relying on fee-for-service ("FFS") Medicare data that is subject to virtually no auditing and includes many provider-submitted diagnosis codes that are not documented in medical charts. Lack of medical-record documentation, it bears stressing, does not mean the patient does not have the condition, but may simply mean that a provider failed to annotate a chart after making a valid diagnosis. Notwithstanding that CMS tolerates diagnoses without medical-record documentation in calibrating the model, the Overpayment Rule imposes a different and much more demanding documentation standard on insurance providers and says that any payment based on a diagnosis code without such documentation is an "overpayment."

This inconsistent approach contravenes accepted actuarial principles, as CMS itself previously determined in 2012, in the context of agency audits of Medicare Advantage plans. Acknowledging the actuarial

impact of imposing a more stringent documentation standard on insurance providers than it uses in calibrating the model, CMS agreed to calculate and apply an "FFS adjuster" as an offset to any payment recovery to account for that impact. In 2014, however, CMS disregarded this same issue and promulgated the Rule with no adjuster. As the agency recognized in 2012, and as petitioners argued below, this about-face is foreclosed by Congress's mandate to ensure actuarial equivalence.

The district court agreed with petitioners and vacated the Overpayment Rule as contrary to law and arbitrary and capricious. In reinstating the Rule, however, the D.C. Circuit held that CMS may ignore actuarial equivalence and prior agency policy, theorizing that the Rule implements a separate provision of the Act that the court claimed does not cross-reference Part C's payment requirements—a clearly erroneous statutory reading that even the government had not advocated. This Court should grant review to resolve that fundamental statutory issue, because the court of appeals decided an exceptionally important issue in a manner that is patently incorrect.

The question presented is exceptionally important to all participants and stakeholders in the Medicare Advantage program—health plans, providers, and the tens of millions of elderly and disabled Americans enrolled in Medicare Advantage plans. The Overpayment Rule fundamentally changes how Medicare Advantage organizations are compensated and by extension what funds are available for providing services to enrollees. Moreover, this change is clearly wrong: It is irrational to define an "overpayment" without taking account of how Congress required that MAOs be paid in the first place. Absent this Court's review, the D.C. Circuit's

decision will effectively be the last word not only on a major economic regulation but also on whether CMS is obligated to ensure actuarial equivalence in implementing the Act's overpayment provision and therefore in how it compensates MAOs.

If—as the D.C. Circuit held—CMS can ignore actuarial equivalence in the overpayment context, then each of Congress's goals in creating Medicare Advantage is placed in jeopardy. The Actuarial Standards of Practice promulgated by the American Academy of Actuaries require data consistency in the development and application of risk-adjustment payment models.[3] Because CMS relies on diagnosis codes without medical-record documentation to calibrate risk-adjustment payments to MAOs, the Rule's demand that MAOs return any payments associated with "undocumented" codes creates an actuarial disconnect that violates that core actuarial requirement. The disconnect threatens to underpay MAOs relative to the risks they assume when agreeing to cover their enrollees' Medicare benefits. The Rule will impose differential coding burdens and obligations on health care providers depending on whether a particular patient that they are seeing is a Medicare Advantage enrollee or an original Medicare patient. And by altering the actuarial assumptions underlying Medicare Advantage, it will require MAOs to modify their annual bids, including by increasing the costs or reducing the benefits and provider networks that have attracted tens of millions of Medicare beneficiaries to Medicare Advantage plans.

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[3] Actuarial Standard of Practice No. 45 § 3.2 (Jan. 2012).

The D.C. Circuit's holding that CMS has no duty to ensure actuarial equivalence in the Overpayment Rule is patently incorrect. That holding defies the plain text of the Act as well as the logic and objectives of the program Congress established. Actuarial equivalence is central to Part C's payment requirements, which establish the funds to which MAOs are entitled. The provision of the Act the Rule implements contains a clear cross-reference to those requirements. Indeed, consistent with simple logic, it defines "overpayment" to mean funds a party receives under the Medicare (or Medicaid) subchapter of the Act to which the party "is not entitled *under such subchapter*." 42 U.S.C. § 1320a-7k(d)(4)(B) (emphasis added). That makes sense, of course, because (as the court of appeals seemed to forget) whether there is an "*overpayment*" to return depends on whether the party was entitled to the *payment* it has received—a determination that can be made only in light of how Congress directed that the party be paid in the first place. The D.C. Circuit's contrary holding nullifies a key provision of an act of Congress and injects unacceptable irrationality into a significant payment-recovery context.

ARGUMENT

I. THE QUESTION PRESENTED IS ONE OF EXCEPTIONAL IMPORTANCE FOR A LARGE SECTOR OF THE U.S. ECONOMY

A. Medicare Advantage Is A Critical Component Of The Nation's Health Care System

More than 28 million Americans—approximately 45% of all Medicare participants—depend on the Medicare Advantage program for their health care. *See* CMS, *Monthly Contract and Enrollment Summary*

Report (Feb. 2022). This number has steadily climbed over the past decade. *See* Jacobson et al., *A Dozen Facts About Medicare Advantage in 2019*, at 1 (June 6, 2019). From February 2021 to February 2022 alone, membership in Medicare Advantage plans grew approximately 8.7 percent. *Compare* CMS, *Monthly Contract and Enrollment Summary Report* (Feb. 2021) (approximately 26.4 million Medicare Advantage members), *with* CMS, *Monthly Contract and Enrollment Summary Report* (Feb. 2022) (approximately 28.7 million Medicare Advantage members). In addition to being popular with Medicare beneficiaries, the Medicare Advantage program enjoys bipartisan congressional support. Earlier this year, more than 400 members of Congress—Democratic and Republican—signed letters expressing strong support for the program. *See* AHIP, *More than 60 Senators Are Clear: Medicare Advantage Should Be Protected* (Feb. 18, 2022); AHIP, *Over 340 House Members Stand Together to Strengthen and Improve Medicare Advantage* (Jan. 28, 2022).

The reason for the Medicare Advantage program's widespread popularity is clear: Medicare Advantage plans deliver better care while decreasing costs and using the cost savings to provide additional services to members. For example, Medicare Advantage plans coordinate physician services, hospital care, and prescription drug benefits through an integrated approach that ensures members receive streamlined services in a timely and efficient manner. *See* AHIP, *Statement for the Record Submitted to the House Ways and Means Committee, Subcommittee on Health* 2 (June 7, 2017). Studies have shown that Medicare Advantage plans outperform FFS Medicare "on nearly all clinical quality and most patient experience measures." Timbie et al., *Medicare Advantage and Fee-for-Service Performance*

on Clinical Quality and Patient Experience Measures, 52 Health Servs. Res. 2038, 2058 (2017).[4] And the Medicare Advantage program itself has spillover effects for FFS spending: In U.S. counties with high baseline Medicare Advantage penetration rates, each 10-percentage-point increase in Medicare Advantage penetration has been associated with a decrease in per-patient annual FFS spending. *See* Johnson et al., *Recent Growth In Medicare Advantage Enrollment Associated With Decreased Fee-For-Service Spending In Certain US Counties*, 35 Health Aff. 1707, 1711, App. Ex. 5a (Sept. 2016).

With the nation's population aging and the proportion of Medicare participants enrolled in Medicare Advantage increasing year after year, this widely popular program obviously is becoming ever more important to the U.S. health care system. Ensuring that higher-quality, lower-cost care continues to grow through competition in the Medicare Advantage market is imperative not only for the health and financial security of the millions of Americans that the program serves but also for the U.S. economy as a whole. Rationally compensating MAOs is foundational to promoting that healthy competition.

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[4] "Evidence from forty-eight studies showed that in most or all comparisons, Medicare Advantage was associated with more preventive care visits, fewer hospital admissions and emergency department visits, shorter hospital and skilled nursing facility lengths-of-stay, and lower health care spending." Agarwal et al., *Comparing Medicare Advantage and Traditional Medicare: A Systematic Review*, 40 Health Aff. 937, 937 (June 2021).

B. "Actuarial Equivalence" Is Central To The Medicare Advantage Program, And Participating Insurance Providers Need Certainty Regarding Its Application

In contrast to original Medicare where the government reimburses beneficiaries' actual health care costs, MAOs manage the care and bear the financial risk for the beneficiaries enrolled in their plans. In exchange, MAOs receive monthly per-member payments. Those payments are tied to the amount the government expects to pay for an average original Medicare beneficiary in the region, 42 U.S.C. § 1395w-23, and adjusted up or down based on members' demographic characteristics and health status relative to the average Medicare beneficiary. *Id.* § 1395w-23(a)(1). Critically, in making these risk-adjustment payments, CMS must "ensure actuarial equivalence." *Id.* § 1395w-23(b)(2). As the government conceded in the district court, that statutory mandate means that CMS must "appl[y] … actuarial principles" to pay "a sum equal to the cost [it] would expect to bear in providing traditional Medicare." Dist. Ct. Dkt. 57-1 at 28. In this way, Congress tethered risk-adjustment payments to the amount CMS would expect to pay for plan enrollees if they were enrolled in original Medicare. By holding that CMS can define a risk-adjustment "overpayment" without reference to the mandate that governs risk-adjustment payments, the D.C. Circuit's decision separates values that Congress expressly linked and threatens the interests of MAOs, providers, and beneficiaries.

CMS has implemented its risk-adjustment mandate by analyzing the government's expenditures in original Medicare and the reported health conditions for those beneficiaries, to calculate risk scores that account for variations in future health care costs based on an

individual's diagnosed conditions. CMS then requires MAOs to submit the same type of diagnostic data for their members, *see* 42 C.F.R. § 422.310, and it revises MAOs' monthly payments based on their enrollees' resulting risk scores, *id.* § 422.308. The Overpayment Rule's proposal to apply a more stringent documentation standard to Medicare Advantage than the agency uses in original Medicare creates an actuarial disconnect at the heart of that system, threatening to underpay MAOs, unsettle the program's financial predictability, and burden health care providers and beneficiaries.

1. By linking payments in Medicare Advantage to the expected costs of caring for a plan's population in original Medicare, Congress ensured that MAOs "are paid appropriately for their plan enrollees (that is, less for healthier enrollees and more for less healthy enrollees)." C.A.J.A.92 (CMS rule establishing Medicare Advantage). As important, parity with original Medicare costs guarantees that MAOs have the resources they need to harness private insurance providers' efficiencies to offer attractive coverage to the populations enrolled in their plans. And by eliminating structural incentives that might otherwise favor enrollment of a younger and healthier population, it furthers Congress's goal of making Medicare Advantage plans broadly available to all otherwise eligible Americans. *See* American Academy of Actuaries, *Risk Assessment and Risk Adjustment* 1 (May 2010) ("A well-designed risk-adjustment system is one that properly aligns incentives, limits gaming, and protects risk-bearing entities (e.g., insurers, health plans).").

The D.C. Circuit's decision upends this bargain, allowing CMS to pay MAOs less for the risks they assumed in committing to cover their beneficiaries' care than original Medicare would pay for the same

population. CMS developed its Medicare Advantage risk-adjustment model using FFS data known to contain a substantial rate of diagnosis codes that do not comply with CMS's documentation and coding standards. *See* Winkelman, *Actuarial Report on CMS' November 1, 2018 Proposed Rule* 10-11 (Aug. 2019) (citing internal CMS documents available at C.A.J.A. 600). If the FFS population were shifted into Medicare Advantage and CMS removed "undocumented" codes (as required by the Rule), the population on average would appear healthier than they were in FFS, and the model would underpay compared to what would be predicted to be paid under FFS. *Id.* at 3. CMS would have remitted original Medicare payments for these claims, but would deny payments to MAOs based on them. The Overpayment Rule seeks to inflict that inconsistent and actuarially unsound result by demanding that MAOs return all payments corresponding to any "undocumented" diagnosis. And by blessing that demand, the D.C. Circuit's decision alters the Medicare Advantage program in a manner that risks systematically underpaying MAOs relative to the health status of their enrolled populations.

The D.C. Circuit tried to mitigate the impact of its decision by suggesting that the Rule reaches only a limited number of codes. *See, e.g.*, Pet. App. 33. But the Rule changes assumptions about which payments MAOs are entitled to, and that fundamental change has cascading effects because the Medicare Advantage risk-adjustment model relies on the law of large numbers. The actuarial principles underlying the model are designed to estimate expected costs not for any given enrollee in isolation, but for a given plan population relative to the average FFS population. *See* American Academy of Actuaries, *Risk Assessment and Risk*

Adjustment 3 (May 2010) ("[R]isk assessment does a much better job of explaining variations in costs among larger groups than among individuals."). Changing a basic assumption about the data describing a population's health status has large-scale payment effects.

In addition to allowing MAOs to be underpaid relative to original Medicare, the decision below vitiates the consistency and predictability that the actuarial-equivalence requirement is intended to safeguard. As with other major public-private partnerships, the success of Medicare Advantage depends on the government "honor[ing] its obligations." *Maine Cmty. Health Options* v. *United States*, 140 S. Ct. 1308, 1331 (2020). That means that CMS must adhere to Congress's payment mandates, including by paying MAOs in a manner that "ensure[s] actuarial equivalence," 42 U.S.C. § 1395w-23(a)(1)(C)(i). MAOs need to know the rules of the road regarding CMS's risk-adjustment payment policies to submit their annual bids to participate in the Medicare Advantage program. That annual bid submission process determines the base monthly amount per member that an MAO will receive for providing Medicare coverage to enrollees as well as an array of additional benefits offered by many MAOs. MAOs' "bids" to CMS set forth actuarially based estimates of the amount of revenue the MAO needs in order to provide "coverage to [a Medicare Advantage] eligible beneficiary with a national average risk profile." 42 C.F.R. § 422.254(b)(1); *see also* 42 U.S.C. § 1395w-24(a)(6)(A). Such a bid "must be prepared in accordance with CMS actuarial guidelines based on generally accepted actuarial principles." 42 C.F.R. § 422.254(b)(5). To make actuarially sound revenue projections, MAOs must therefore have a "valid and consistent definition of a beneficiary with a 'national average profile' and a

consistent method for computing risk scores." Winkelman 36 (explaining that revenue projections rely on expectations about CMS's risk-adjustment payment policies, including MAOs' and actuaries' expectations regarding required offsets in audits and other payment recovery).

Uncertainty regarding the statutory and actuarial principles underlying CMS's risk-adjustment payment policies also affects the ability of MAOs to design and offer plan benefits that are valuable to consumers; to contract with hospitals, physicians, and other providers to improve quality and implement appropriate payment structures; and to structure business operations to ensure compliance with statutory and regulatory obligations. These decisions often require analyses, investments, and long-term business arrangements that must be made years in advance.

Congress itself recognized that early information regarding any changes to CMS's risk-adjustment payment model is essential to the Medicare Advantage program and directed CMS to make an annual announcement of benchmark rates and risk and other factors used to adjust benchmark rates. 42 U.S.C. § 1395w-23(b)(1). At least 60 days before making that announcement, CMS must provide advance notice of any proposed methodological changes and allow MAOs to comment on those proposed changes. *See id.* § 1395w-23(b)(2). Allowing *retroactive* changes to the manner of making risk-adjustment payments raises particular actuarial concerns. *Cf.* Winkelman 35-36 (discussing retroactive application of proposed regulation regarding agency audits). MAOs that submit bids to provide coverage based on certain baseline assumptions should not be held to different assumptions after the fact, simply because CMS has (for unexplained

reasons) changed its mind about a fundamental aspect of the Medicare Advantage program like the requirement of actuarially equivalent payments.

The D.C. Circuit's decision decoupling risk-adjusted payments from actuarial equivalence will also impose differential costs on health care providers, exacerbating the disconnect between CMS's costs under original Medicare and the compensation it pays MAOs. In providing data to CMS about the health status of their members, MAOs rely on diagnosis codes reported by providers, most of whom are the same providers who see patients covered by original Medicare. Under the D.C. Circuit's ruling, diagnosis codes submitted by those providers that CMS uses—without objection—to calculate diagnosis code values would not support payments to MAOs. As a result, providers face differential burdens with respect to CMS's complex coding guidelines depending on whether they are treating a Medicare Advantage patient or an original Medicare patient. These differential burdens will raise costs and potentially chill Medicare Advantage participation by these providers.

2. Most important, the D.C. Circuit's decision threatens to alter the benefits that MAOs offer plan enrollees. Leaving the D.C. Circuit's decision in place and allowing CMS to treat any payment based on a diagnosis code without medical-record documentation as improper would inappropriately and significantly reduce the resources available for MAOs to provide beneficial services to consumers. The net impact of the D.C. Circuit's decision would, under the actuarial rules governing Medicare Advantage, lead to consumer harm through higher premiums, higher cost-sharing arrangements (such as co-payments and deductibles), and fewer supplemental benefits.

Beneficiaries have faced this problem before. When Congress created Medicare Advantage's predecessor program, Medicare+Choice, it directly set plan payment rates. *See* 42 U.S.C. § 1395w-23(c)(1)(A), (B). As CMS later explained, under the original "administered pricing" scheme, "payment rates grew modestly in relation to costs health plans incurred, resulting in fewer health plans participating …, decreased choice of plans available to beneficiaries, and fewer extra benefits available to enrollees." Establishment of the Medicare Advantage Program, 69 Fed. Reg. 46,866, 46,867-68 (Aug. 3, 2004). The Overpayment Rule threatens to similarly disrupt the Medicare Advantage program—and to inflict similar harms on beneficiaries—by undermining the basic bargain on which Medicare Advantage was founded.

For all of these reasons, certainty that actuarial equivalence applies is essential in keeping Congress's promises under the Medicare Advantage program. To function properly, risk adjustment must fairly and adequately compensate insurance providers that partner with the government for the financial risk they assume in providing health coverage for the nation's most vulnerable populations. If CMS does not ensure actuarial equivalence, it necessarily fails to fulfill Congress's goal of avoiding structural incentives that may prevent Medicare Advantage plans from being broadly available to all eligible Americans. CMS's failure to meet its statutory obligation of actuarial equivalence may also undermine predictability and actuarial soundness in a manner that weakens Medicare Advantage, by reducing competition that has led to expanded benefits, lower costs, and better care for beneficiaries. In short, lack of certainty about this core payment requirement will

harm the health of the Medicare Advantage program and the millions of Americans it serves.

II. THE DECISION BELOW IS MANIFESTLY WRONG

A. Contrary To The D.C. Circuit's Decision, CMS Was Bound By The Act's Requirement Of Actuarial Equivalence In Promulgating The Overpayment Rule

For the reasons petitioners have explained, this Court's review is also necessary to correct the clear error of statutory interpretation underlying the D.C. Circuit's reinstatement of the Overpayment Rule. The Act mandates that CMS pay MAOs in a manner that ensures actuarial equivalence. The provision of the Act that the Rule here implements defines an "overpayment" as funds a party receives under the Medicare (or Medicaid) subchapter to which it is not entitled *under that subchapter*. Thus, if an MAO is entitled to the funds it received in light of Part C's actuarial-equivalence requirement, that precludes the government from later claiming that the MAO must return the funds under the Act. The D.C. Circuit's holding that these are entirely separate inquiries defies both logic and the plain text of the relevant statutory provisions.

The D.C. Circuit concluded that "[n]othing in the text of either the actuarial-equivalence requirement in section 1395w-23(a)(1)(C)(i) or the overpayment-refund obligation in section 1320a-7k(d) applies the former to the latter. There is no cross-reference or other language suggestive of overlap, nor does UnitedHealth so contend." Pet. App. 34a.

The D.C. Circuit's determination that there is "no cross-reference" is simply wrong. The Act defines an "overpayment" as "any funds that a person receives or

retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled *under such subchapter*." 42 U.S.C. § 1320a-7k(d)(4)(B) (emphasis added). The D.C. Circuit's decision modifies this text and omits the relevant cross-reference that it claims is absent, quoting the same provision as "defining 'overpayment' as 'any funds that a person receives or retains under [the Medicare or Medicaid programs] to which the person, after applicable reconciliation, is not entitled." Pet. App. 23a. Indeed, the opinion omits "under such subchapter" after "entitled" each time it quotes this provision. *See* Pet. App. 23a, 24a, 65a. That omission, however, does not change the clear cross-reference in the actual text of the Act.

Subchapter XVIII of the Act is the Medicare subchapter, which contains Medicare Part C and the requirement that CMS "shall adjust" its payments to MAOs "so as to ensure actuarial equivalence" with the expected costs to provide original Medicare for the same beneficiaries. By limiting "overpayments" to funds an MAO is not entitled to *under the relevant subchapter*, the Act explicitly refers to and incorporates Congress's directives regarding payment to MAOs.

Although the D.C. Circuit's quotations of the Act omit the relevant cross-reference, Congress itself did not repeal, explicitly or impliedly, Part C's payment requirements in amending the Act to require self-reporting of overpayments. Congress was clear that whether there is an "overpayment" depends on whether the MAO is entitled to the funds under the Act's Medicare (and Medicaid) provisions. The Act's overpayment provision thus grants no license to CMS to ignore Part C's actuarial-equivalence requirement. The D.C. Circuit's contrary holding invites CMS to use the overpayment provision to write any Medicare or

Medicaid payment provision it dislikes out of the statute by defining "overpayment" in a way that is different from the underlying payment provision. There is no suggestion in the statutory text or legislative history that Congress intended the overpayment provision to work such a radical revision of payments for massive parts of the U.S. economy. And the clear incorporation of statutory payment provisions in defining "overpayment" shows the opposite: Before CMS can recover payments to an MAO as an "overpayment," it is obligated to determine whether those payments were required to ensure actuarial equivalence.

B. The Overpayment Rule Fails To Ensure Actuarial Equivalence

As discussed, the D.C. Circuit's principal reason for reinstating the Overpayment Rule—that CMS was not bound by actuarial equivalence in promulgating the Rule—was clear error. Absent that obvious mistake, the D.C. Circuit identified no credible basis to reinstate the Rule. And the government has offered none, either contemporaneously in the rulemaking (as required by the Administrative Procedure Act) or since.

The regulation of health care markets is complicated, but the statutory question in this case is simple: Can CMS treat the health data for Medicare beneficiaries differently in determining whether there is an "overpayment" than it does in determining the up-front payment amounts to which MAOs are entitled? Common sense and actuarial science dictate the same answer: no. Under accepted actuarial principles promulgated by the American Academy of Actuaries, the data that the Medicare Advantage risk-adjustment model is applied to must be "reasonably consistent" with the data that CMS used to develop the model, or "appropri-

ate" adjustments must be made to account for the inconsistency. Actuarial Standard of Practice No. 45 § 3.2 (Jan. 2012). Because CMS developed its model using FFS data known to contain a significant rate of diagnosis codes that are not documented in medical records, it cannot require more stringent documentation of MAOs without adjusting for that inconsistency.

In 2012, in the context of its own risk-adjustment data validation ("RADV") audits of MAOs, CMS agreed with the actuaries and MAOs and stated that it would apply an "FFS adjuster" as an offset against any payment recovery. C.A.J.A. 397-398. In the Overpayment Rule, however, CMS rejected the need for an adjuster—with no meaningful explanation for this change in position. *See* 79 Fed. Reg. 29,844, 29,918-29,925 (May 23, 2014) (promulgating 42 C.F.R. § 422.326). In the proceedings below, the government's defense of that about-face spawned shifting and contradictory post-hoc justifications that confirm the unlawfulness of the Rule and CMS's lack of explanation for its departure from prior agency policy. But even as it staked out a series of inconsistent positions on that issue, the government never took the extreme view adopted by the D.C. Circuit that actuarial equivalence has no application whatsoever to a regulation implementing the Act's overpayment provisions.

In defending the Overpayment Rule in the district court, the government was "essentially silent" on the fundamental actuarial issue until the court entered judgment. Pet. App. 83a. Although the government did contend that petitioners should have challenged the model's calibration—an argument the D.C. Circuit recited in dicta, Pet. App. 5a—neither the government nor the D.C. Circuit offered any meaningful rebuttal to the point that the "actuarial problem" here arises,

exactly as it does in a RADV audit, not from improper calibration but from the *combination* of calibrating the model on one set of assumptions about FFS data, while subjecting data from MAOs to different assumptions when determining "overpayments." Pet. App. 72a. That problem can be solved in multiple ways, including by applying an FFS adjuster. But it must be addressed in *some* way, consistent with the Act's requirement to ensure actuarial equivalence between Medicare Advantage payments and expected FFS costs.

The government then sought reconsideration based on a new proposed rule not to apply an FFS adjuster even in RADV audits. In support of the proposed RADV rule, CMS in October 2018—more than six and a half years after its original FFS adjuster decision but only eight weeks after losing in the district court—issued a study purporting to show no payment impact from using audited versus unaudited FFS data in calibrating the risk-adjustment model. *See* 83 Fed. Reg. 54,982, 55,040-55,041 (Nov. 1, 2018). Contrary to CMS's assertions, the data underlying the study—which CMS did not disclose until months later—in fact corroborates the need for such an adjuster, as petitioners and AHIP explained to the district court. The government again offered no meaningful rebuttal on the merits, and in fact disclaimed any reliance on the study "for the validity of its conclusions." Pet. App. 102a-103a (quoting Dist. Ct. Dkt. 97 at 24). CMS's proposed RADV rule likewise disclaims the need for ultimate empirical support, stating that even if the agency "found that diagnosis error in FFS claims data led to systematic payment error," it now believes an FFS adjuster would be inappropriate in the audit context because no adjuster is applied outside that context. 83 Fed. Reg. at 55,041.

In yet another shift, the government's briefing in the D.C. Circuit made an entirely new argument, effectively conceding that different data standards would raise actuarial concerns but contending for the first time that the Overpayment Rule did not raise those concerns because any payment recovery was supposedly narrowly cabined to only the overpayments an MAO actually identified. The government claimed that the Rule thus achieves a kind of rough parity in the "error correction mechanisms" in FFS Medicare and Medicare Advantage. C.A. Gov't Br. 33. Although the government itself agreed in the district court that FFS data "contain[s] errors" precisely "*because it is unaudited*," Dist. Ct. Dkt. 57-1 at 37 (emphasis added), the government pointed to extremely limited auditing of FFS data and argued that "[t]he Overpayment Rule is of a similar nature" because an MAO's repayment obligation attaches only to diagnosis codes the MAO "has identified" as lacking medical-record documentation, C.A. Gov't Br. 24.

This new defense of the Rule thus sought to justify CMS's departure from prior policy in RADV audits in a manner never articulated by CMS during the rulemaking or indeed by the government prior to the proceedings in the D.C. Circuit. In particular, the government contrasted the purportedly cabined payment recovery under the Overpayment Rule with the more comprehensive payment recovery in a RADV audit, arguing that "CMS's original rationale" for including an FFS adjuster in RADV audits was rooted in "the difference between data that is comprehensively audited through extrapolation and data subject only to limited error correction." C.A. Gov't Br. 19; *see id.* at 30. In arguing that the extent of error correction and payment recovery was the primary driver of CMS's change in

position, the government appeared to suggest that CMS was therefore right in 2012 to require an FFS adjuster in the RADV context, *id.* at 18-19, 30, even though CMS was disputing that position just a few years ago and its proposal to eliminate the FFS adjuster in RADV audits is still pending.

Because they are post-hoc, none of these justifications is permissible. *See DHS* v. *Regents of Univ. of California*, 140 S. Ct. 1891, 1907 (2020) ("It is a 'foundational principle of administrative law' that judicial review of agency action is limited to 'the grounds that the agency invoked when it took the action.'"). But they also demonstrate that CMS at least understood itself to be bound by Part C's payment requirements and thus argued—however incorrectly—that the Rule complied with those requirements. According to the D.C. Circuit, CMS never needed to go to the effort. That remarkable holding rubberstamps a major economic regulation without requiring the agency to account for its compliance with a critical directive of Congress or even provide a "reasoned explanation" for "depart[ing] from a prior policy," *FCC* v. *Fox Television Stations, Inc.*, 556 U.S. 502, 515-516 (2009). The Court should grant review to resolve the question presented and require that CMS regulate Medicare Advantage consistent with those directives from Congress.

A nationwide regulation affecting CMS's administration of a major part of the U.S. economy would be reason enough to warrant this Court's review. But the D.C. Circuit's rationale for reinstating the Rule is also plainly contrary to the Act. That error of statutory interpretation is egregious. It rewrites the Act to create an incoherent payment system with substantial adverse consequences for the vitality of the Medicare Advantage program and the growing number of Medicare

beneficiaries who depend on it. Now that the six-year statute of limitations for a pre-enforcement challenge has run, there is also no realistic opportunity for other courts to address the question wrongly decided by the D.C. Circuit. Unless this Court steps in, the decision below will therefore effectively be the final word on the meaning of a key provision of the Act and the Rule implementing it.

CONCLUSION

The petition should be granted.

Respectfully submitted.

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