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Recent Activity in Medicare Audit Programs: CMS Announces Increase in Audit Contractor Oversight

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The Centers for Medicare and Medicaid Services ("CMS") healthcare audit programs – including the Unified Program Integrity Contractors ("UPICs") audit program, the Recovery Audit Contractor ("RAC") program, the Comprehensive Error Rate Testing ("CERT") program, etc. – have been the subject of regular complaints and calls-for-action by the Medicare/Medicaid provider community for many years.

In significant part, the provider complaints have focused on CMS's lack of oversight over the activities of CMS's third-party audit contractors – UPICs, RACs, etc. – and the improper audit procedures utilized by such auditors which often produce unsupportable audit adjustments and, in turn, significant hardship for providers. For example:

1. On December 3, 2014, the American Medical Association ("AMA") wrote a letter to CMS urging CMS to correct a two-year backlog of appeals in connection with the RAC program. The letter claimed that more than 60% of RAC determinations were overturned on appeal in 2013, thus demonstrating that RAC auditors are often wrong, causing significant hardship for physicians;
2. More recently, in a 2018 letter campaign, AMA continued to push for additional RAC reforms in two letters addressed to CMS Administrator Seema Verma dated June 13, 2018 and September 11, 2018. In these letters, the AMA voiced its

opposition to the congressionally-mandated contingency fee structure used by CMS to pay the RACs. The AMA described RAC contingency fee payments as a "pay and chase model;" and
3. In addition to the concerns described above, AMA, in its September 11, 2018 letter, cited CMS statistics showing that out of the nearly 47,000 RAC Medicare Part B determinations that were appealed in fiscal 2015, 70% were overturned in the provider's favor. As cited by the AMA, RAC accuracy actually decreased from 2013 – the year identified by the AMA in its December 13, 2014 letter.

CMS Responds to Provider Complaints Regarding RAC Program.

In a CMS blog article posted on May 2, 2019, CMS Administrator Seema Verma highlighted recent progress made by CMS in reducing provider complaints related to the RAC program. According to Administrator Verma, CMS has made a concerted effort to increase oversight of RACs and, as a result, "[CMS has] reduced RAC-related provider burden to an all-time low, as evidenced by the significant decrease in the number of RAC-reviewed claim determinations that are appealed and the corresponding reduction in the appeals backlog."

In describing some of the actions that CMS has taken to improve RAC oversight, Administrator Verma highlighted the following:

1. CMS is now holding RACs accountable for performance by requiring RACs to maintain a 95% accuracy score. RACs that fail to maintain this rate will receive a progressive reduction in the number of claims they are allowed to review;
2. CMS now requires RACs to maintain an overturn rate of less than 10%. Failure to maintain such a rate, will also result in a progressive reduction in the number of claims the RAC can review; and
3. CMS has revised the RAC program to provide that RACs will not receive a contingency fee until after the second level of appeal is exhausted. Previously, RACs were paid immediately upon denial and recoupment of the claim. According to CMS, this delay in RAC payment will help assure providers that a RAC's decision is correct before the RAC is paid for its auditing services.

Simply Home Healthcare, LLC v. AZAR et al:

Simply Home Healthcare, LLC ("Simply"), a Chicago-based home health provider, filed a class action complaint on April 5, 2019, against the U.S. Department of Health and Human Services ("HHS") and AdvanceMed, a Medicare contractor (the "Complaint"). The Complaint alleges that AdvanceMed misapplied federal Medicare billing rules regarding overpayments. This alleged conduct, the Complaint argues, caused Simply and potentially numerous other home health providers to go out of business due to reimbursement disputes with AdvanceMed.

Background

Prior to closing its operations in 2018, Simply provided therapy services to patients residing in assisted and independent living facilities in the Chicago area for over six years. AdvanceMed is a Unified Program Integrity Contractor ("UPIC") – an entity that contracts with the Centers for Medicare & Medicaid Services ("CMS") to provide data

mining services to discover overpayments or patterns of fraud.

In 2016, AdvanceMed requested Simply to provide medical charts for a routine audit. While Simply waited on the audit to conclude, Medicare payments to Simply, which averaged over $250,000 per month, suddenly stopped on April 17, 2017. Two days later, Simply received two letters from AdvanceMed – the first letter stated that a payment suspension was put into place due to "reliable information that an overpayment exist[ed];" and the second letter requested that Simply provide additional medical charts for AdvanceMed's review. Simply complied with the request, producing over 20,000 pages of information within 15 days.

After producing the additional records, Simply repeatedly contacted AdvanceMed to suggest various plans of correction and attempted to convince AdvanceMed and CMS to lift the payment suspension. AdvanceMed responded by claiming the payment suspension would not be lifted, because CMS "decided to continue the suspension based on credible evidence of fraud."

Finally, in September of 2017, AdvanceMed lifted the payment suspension and informed Simply that it owed Medicare $5.4 million in overpayments based on AdvanceMed's extrapolation of payments in previous years. Simply appealed this decision, reducing the repayment obligation to $4.8 million. At this point, Simply had laid off all but two staff members, was not taking on any new patients, and was ultimately forced to shut down its operations.

The Complaint

The Complaint, which was filed in the U.S. District Court for the Northern District of Illinois, alleges that over 100 healthcare providers may have ceased operations or otherwise been damaged by payment suspensions and extrapolations of overpayments by AdvanceMed. Simply alleges that the payment suspensions and extrapolations of overpayments were contrary to Medicare regulations and an overstep of AdvanceMed's powers as a UPIC. Among other things, Simply alleges that AdvanceMed (i) inflated the hours that it spent reviewing reimbursement documents, and thus receive more payment from HHS, by imposing payment suspensions as a way to require providers to submit additional documentation; and (ii) withhold payments on the basis of fraud without consulting with law enforcement officials, as is required under Medicare regulations.

As demanded in the Complaint, Simply is seeking both (i) a declaratory judgment from the court that AdvanceMed intentionally exceeded its powers as a UPIC; and (ii) actual and punitive damages caused by AdvanceMed's alleged illegal payment suspensions and extrapolations of overpayments.

Where are we now?

The Simplify complaint and Administrator Verma's recent report show that the comings-and-goings of CMS's third-party audit contractors continue to attract much attention within CMS, the Medicare provider community, and with other stakeholders. The activity described in this article not only calls attention to the current state of CMS's various audit programs but also calls attention to possibility

of future activity that will both increase transparency as well as the effectiveness of RACs, UPICs, and other program integrity auditors. We will provide further updates as the world of Medicare and Medicaid audits revolves and evolves.