HIDDEN DANGERS EMBEDDED IN THE AFFORDABLE CARE ACT FOR HEALTH CARE PROVIDERS RECEIVING MEDICAID PAYMENTS

by Michelle R. Peirce*

The massive changes of the Affordable Care Act (ACA) are well known, but there are other provisions of the ACA that have garnered less attention, despite their significant impact on providers in Massachusetts and across the country. The ACA now *mandates* suspension of a provider's Medicaid payments where there is a credible allegation of fraud. In addition, the ACA, and accompanying regulations, lowers the standard of proof for states seeking to suspend Medicaid payments based on a suspicion of fraud. These changes are particularly important given the now-mandatory referral to law enforcement whenever payments have been suspended.

The ACA prohibits federal dollars from being paid to the states for payments that stem from a "credible allegation of fraud." Specifically, section 6402(h)(2) of the ACA amended section 1903(i)(2) of the Social Security Act to provide that Federal Financial Participation in the Medicaid program shall not be made to a state for any amounts paid to a provider where the state had a pending investigation of a "credible allegation of fraud" against that provider, unless the state determines that a good faith exemption exists not to suspend those payments. 42 U.S.C. §1396b(i)(2)(C) (*See* Tab 1.) The regulations implementing the ACA include provisions that have the potential to greatly impact providers' Medicaid reimbursements. Beginning on March 11, 2011, the Medicaid payment suspension rules changed in several important ways. The impact of this change is discussed below.

Mandatory Suspension of Payments. As an initial matter, suspending a provider's Medicaid payments is no longer discretionary—if there are "credible allegations of fraud," the state "must" suspend payments, unless the situation falls into one of the good faith exceptions articulated in the regulations, or the state risks losing some of its federal funding. In Massachusetts, that suspension can extend to "any provider under common ownership." 130 C.M.R. §450.249(c) (*See* Tab 10.) "Common ownership" is defined as: "two or more providers in which a person or corporation had or had, at any time, an ownership or control interest, whether concurrently, sequentially, or otherwise." 130 C.M.R. §450.101 (*See* Tab 12.)

The Burden of Proof is Now Lower to Suspend Providers' Payments. More significantly, the standard for suspending a provider's Medicaid payments has been relaxed. Until March 2011, the rule was that the state Medicaid agency "may" withhold Medicaid payments upon receipt of "reliable evidence that the circumstances giving rise to the need for a withholding of payments involved fraud or willful misrepresentation under the Medicaid program." 42 C.F.R. §455.23 (effective until March 25, 2011) (*See* Tab 2.)

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But under the current federal regulations, and consistent with the ACA, suspension will now result if there is merely a "credible allegation of fraud for which an investigation is pending.…" 42 C.F.R. §455.23 (*See* Tab 3.) The Department of Health and Human Services has openly acknowledged that this standard will allow payments to be suspended more readily: "we believe that there is a substantive difference between the threshold level of certainty or proof necessary to identify a 'credible allegation' versus the heightened requirement of 'reliable evidence' in the current [former] regulation." Vol. 76, No. 22 Federal Register, Feb. 2, 2011, at 5932 (*See* Tab 4.)[1] The public comments further observed: "We believe that State agency investigations, though they may be preliminary in the sense that they lead to a referral to a law enforcement agency for continued investigation, are adequate vehicles by which it may be determined that a credible allegation of fraud exists sufficient to trigger a payment suspension to protect Medicaid funds." *Id.*

What constitutes a "credible allegation of fraud" is not entirely clear. The regulations provide that, "[a] credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) fraud hotline complaint. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations." 42 C.F.R. §455.2 (*See* Tab 5.) The regulations further state that, "[a]llegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis." *Id.*

A March 25, 2011, CMS Bulletin shed additional light on what constitutes a "credible allegation of fraud"—and how much discretion there is in interpreting that new standard. (*See* Tab 6.) According to that Bulletin, "CMS believes States should have the flexibility to determine what constitutes a 'credible allegation of fraud' consistent with individual state law." The Bulletin gives the example of a complaint lodged by an employee that a physician repeatedly bills for services at a higher level than is justified by the services; upon review of the physician's billings, the state may determine that there are indicia of reliability. "Mere errors" found in an audit should not rise to the level of "an investigation of a credible allegation of fraud" sufficient to warrant a suspension, according to the Bulletin. *Id.*

State agencies have struggled somewhat with the definition of "credible allegation of fraud." The Office of Inspector General acknowledged this struggle in its recently released report addressing, among other things, implementation of the new payment suspension provisions:

> During OIG's recent onsite reviews of MFCUs, representatives from some MFCUs and State agencies identified potential challenges associated with payment suspension based on credible allegations of fraud. One challenge involves State entities determining what constitutes

[1] The comments in the Federal Register, attached at Tab 4, provide additional insight and analysis of these changes.

> a credible allegation of fraud. Although, in many cases, the fraudulent activity may be obvious on the basis of initial evidence, interviewees explained that other circumstances may require substantial review to determine whether payment suspension is warranted….Another challenge involves determining standards for use of "good cause" exceptions. A Unit may request a "good cause" exception to avoid compromising a case by alerting suspects that they are under investigation. A State Medicaid agency may invoke a "good cause" exception if it determines that a payment suspension is not in the best interests of the Medicaid program, such as when no other providers are available to treat Medicaid beneficiaries in a specific geographical area. To further examine these issues, OIG has undertaken additional reviews regarding payment suspension for a credible allegation of fraud.

(Office of Inspector General, Fiscal Year 2013 Annual Report (OEI-06-13-00340)(March 2014), at 12 (*See* Tab 7.)

Mandatory Reporting to Law Enforcement. In addition to lowering the standard for suspending a provider's Medicaid payments, and making suspensions mandatory, the March 2011 changes increased the ramifications of a suspension. Now, when a state Medicaid agency such as MassHealth suspends payments, the state Medicaid agency must make a fraud referral to the Medicaid Fraud Control Unit. 42 C.F.R. §455.23(d)(1) (*See* Tab 3.)

The March 2011 Center for Medicare and Medicaid Services Bulletin notes the potential for confusion given that state agencies like MassHealth exchange information with the Medicaid Fraud Control Unit as part of their ongoing dealings and that these exchanges do not necessarily constitute a "referral." (*See* Tab 6.) The Bulletin notes that, "CMS recognizes that States may need to consult and/or exchange information with their respective MFCUs prior to making a formal referral." CMS recommends that "to limit confusion between informal discussions and formal referrals," states agencies should consider using a term like "provider notice" in order to distinguish such communications from formal referrals.

Implications for Data Mining. The lowered standard for suspending Medicaid payments—and therefore mandatory referrals to law enforcement—could have even greater impact in the age of data mining and predictive analytics.[2] Indeed, the definition of "credible allegation" specifically embraces data mining techniques. As noted above, the new regulations make clear that information gleaned from "claims data mining" can constitute a "credible allegation of fraud." 42 C.F.R. §455.2 (*See* Tab 5.)

[2] Predictive analytics are applications that allow real-time assessment of potential fraud before the claim is paid, allowing investigators to move away from a "pay and chase" model.

MassHealth has been at the forefront of predictive analytics. *See* "How MassHealth cut Medicaid fraud with predictive analytics," GCN Technology, Tools and Tactics for Public Sector IT, Feb. 24, 2014 (*See* Tab 8.) Combining these automated claims reviews with lower standards for showing fraud for payment suspension purposes could cause a large increase in suspensions and referrals. According to that article, MassHealth's analytics include running claims against a master death file and a provider exclusion list; two areas of proverbial low-hanging fruit for the agency. *Id*. According to a 2014 audit by the Commonwealth's Office of the State Auditor, MassHealth also has a mechanism that denies duplicate claims for the same service code billed by the same provider for the same member on the same date of service. Office of the State Auditor – Annual Report Medicaid Audit Unit, March 15, 2013—March 14, 2014 ("2014 Audit")(Issued March 15, 2014) (*See* Tab 9.)[3] Not surprisingly, the Massachusetts State Auditor also relies on data mining in performing audits of the Medicaid program. *Id*., at 22. This permits the audit to cover 100% of a service provider's claims. *Id*., at 3. The technology is improving all the time, which can only increase the investigations, suspensions, and referrals in the future.

Length of Suspended Payments. Although the regulations' goal is to resolve a fraud investigation and suspension promptly, the suspension can last for significant periods of time, running the risk of putting some providers out of business. The federal regulations state that payment suspensions are "temporary" and shall continue until (1) the agency or prosecuting authorities determine there is insufficient evidence of fraud, or (2) legal proceedings related to the alleged fraud are completed. 42 C.F.R. §455.23(c) (*See* Tab 3.) If the Medicaid fraud unit declines to accept the fraud referral, the payment suspension must be discontinued unless a referral is made to a different law enforcement agency. *Id*., at §455.23(d)(4).

These time limits for suspending payments are echoed in the Massachusetts regulations. 130 C.M.R. §450.249 (*See* Tab 10.) Those regulations state that the payments are "released" if the Attorney General's Medicaid Fraud Division, or other law enforcement agency, declines to accept the fraud referral, unless MassHealth notifies the provider in writing that the provider "has received any overpayments or committed any violations," allowing the suspension to continue even after the referral is rejected.

The length of these suspensions, and the lack of a clear end date, is problematic for providers, especially when there is a full, versus a partial, suspension. As the OIG noted in its recent report concerning the suspension payment provisions: "Another challenge involves making determinations in a timely manner. To ensure prompt suspension of payments, if warranted, Units and State Medicaid agencies must coordinate in a timely manner when determining whether an allegation is credible." Office of Inspector General, Fiscal Year 2013 Annual Report (OEI-06-13-00340)(March 2014) (*See* Tab 7.) In the meantime, and unlike the parallel Medicare process that does have more definitive time limits on suspensions (e.g. it must be reevaluated every 180 days), there is no definitive limit to a provider's Medicaid suspension.

[3] The March 15, 2014, Audit Report, attached at Tab 9, provides a helpful overview of MassHealth's activities last year.

Challenging Medicaid Suspensions. There are few cases in Massachusetts litigating Medicaid payment suspensions under the new rules ushered in by the ACA. Some attorneys who represent providers have complained that these suspensions violate due process.

One Massachusetts home health agency made this argument, among others, in seeking relief from a payment suspension under the new rules. In that case, the provider of home health care services sought an injunction ordering MassHealth to release suspended funds. Because there is so little case law on the subject, and so little information about how MassHealth and law enforcement are approaching these new rules, the pertinent pleadings in that matter, including the Commonwealth's detailed brief in opposition to the motion for preliminary injunction, are attached at Tab 11. The accompanying affidavit of the Chief Compliance Officer of the Massachusetts Executive Office of Health and Human Services also provides some insight into the process followed upon receipt of a "credible allegation of fraud." In that case, the home health agency's motion was denied in September 2012.[4] The provider was still listed on the suspended/excluded MassHealth provider list as of March 31, 2014.

Conclusion. It is perhaps too early to evaluate the impact of these changes.[5] The full impact may be impossible to measure, except anecdotally, because many of the changes are not public but, rather, play out in the internal communications at MassHealth, and in the communications between MassHealth and the Medicaid Fraud Control Unit. But there can be no doubt that the combination of new factors—a lower threshold for suspending payments, mandatory referrals to law enforcement, and predictive analytics—will greatly affect providers in Massachusetts and elsewhere.[6]

[4] The case involved guilty pleas of certain company officers and managers.

[5] A 2014 state Medicaid audit concluded that MassHealth paid more than $10.8 billion to healthcare providers. (Office of the State Auditor – Annual Report Medicaid Audit Unit, March 15, 2013—March 14, 2014 (Issued March 15, 2014) (Copy attached at Tab 9.) That Report identified over $21 million in unallowable, excessive, unnecessary, duplicative, or fraudulent billings. (*Id*., at 2.)

[6] In June 2013, New Mexico suspended payments to fifteen behavioral health providers in that state following an audit that lead the state agency to conclude that there were "credible allegations of fraud." It is unclear if the same steps would have been taken absent the lower standard.