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CMS Pledges No Rush to Judgment in Pay Suspensions, But Some Concerns Remain

Medicaid payment suspensions may be imposed a tad more cautiously under the health reform law in light of new guidance from CMS. States will be expected to determine the veracity of fraud allegations against providers and decide whether to impose a payment suspension, according to a March 25 informational bulletin. The health reform law precludes federal financial participation (FFP) payments to the states for providers and suppliers who are under investigation for a "credible allegation of fraud." But states can forgo the payment suspension if there's "good cause," as the bulletin explains in more detail.

"Generally, a 'credible allegation of fraud' may be an allegation that has been verified by a state and that has indicia of reliability that comes from any source. Further, CMS recognizes that different states may have different considerations in determining what may be a 'credible allegation of fraud,'" CMS says in answers to frequently asked questions (FAQs) that accompany the new bulletin.

The "verification" requirement should reassure providers, says San Francisco attorney Judy Waltz, with Foley & Lardner LLP. She says some providers are worried payment suspensions could be imposed even when the underlying allegations are weak. For example, if the state Medicaid agency receives a hotline call alleging billing fraud by a provider, that should not, on its own, be enough to suspend Medicaid payments. States should follow up — for example, by data mining, examining past files for that provider and coordinating with law enforcement — to nail down the allegation as credible, Waltz says.

The state Medicaid agency must seek "verification" of the credibility of the allegation from a law enforcement component, such as the Medicaid Fraud Control Unit (MFCU). Presumably, that component will have more experience in evaluating such allegations given its enforcement focus, and can make a fair assessment based on the particular circumstances alleged.

The CMS guidelines and FAQs were issued to flesh out Sec. 6402(h) of the health reform law, a program-integrity provision that cracks down on provider enrollment and screening (MCN 2/11, p. 1). CMS on Feb. 2, 2011, finalized regulations implementing that provision.

Though in many ways similar, Medicare is not explicitly required to suspend payments while Medicaid is required, as enforced by the loss of FFP. Despite their similarity, implementing Medicaid payment suspensions when there are credible allegations of fraud against providers is trickier for the federal government than imposing Medicare payment suspensions. CMS can't enforce Medicaid payment suspensions directly because providers and suppliers receive their payments from the states even though the payments include FFP. That means states have to handle this on their own. But CMS is doing its best to make sure suspensions happen, when necessary, by turning off the federal Medicaid cash flow to the states when they don't take action against providers in the face of credible fraud allegations.

The only way out of a suspension for a credible allegation of fraud, the regulation says, is a finding by the state of "good cause" not to suspend payments. There are a number of good-cause exceptions. For example, if law enforcement agencies ask the state not to suspend payments because that may tip off the target of an investigation, the state may go along with the request despite credible allegations of fraud.

Suspensions Could Have a Life of Their Own

Waltz says providers should be worried that once states impose payment suspensions, they may take on a life of their own and continue forever. Providers may never again see a dime of Medicaid money before they eventually give up and stop business operations as a result of lack of payment. But CMS reassures providers that shouldn't happen because CMS requires states to confirm quarterly with law enforcement that there are actually ongoing investigations moving towards resolution.

It's still a little nerve-wracking, Waltz says, because providers must passively hope that states are doing the right thing and ensuring credible fraud allegations persist. Waltz had a client whose California Medicaid (Medi-Cal) payment suspension dragged on for months while a state's attorney's office there inter-

mittently investigated a fraud case against the client. Without the client's active objections to the Medicaid agency, the office may never have bothered to actively pursue the case to conclusion (and ultimately drop it), or tell Medi-Cal the case was over so payments could resume, she says. (This preceded the health reform law's payment suspension rules; California state law already authorized Medicaid payment suspensions during investigations.)

Meanwhile, Sen. Charles Grassley (R-Iowa) has decided the health reform payment-suspension provisions don't go far enough and introduced legislation March 2 to sharpen their teeth. The Strengthening Program Integrity and Accountability in Health Care Act of 2011 (S.B. 454) requires HHS to suspend providers' Medicare payments when there are credible allegations of fraud, instead of just giving HHS that authority, as the health reform law does. That would make Medicare payment suspensions as potent a tool as Medicaid payment suspensions, which get their juice from the threat of states losing FFP when they fail to suspend payments.

The new CMS informational bulletin was issued by Peter Budetti, director of the Center for Program Integrity, and Cindy Mann, director of the Center for Medicaid, CHIP and Survey & Certification. It cites the good-cause exceptions for not suspending Medicaid payments, which means states won't jeopardize their federal Medicaid funding if the exceptions are affirmatively determined by the state to apply in a particular situation.

Seven Good-Cause Exceptions Exist

The exceptions are:

(1) "Specific requests by law enforcement that State officials not suspend (or continue to suspend) payment.

(2) "If a State determines that other available remedies implemented by the State could more effectively or quickly protect Medicaid funds than would implementing (or continuing) " a payment suspension.

(3) "If a provider furnishes written evidence that persuades the State that a payment suspension should be terminated or imposed only in part.

(4) "A determination by the State agency that certain specific criteria are satisfied by which recipient access to items or services would otherwise be jeopardized.

(5) "A State may, at its discretion, discontinue an existing suspension to the extent law enforcement declines to cooperate in certifying that a matter continues to be under investigation and therefore warrants continuing the suspension.

(6) "A determination by the State agency that payment suspension (in whole or in part) is not in the best interests of the Medicaid program.

(7) "The credible allegation focuses solely on a specific type of claim or arises from only a specific business unit of a provider and the State determines that a suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid."

This list appears to be CMS's attempt to provide direction to states, and reassure providers that states should not indiscriminately cut off Medicaid cash flow, Waltz says. "CMS is trying to say that this is out there and states must comply, but here are safeguards and we will make sure this new law won't result in unfairly imposed suspensions," she says.

"I have hope that this will work the way CMS promises, because payment suspensions can be a disaster for providers and suppliers." Given the financial situation most states face, she is worried they will recoup money first and ask questions later to avoid a potential loss of FFP. "Providers can't take a lot of months of providing services without being paid."

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