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Payment Suspension for Credible Fraud Allegation Turns Up the Heat on Providers

Providers should brace for more Medicare and Medicaid payment suspensions based on a credible allegation of fraud. CMS and state Medicaid agencies may block payments to large swaths of providers in one fell swoop, which happened in the nation's capital this spring, and impose suspensions on a variety of services and care providers.

"If someone learns they are under investigation, they need to be prepared for the possibility — moving up to the probability — for payment suspension, especially on the Medicaid side," says San Francisco attorney Judy Waltz, with Foley & Lardner LLP.

Sec. 6402(h) of the Affordable Care Act requires the suspension of Medicare and/or Medicaid payments to a provider when there is a credible allegation of fraud unless there is "good cause not to suspend payments." Suspension of payments means shutting down some or all of a provider's Medicare cash flow while the allegation is investigated. The money is put in a suspense account — akin to escrow — and released to the provider only if a case is not pursued and there's no determination of an overpayment, Waltz says. Although Medicare payment suspensions max out at 18 months and can't last longer than six unless there are special circumstances (i.e., OIG or DOJ requests it), states decide for themselves how long Medicaid payment suspensions will last, Waltz says.

As defined in 2011 CMS interim final regulations, a "credible allegation of fraud" includes an allegation from patterns identified by audits, civil false claims cases, law enforcement investigations, hotlines and claims data mining, Waltz says. "Allegations are considered to be credible when they have indicia of reliability," the regulations state (42 CFR Sec. 405.370 for Medicare and 42 CFR Sec. 455.2 for Medicaid). CMS and states can skip payment suspensions for credible allegations of fraud if there is good cause (e.g., it would hinder beneficiary access or alert the target of an investigation). "A credible allegation is a much lower standard than what used to be required for payment suspensions," she notes.

There's more discretion on the Medicare side in terms of whether to suspend a provider's payments, Waltz says. But states must wield this axe unless they can meet a good-cause exception. If CMS thinks the state had grounds to suspend a provider's payments but failed to act, the state loses the federal share of Medicaid for the services that are in the vortex of a credible allegation of fraud, Waltz says.

Atlanta attorney Sara Kay Wheeler also sees more payment suspensions based on credible allegations of fraud, which can stem from a Medicare administrative contractor, zone program integrity contractor or other audit or investigation. "We have seen an increase in cases where payment suspensions are at issue," says Wheeler, who is with King & Spalding.

There's nothing stopping Medicare or Medicaid from suspending payments for a type of service — joint replacements or cardiac surgery, for example — rather than all payments to a provider based on a credible allegation of fraud, Waltz says, although she doesn't know of any cases like this yet.

Mass Payment Suspensions Are a New Tactic

But she noted that one new enforcement technique is mass payment suspensions of unrelated providers based on credible allegations of fraud. In Washington, D.C., for example, the Medicaid agency recently suspended payments to 52% of the city's home health agencies (HHAs) for personal care aid services. Although Judge Rosemary Collyer of the U.S. District Court for the District of Columbia on April 9 granted a temporary restraining order to stop the payment suspension, she later refused to grant permanent injunctive relief after considering the case in more depth. That left the payment suspensions in place, although two HHAs got their payment suspensions lifted and are back in Medicaid while six HHAs face Medicaid termination.

A sweeping payment suspension is eye-opening. "This is such a huge number of providers," Waltz says. "It is not clear how much differentiation the government can make between providers when these credible fraud allegations are evaluated. Some may be decent providers, some may not."

The D.C. Medicaid agency, the Department of Health Care Finance, suspended payments without notice to Premier Health Services, ABA Inc., Health Management

Inc., Immaculate Health Care Services and other agencies based on credible allegations of fraud. The Medicaid agency alleges the HHAs "repeatedly billed and [were] reimbursed for PCA services that were not supported by the documentation," the court decision states. While plans were made to transfer patients to other providers, the HHAs were required to continue providing services to Medicaid enrollees. After four weeks, the HHAs sued to force the city to pay them before they went broke, and for breach of contract, violation of their due process rights and other alleged wrongdoing. At an April 9 hearing, the HHAs persuaded the judge there was a good chance they would win their case, so she ordered the Medicaid agency to pay them retroactively and keep the money flowing. For their part, the HHAs had to keep providing personal care aide services because "there was an insufficient number of home health care providers in the District of Columbia to which to transfer Plaintiffs' patients."

But after the judge reviewed more court filings, she concluded the HHAs probably wouldn't prevail. For one thing, the judge wrote that "in contrast to a provider's right to participate in the Medicaid program, there is no constitutional right to receive Medicaid payments." Also, the Medicaid agency apparently acquired enough capacity to transfer the plaintiffs' patients to other providers so the HHAs don't have to keep treating them for free. And the judge wasn't persuaded the payment suspension would force the HHAs out of business because Medicaid pays them for other services, the May 9 decision states.

Finally, the HHAs should exhaust administrative remedies before seeking relief from the federal courts, the judge said. "Plaintiffs' failure to exhaust administrative remedies is yet another reason why they have not shown a likelihood of success here."

Ultimately, the outcome for the HHAs was mixed. Washington, D.C., attorney Brad Johnson, who represents Premier, said for his client, "the District of Columbia has not disclosed any evidence of fraud and the suspension has been withdrawn." After failing to get injunctive relief, Premier appealed the payment suspension to the Medicaid Office of Administrative Hearings (OAH). But the two sides worked it out, and everything is back to normal for Premier, which withdrew its appeal, Johnson says. Meanwhile, the Medicaid agency is terminating some of the HHAs, including ABA and Nursing Unlimited Services, from Medicaid. Their attorney, Reggie Richter, says he is appealing the terminations to OAH and once he files the paperwork, the terminations will be stayed pending a hearing. Richter is concerned that providers face payment suspension based on credible allegations of fraud they are not privy to. "I have reviewed what has happened in other states, and I think a problematic aspect of the law is you don't have the opportunity to basic due process," Richter says. "The government should not be able to make these claims without putting up the evidence against them." Meanwhile, he notes that KBC also got its payment suspension reversed and Immaculate and Health Management are allowed to provide Medicaid personal care aide services but their payment suspensions stand.

CMS has also suspended payments *en masse*. In cooperation with an HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (HEAT), CMS suspended the payments of 78 Dallas area HHAs, Waltz says. Last year's Health Care Fraud and Abuse Control program report says 297 providers are under "active suspension" from Medicare in fiscal year 2013 and 105 more suspensions were approved that year.

"Payment suspension is a powerful weapon," Wheeler says. "By the time the time period runs out, you could be out of money," especially if Medicare or Medicaid is one of your main payers.

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