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Protecting Medicaid Providers and Enrollees from Payment Suspensions Based on "Credible Allegations of Fraud:" A Lesson from New Mexico

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I. INTRODUCTION

A Medicaid antifraud initiative enacted as part of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010), 124 Stat. 119 (ACA) made it possible to quickly dismantle the greater part of New Mexico's behavioral health system in 2013.[1] This ACA initiative requires states to immediately stop payments to Medicaid providers based on a credible allegation of fraud (CAF) and to refer suspected providers to law enforcement for investigation.[2] However, for Medicaid service providers that do not operate with huge reserves, and for whom Medicaid recipients provide a significant portion of revenue, this ill-conceived federal mandate can put them out of business in a matter of weeks. As fifteen New Mexico behavioral health provider organizations[3] accused of Medicaid fraud soon

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[1] Ruth McCambridge, *10 New Mexico Nonprofits Punished out of Existence in Kafka-esque Purge*, NONPROFIT Q. (Feb. 8, 2016), https://nonprofitquarterly.org/a-big-purge-but-no-fraud-10-new-mexico-nonprofits-punished-out-of-existence/ (characterizing this as a "Kafka-esque Purge.").

[2] Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119 (2010).

[3] JOANNE M. CHIEDI, OFF. OF INSPECTOR GEN., U.S. DEP'T. OF HEALTH & HUM. SERVS., OEI-02-17-00490, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE 4-5 (Sept. 2019) ("While outpatient behavioral health services can be provided by individuals (and by individuals who form group practices), "behavioral health organizations (BHOs) are core providers that play a critical role in providing services to the State's Medicaid enrollees as well as to uninsured residents. BHOs include federally qualified health centers, community mental health centers, behavioral health agencies, rural health clinics, and core service agencies.")).

learned, the CAF law and its implementing regulations lack safeguards that have historically existed under common law to protect those accused of fraud, with predictable dire consequences.[4] Further, absent a right to expedited review and other protections under state law, Medicaid providers suspended based on CAF have little meaningful recourse. In 2013, New Mexico had no such law.

In 2013, New Mexico utilized a single managed care organization[5] for behavioral health services paid for in whole or in part by the state. OptumHealth New Mexico[6] (OptumHealth), the state's behavioral health managed care organization (MCO), instigated the suspension of payments due to fifteen Medicaid behavioral health provider organizations for services rendered.[7] The administration of Governor Susana Martinez suspended payments and referred the fifteen providers to the New Mexico attorney general for investigation. OptumHealth also took an early and active part in locating replacement providers from out of state, even before audits allegedly justifying these suspensions had begun. Despite the attorney general's later findings that the suspended providers had not engaged in fraud, the damage to their reputations and businesses — and to the 88,000 New Mexicans formerly receiving behavioral health services from them — had been done.[8] By the time they were exonerated by the attorney general, thirteen of the providers had gone out of business.[9] Of

[4] Memorandum from Everet Apodaca, N. M. Hum. Servs. Dep't Med. Assistance Div. (June 24, 2013) (on file with the author) (The fifteen suspended providers were " Partners in Wellness LLC, Easter Seals El Mirador, Southwest Counseling Center [Inc.], Hogares Inc., The Counseling Center [Inc.] , Border Area Mental Health Services [Inc.], Counseling Associates Inc., Families and Youth Inc., Valencia Counseling [Services Inc.], Southern New Mexico Human Development, Pathways Inc., TeamBuilders Counseling Services Inc, Presbyterian Medical Services, Service Organization for Youth, Youth Development Inc."), https://media.kjzz.org/s3fs-public/field/docs/2013/07/nmhsd-memo-15-audited-behavioral-health-providers.pdf.

[5] Niharika Namburi & Prasann Tadi, *Managed Care Economics,* NAT'L INST. OF HEALTH NAT'L LIBR. OF MED., (Jan. 2024), https://www.ncbi.nlm.nih.gov/books/NBK556053/ ("Managed Care is defined as a group of activities or techniques intended to control costs, utilization, and maintain quality of care through health insurance plans." According to the authors, managed care is a healthcare delivery system that integrates four basic healthcare delivery functions: finance, insurance, provider services, and payment).

[6] State of New Mexico Professional Services Contract 09-630-7903-0063 (Jan. 22, 2009) between the State of New Mexico Interagency Behavioral Health Purchasing Collaborative and United HealthCare Insurance Company and United Behavioral Health through their joint venture OptumHealth New Mexico (hereinafter *BHS Contract*); Chiedi, *supra* note 3, at 2.

[7] OFF. OF INSPECTOR GEN., U.S. DEP'T. OF HEALTH & HUM. SERVS., OEI-02-17-00490, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE (2019).

[8] *See infra* Part II(c) and (d).

[9] Chiedi, *supra* note 3, at 2.

the five Arizona-based behavioral health providers[10] brought in to replace the fifteen suspended providers, none remain in the state as of this writing.[11]

At the time of the suspensions, New Mexico's annual total behavioral health spending approached $250 million, all of it managed by OptumHealth.[12] Of this, more than 65% was spent on those under the age of eighteen; two-thirds of the state's behavioral health expenditures were for those under the age of twenty-one[13]; and two-thirds of all behavioral health clients were under the age of twenty-one.[14] These clients were "particularly vulnerable" and included "individuals with homicidal and suicidal ideation, children in foster care homes, and individuals dependent on psychotropic drugs."[15] The disruption of services[16] would lead many clients to disengage with treatment and lose access to medication — increasing the number of incarcerations, hospitalizations, overdoses and suicides.[17] According to many, New Mexico's behavioral health system has not recovered to this day.[18]

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[10] The five Arizona provider agencies were: La Frontera, Southwest Behavioral Health Services, Inc., Southwest Network, Lifewell and Valle Del Sol. Each of these agencies incorporated a non-profit entity in New Mexico to provide behavioral health services: La Frontera Center of New Mexico, Inc., Agave Health, Inc., Open Skies Health, Inc., Turquoise Health and Wellness, Inc. and Valle Del Sol of New Mexico, Inc.; Suppl. Aff. of Diana McWilliams, Exhibit 1 ¶10 (8/2/13) Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453 (D.N.M.) ("McWilliams Affidavit").

[11] Email No. 1 from Patricia Romero, CEO and President, Santa Maria El Mirador (former COO of Easter Seals El Mirador, one of the 15 New Mexico behavioral health providers discussed in this article) (Apr. 16, 2024) (on file with the author).

[12] *Annual Report 2012*, N.M. HUMAN SERVS. DEP'T, at 3 (2012) (stating figures for the fiscal year 2012).

[13] *Id.*

[14] *Id.*

[15] Border Area Mental Health Servs., Inc. v. Squier, No. 13-cv-00613, 2013 U.S. Dist. LEXIS 188209, 8 (D.N.M. July 25, 2013); E-mail from Patsy Romero, Chief Exec. Officer, Easter Seals El Mirador (May 26, 2020) (on file with the author). Easter Seals El Mirador provided services to seriously emotionally disturbed (SED) children and adolescents and to families of SED children, and to adolescents for substance abuse.

[16] E-mail from Brian Kavanaugh, Chief Exec. Officer, Families & Youth, Inc. (June 4, 2020) (on file with the author). Among the services lost: behavior management services, comprehensive community support services, respite, drug court, intensive outpatient, children's advocacy center, counseling services, multi-systemic therapy, treatment foster care, boys group home and shelter care, girls group home and shelter care, and psychiatric services.

[17] E-mail from Patsy Romero, Chief Exec. Officer, Easter Seals El Mirador, *supra* note 15.

[18] *See* Chiedi, *supra* note 3, at 2 (stating that this investigation was requested by New Mexico's congressional delegation following the 2013 "major disruptions in services, with the closure and replacement of many of [New Mexico's] largest behavioral health organizations"); *Our view- Cut the red tape then grow the behavioral health system,* SANTA

Following an in-depth exposition of the events leading up to and surrounding the suspensions of payments to the New Mexico behavioral health providers, this article will focus on the continuing threat posed to Medicaid providers by the flawed CAF provisions of the ACA. It will revisit Federal Rule of Civil Procedure 9(b)'s longstanding protections afforded those accused of fraud and contrast these protections with current draconian and absurdist CAF measures enacted by the federal government to stop Medicaid fraud "before it happens." Further, the article will direct attention to the Centers for Medicare and Medicaid Services' (CMS) policy of deference to state Medicaid agencies, and its refusal to intervene when a state misuses or abuses its CAF authority. Finally, it will spotlight yet another disruption to a state's system of care following ill-advised CAF suspensions of payments to behavioral health providers serving indigenous persons in connection with a breaking Medicaid fraud scandal in Arizona.[19]

A summary of challenges brought by Medicaid providers whose payments were suspended based on CAF, both in New Mexico and elsewhere, shows how little help is available administratively or through the courts without a state statute giving Medicaid providers a right of expedited review and other protections. In 2019, New Mexico enacted such a legislative workaround to require a preliminary process before the state Medicaid agency comes to a CAF determination and to afford providers expedited CAF review. [20] At the preliminary stage, the state Medicaid agency is required to disclose the factual and legal basis for each claim forming the basis of any alleged overpayment to the Medicaid provider.[21] If the provider requests, the state must meet informally with the provider in the hope of resolving misunderstandings or disputes early and with as little disruption to services as possible.[22] Should the state

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FE NEW MEXICAN ("The virtual destruction of New Mexico's behavioral health system more than 10 years ago still reverberates today.") (April 13, 2024), https://www.santafenewmexican.com/opinion/editorials/cut-the-red-tape-then-grow-the-behavioral-health-system/article_680d4a8a-f908-11ee-9738-4b9e2d3707f2.html.

[19] Hannah Bassett & Maria Polletta, *Patients, advocates describe 'pure chaos' in state response to AHCCCS fraud*, ARIZ. CTR. FOR INVESTIGATIVE REPORTING, Tucson.com (Nov. 6, 2023), https://tucson.com/news/state-regional/government-politics/patients-advocates-describe-pure-chaos-in-state-response-to-ahcccs- fraud/article_f3ee8be2-7a6c-11ee-8240-73873b8190f1.html.

[20] S.B. 41, 54th Leg., Reg. Sess. (N.M. 2019) (as sponsored by Senate President Pro Tempore Mary Kay Papen and signed into law by Governor Michelle Lujan Grisham, after Governor Susana Martinez left office).

[21] *See infra* Part VI, discussing elements of Medicaid Provider and Managed Care Act, S.B. 41 (2019).

[22] N.M. Stat. Ann. §§ 27-11-7(D)(3) and 27-11-8 (1978).

Medicaid agency later make a CAF determination followed by suspension of payments, the provider is afforded an expedited adjudicatory proceeding that can be appealed to a district court.[23] Other provisions are intended to keep the Medicaid provider solvent and its doors open during the CAF investigation, while protecting the public fisc.[24] Changes to New Mexico's law provide wrongly accused Medicaid providers with needed protections that are missing from the ACA's CAF initiative, rein in the state's Medicaid agency and should prevent future unnecessary disruptions of Medicaid services.

II. BACKGROUND

A. OptumHealth becomes the statewide entity for behavioral health

For years, New Mexico has had a shortage of mental health professionals.[25] This shortage is keenly felt in rural areas where approximately a quarter of New Mexicans live.[26] In 2005, to address these workforce and geographical challenges, New Mexico's public behavioral health services system blended and braided "all public monies for behavioral healthcare that had been administered" by over a dozen state agencies.[27]

The state, through a contract let by its Interagency Behavioral Health Purchasing Collaborative (Collaborative), used a single contractor to manage all behavioral health services that were funded by various state agencies.[28] Beginning in 2009, OptumHealth served as the "statewide entity" under a four-year contract, to have ended June 30, 2013.[29] Among its provisions, OptumHealth was paid a capitated rate[30] for Medicaid managed care, whereby OptumHealth assumed "full financial risk for all medical and administrative expenditures" for the applicable Medicaid

[23] N.M. Stat. Ann. §§ 27-11-9 - 27-11-11 (1978).
[24] N.M. Stat. Ann. §§ 27-11-13 - 27-11-14 (1978).
[25] *Health Professional Shortage Areas: Mental Health, by County, 2024 – New Mexico,* RURAL HEALTH INFO. HUB (Jan. 2024), https://www.ruralhealthinfo.org/charts/7?state=NM.
[26] U.S. CENSUS BUREAU, URBAN & RURAL DATA, 2010 & 2020.
[27] Cathleen E. Willging, et al., *The Transformation of Behavioral Healthcare in New Mexico*, ADMIN. POL'Y MENTAL HEALTH 1, 3 (2015) (discussing how the behavior health issues in New Mexico have changed consistently over the years).
[28] N.M. Stat. § 9-7-6.4 (1996) (stating that the agencies under the collaboration include: the Department of Health; the Human Services Department; the Children, Youth and Families Department; the Aging and Long Term Services Department; the Department of Finance and Administration; the Public Education Department; the New Mexico Corrections Department; and the Administrative Office of the Courts).
[29] *BHS Contract, supra* note 6, at 6.
[30] *Id.* at 126.

cohort.[31] The contract provided that the Human Services Department (HSD, the state Medicaid agency) would pay OptumHealth monthly capitation payments for all Medicaid managed care consumers enrolled as of the first day of the month.[32] According to the New Mexico Legislative Finance Committee (LFC), due to "technical issues," OptumHealth was "unable to provide meaningful encounter data to the HSD, leaving the capitated rate to be set based on estimates rather than actual claims data."[33] The LFC determined that in fiscal 2010, OptumHealth was paid "$243 million in capitation payments based on this alternate formula."[34] It is unknown whether these estimates continued to be used as a basis for monthly capitation rates or whether later rates were based on actual encounter data. It is also unknown whether the fiscal estimates were ever reconciled against actual encounter data to ensure that OptumHealth had not been overpaid in any given year.[35]

In August 2012, the contract between the State and OptumHealth was amended to, among other things, extend the term to December 31, 2013. OptumHealth was to receive an additional $43.3 million (of which $39 million was for Medicaid behavioral health with the remaining balance for non-Medicaid behavioral health).[36] Of note, this amendment also required OptumHealth to comply with the new suspension of payments provisions of the ACA based on CAF.[37] The amendment provided that recouped Medicaid funds were to be returned to the State.[38]

B. Performance problems plague OptumHealth throughout the contract

A few months into the contract, OptumHealth was placed under corrective action for various contract violations, including the lack of a fully functioning claims management system and its failure to make timely

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[31] *Id.* at 127.
[32] *Id.* at 128.
[33] *Medicaid Fraud, Waste, & Abuse Controls 27*, LEGIS. FIN. COMM., HUMAN SERVS. DEP'T & OFF. OF THE ATT'Y GEN. (July 14, 2011).
[34] *Id.*
[35] *Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks*, U.S. GOV'T ACCOUNTABILITY OFF., at 9 (July 2018) (CMS requires states to establish actuarially sound capitation rates to ensure program integrity. Inaccurate encounter data and overpayments that are not adjusted contribute to inaccurate capitation rates, which are considered payment risks for managed care).
[36] State of New Mexico Professional Services Contract Amendment No. 11, at 16 and 20 (Amendment to the *BHS Contract*) (Aug. 24, 2012).
[37] *Id.* at 3.
[38] *Id.* at 12.

claims payments, which put providers under financial strain and jeopardized consumer access to services.[39] As a result, OptumHealth was sanctioned $1 million for failure to timely pay claims. OptumHealth's costs were later reported to have exceeded revenue in fiscal years 2010 and 2011, "resulting in an operating loss for those two years."[40] OptumHealth's troubles did not end there. The contract required OptumHealth to "have and implement policies and procedures to address prevention, detection, preliminary investigation and reporting of potential and actual. . . provider fraud and abuse."[41] In addition, it provided that OptumHealth was "solely responsible for ensuring that it issues no payments for services for which it is not liable" under the contract.[42] In 2012 and 2013, whistleblower lawsuits were filed by OptumHealth insiders who claimed that they were fired in retaliation for reporting problems with OptumHealth's claims payment and fraud detection systems and practices.[43] Of note, both whistle-blowers were OptumHealth's own fraud investigators and one specifically alleged that OptumHealth had paid in error or "misplaced" approximately $4 million in state behavioral health funds.[44]

Since both of these lawsuits were filed under seal, the fact of their filing and the allegations raised in them remained a secret for years. Only the New Mexico Attorney General (and the U.S. Attorney in the second suit) would have known that the cases had been filed and about the specific system deficiencies and cover-up alleged by these whistleblowers.[45] Had these lawsuits been unsealed and made public in 2012 or 2013, the cumulative impact of the allegations would surely have compromised the state's Medicaid fraud and overpayment case against the fifteen behavioral health providers that is the subject of this article.

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[39] Linda R. Homer et al., *Update on OptumHealth NM,* at 2, 5, 6-9 (Nov. 18, 2009).
[40] *Final Report- Independent Assessment of New Mexico's Medicaid Program—Behavioral Health Statewide Entity,* HEALTHINSIGHT N. M., at 7 (June 28, 2013).
[41] *BHS Contract*, supra note 6, at 91.
[42] *Id.* at 150 (Language provided in Article 23.2).
[43] *See* United States ex rel. Clark v. UnitedHealth Group, No. 13-00372 MV/CG, 2016 U.S. Dist. LEXIS 140311 (D.N.M. Sep. 22, 2016).
[44] Tafoya v. New Mexico*,* 517 F. Supp 3d 1250, 1255 (D.N.M. 2021) (Approximately the amount of unrecouped overpayments reported by the monitor overseeing the corrective action).
[45] *See id.* (The *Tafoya* lawsuit remained under seal and thus out of the public eye for more than three years upon motion filed by the assistant attorney general who was in charge of the state's Medicaid Fraud Control Unit. Motions to extend the seal were filed on: November 15, 2012; May 10, 2013; November 22, 2013; and May 14, 2014, State of New Mexico *ex rel* Tafoya v. OptumHealth, *Inc.* et al. The *Clark* lawsuit only became public in July of 2015. Order (July 10, 2015) U.S. *ex rel* Clark v. UnitedHealthGroup, Inc. et al. lifting seal).

Shortly after the Medicaid provider suspensions, a state behavioral health official appearing before a legislative subcommittee explained that the suspensions were precipitated by an early 2012 "enhancement" to OptumHealth's program integrity protocols that changed the way that OptumHealth looked at its data.[46] She gratuitously added that OptumHealth had "always been in compliance" with previous protocols.[47] The effort to paint OptumHealth's past and present program integrity performance as fully compliant was surprising, given OptumHealth's earlier $1 million fine, the imposition of corrective action, and the LFC's earlier finding that OptumHealth was "unable to provide meaningful encounter data"[48]— data that would be critical to any program integrity responsibilities of either OptumHealth or the state.

On May 28, 2014, an OptumHealth compliance manager identified in the first whistleblower suit as having ordered employees to change dates, names and information on some documents and to destroy others was publicly charged with Medicaid fraud for falsification of documents, a fourth-degree felony.[49] This case involved the alteration of records to make it appear that OptumHealth was timely processing grievances from clients or providers about denials or reductions in behavioral health services, as required by its contract.[50] The acting director of the attorney general's Medicaid Fraud Control Unit (MFCU) told the press that this was not a typical case for the MFCU, as it involved the corporate office of a managed care organization.[51] The compliance manager eventually pleaded no contest to two of the ten counts in "a deal with the Attorney General's office that went largely unnoticed" until after OptumHealth's contract expired.[52]

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[46] Diana McWilliams, Dir. of the Behav. Health Servs. Div. of the N.M. Human Servs. Dep't & Chief Exec. Officer of the Interagency Behav. Health Purchasing Collaborative, Presentation at Behavioral Health Subcommittee: Update on Behavioral Health Servs. (Sept. 30, 2013).

[47] *Id.*

[48] *Medicaid Fraud, Waste, & Abuse Controls*, *supra* note 33.

[49] Justin Horwath, *Whistleblower suit alleges OptumHealth profited from false claims before shake-up,* SANTA FE NEW MEXICAN (Jan. 8, 2016), https://www.santafenewmexican.com/news/health_and_science/whistleblower-suit-alleges-optumhealth-profited-from-false-claims-before-shake-up/article_859ae809-4bc3-5313-9032- bec981ba161e.html.

[50] Colleen Heild, *AG: Behavioral health boss falsified records*, ABQ. J., (Oct. 10, 2014), https://wwww.abqjournal.com/477521/ag-behavioral-heallth-records-falsified.html.

[51] *Id.*

[52] Justin Horwath, *OptumHealth accused of fraud in three lawsuits*, SANTA FE NEW MEXICAN (Mar. 28, 2016), https://www.santafenewmexican.com/news/local_news/optumhealth-accused-of-fraud-in-three- lawsuits/article_63b6b337-fc01-5c89-a828-c573977fcdb2.html.

To summarize, evidence from various sources has revealed that while it served as the state-wide behavioral health managed care organization, OptumHealth's billing and claims processing system was not operating properly. It was being paid, at least in part, with state Medicaid funds for services that were not being performed as required by its contract and for which there were allegations of a cover-up.[53] OptumHealth's encounter data was faulty; its corrective action response led to further accounting errors and overpayments; and the system was not reliable enough to flag or act on potentially false or fraudulent claims. Even more, OptumHealth was losing money.

C. Laying the groundwork for the suspensions

Following the separate firings of its own fraud investigators in January and April of 2012, OptumHealth's management was concerned about being sanctioned once again by the state for noncompliance with its contract. According to yet another lawsuit, OptumHealth "helped trigger [a 2013] audit that led to the state's decision to halt funding to fifteen nonprofits that served the mentally ill and addicted" by contending that "it found questionable billing practices involving the providers."[54] According to La Frontera, one of the Arizona providers brought in to take over behavioral health services from the suspended providers, OptumHealth's exit strategy "was to cover up its defective data and claims processing system and its mismanagement of state and federal money by blaming its subcontracted providers for billing errors…characterized as 'institutional fraud'."[55]

It was no doubt easy for OptumHealth to convince Governor Susana Martinez, a former prosecutor, and her HSD Secretary to initiate a special program integrity project to follow up on so-called suspicious findings made by Optum for the fifteen behavioral health providers. Susana Martinez became New Mexico's Governor on January 1, 2011.[56] She was a former prosecutor and was considered a rising GOP star, garnering

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[53] *Id.*

[54] *Minutes of the Second Meeting of the Behavioral Health Subcommittee,* LEGIS. HEALTH & HUM. SERVS. COMM. (Sept. 3, 2013) (Deputy Secretary of HSD Brent Earnest tells committee members that OptumHealth referred 15 provider agencies to HSD for "suspicious billing activity" in November of 2012).

[55] Complaint at 45, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al., No. D-202-CV-2016-00857 (D.N.M. Feb. 9, 2016).

[56] Amber Phillips, *Once hailed as the GOP's ideal VP pick, Susana Martinez finds herself clashing with Donald Trump*, THE WASH. POST (May 25, 2016), NAT'L GOVERNOR'S ASS'N https://www.nga.org/governor/susana-martinez/.

national attention when she spoke at the Republican National Convention in late August of 2012.[57] And she was coming up for re-election. The prospect of becoming known for being tough on Medicaid fraud would have been hard to resist. To be fair, in a report issued six months after she became governor, LFC had been critical of the state's return on investment in reducing Medicaid fraud, waste and abuse.[58] In its report, LFC urged HSD to do a better job of identifying and stopping Medicaid fraud.[59] It recommended that HSD "pursue punitive sanctions or phase out terminations of providers guilty of fraud, waste, and abuse to allow other providers to come in and establish themselves, minimizing service disruption."[60]

Further, the end of OptumHealth's contract (December 2013) coincided with the Martinez administration's plans to modernize the state's Medicaid program (branded in honor of New Mexico's 100 years of statehood as "Centennial Care") by integrating behavioral health with physical health, thus eliminating the need for a separate managed care organization for behavioral health services.[61] As one door was closing for OptumHealth, another opened for one of its affiliates. By early Spring of 2013, United Healthcare Community Plan of New Mexico was one of four managed care organizations chosen by HSD's Medicaid division to implement "Centennial Care," the state's re-imagined Medicaid program.[62]

The decision to replace the New Mexico behavioral health providers had been made long before the suspensions were announced on June 24, 2013; events taking place for months beforehand were designed to justify the decision after the fact and ensure that there would be no going back. In mid-November 2012 and again in January 2013, OptumHealth contacted La Frontera to discuss replacing an existing New Mexico contracted behavioral health provider.[63]

Among its duties as the statewide entity, OptumHealth (in conjunction with the HSD Inspector General) was responsible for conducting program

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[57] KOAT, *Full Speech: Gov. Susana Martinez at the RNC,* YOUTUBE (Aug. 30, 2012), https://www.youtube.com/watch?v=_b0yuSTVARc.
[58] *Medicaid Fraud, Waste, & Abuse Controls, supra* note 33 at 8.
[59] *Id*. at 29.
[60] *Id*.
[61] *Annual Report 2012*, *supra* note 12 at 9 (explaining that the new Medicaid program, called "Centennial Care" was to be fully implemented by January 1, 2014).
[62] Julie Weinberg, Dir. of the Med. Assistance Div., N.M. Hum. Servs. Dep't, Presentation to the Legislative Health and Human Services Committee on Centennial Care Update to the LHHS (Oct. 21, 2014).
[63] La Frontera Center, Inc. v. United Behavioral Health, Inc. et al., No. D-202-CV-2016-00857 (D.N.M. Feb. 9, 2016) at 13.

integrity activities for the state's behavioral health services that OptumHealth administered.[64] Despite OptumHealth's existing program integrity obligations, HSD executed a contract in early February 2013 with Public Consulting Group ("PCG") for an intensive audit[65] of the fifteen behavioral health providers flagged by OptumHealth.[66] Perhaps HSD's decision to conduct this extraordinary audit was driven by concern that suspensions based solely on information derived from OptumHealth's defective billing and claims payment system would not hold up if later challenged in court. When questioned repeatedly by legislative committee members about why OptumHealth's own fraud detection system failed to stop any alleged fraud over the three-year period covered by the PCG audit, the Martinez administration had OptumHealth's back.[67]

On February 25, 2013, HSD requested approval to enter emergency procurement contracts with two Arizona behavioral health providers (including La Frontera) before the PCG audits were concluded, with an option to extend the contracts. Three days later, the head of the Collaborative, an OptumHealth executive and a representative of PCG met in Arizona with executives from the two Arizona providers.[68] Soon, HSD would bring in a total of five Arizona companies to replace the fifteen New Mexico behavioral health providers.[69]

In a 2016 lawsuit seeking payment from OptumHealth for services rendered during this manufactured "emergency," La Frontera would claim that OptumHealth fraudulently induced it to become a replacement

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[64] *Cost & Outcomes of Selected Behavioral Health Grants & Spending 8,* LEGIS. FIN. COMM., HUMAN SERVS. DEP'T (May 16, 2013).

[65] *See* Section II (d), *infra* (Relating later findings of the state auditor that the PCG audit violated HSD's own procedures for evaluating allegations of fraud.).

[66] *Professional Services Contract*, STATE OF N.M. HUM. SERVS. DEP'T (2013) (The state paid PCG $3 million to conduct the audit; *See Cost & Outcomes of Selected Behavioral Health Grants & Spending*, *supra* note 64 at 7).

[67] Sidonie Squier, Secretary, New Mexico Human Services Department, Appearance before the Legislative Health and Human Services Committee (July 3, 2013) (HSD Secretary Sidonie Squier told committee members that OptumHealth had been making fraud referrals all along, but that an "updated" and "new" process gave HSD more information than before, and that OptumHealth "was doing what it was supposed to do." An HSD handout from the meeting states, "In early 2012, OptumHealth implemented an enhanced software system designed to more efficiently detect potential fraud, waste and abuse to assist in monitoring providers within its network." Referencing Behavioral Health Provider Audit Results from June 24, 2013) (on file with the author).

[68] Suppl. Aff. of Diana McWilliams (8/2/13); Border Area Mental Health Servs., Inc. v. Squier, No. 13-cv-00613, 2013 U.S. Dist. LEXIS 188209, at *8 (D.N.M. July 25, 2013).

[69] Dan McKay, *State settles for $484 after $2.8M demand*, ABQ. J., https://www.abqjournal.com/1022848/nms-overpayment-demond-falls-from-2-8m-to-485.html (last visited June 23, 2017).

behavioral services provider. According to La Frontera, OptumHealth misrepresented that OptumHealth had "a fully functional information management system for all data validation and required reporting on Medicaid and non-Medicaid" enrollees and a "claims processing and adjudication system" that "would easily interface with La Frontera for prompt payment of claims for services."[70]

D. The PCG audit

The fact that HSD had already chosen and contracted with Arizona providers to replace the accused New Mexico behavioral health providers before PCG started the audit was only the first of many irregularities leading to questions regarding the audit. The audited providers complained about PCG's loss or mishandling of provider electronic data and scanned files during the audit, about not being afforded a closing meeting and of not being provided with the audit findings or given an opportunity to respond to them.[71] A PCG employee would later testify at an administrative hearing that PCG's common practice was to meet with audited providers following an audit to ensure that all relevant documents were collected and reviewed; in this case, however, HSD refused to allow PCG to do this follow-up.[72]

Following its audit of 150 randomly chosen claims from each provider, PCG advised HSD that 71% of the providers failed the audit's initial criteria.[73] Using "an audit tool developed and refined through auditing behavioral health providers nationally and tailored to New Mexico's payment regulations," and "a statistically significant extrapolation methodology," PCG claimed to have identified more than $33.8 million in overpayments to the fifteen providers over a three-year period (2009-

[70] La Frontera Center, Inc. v. United Behavioral Health, Inc. et al., No. D-202-CV-2016-00857 (D.N.M. Feb. 9, 2016) at 97 (explaining that the participating provider agreement between La Frontera and United Behavioral Health contained an arbitration clause. After being brought in by HSD and OptumHealth to take over for suspended behavioral health providers, La Frontera alleged that it sustained losses of several million dollars over the latter half of 2013. When it remained unpaid, La Frontera filed suit against various United Healthcare affiliates, including OptumHealth.

[71] Letter from Easter Seals El Mirador to Sen. Mary Kay Papen, Sen. Michael Sanchez, & Rep. Brian Egolf (Apr. 19, 2016).

[72] Knicole C. Emanuel, *New Mexico Leads the Nation in Ground-Breaking Legislation in Support of Medicaid Providers*, MEDICAID & MEDICARE: A LEGAL BLOG, https://medicaidlawnc.com/2019/04/05/new-mexico-leads-the-nation-in-ground-breaking-legislation-in-support-of-medicaid-providers/ (last visited Jan. 27, 2023).

[73] Border Area Mental Health Servs., Inc. v. Squier, No. 13-cv-00613, 2013 U.S. Dist. LEXIS 188209, at 4 (D.N.M. July 25, 2013).

2011). In addition, PCG claimed to have found an additional $2.1 million in overpayments to the same providers over the same period using longitudinal reviews, for a total of $36 million in overpayments.[74]

On June 21, 2013, representatives of HSD and PCG met with members of the MFCU, the United States Attorney's Office and the New Mexico Taxation and Revenue Department to present the audit findings.[75] Based on its determination that the audit findings were "credible allegations of fraud," HSD referred the fifteen providers to the MFCU and the MFCU accepted the referrals for investigation.[76] Shortly before this meeting, OptumHealth's contract had been amended to specify that OptumHealth would receive a percentage of the state share of any CAF recovery based on allegedly fraudulent claims identified by OptumHealth.[77]

On June 24, 2013, HSD and PCG met with the fifteen providers to advise them of the referrals to the MFCU based on CAF.[78] At this meeting, HSD gave the providers an "audit summary" and letter advising each provider that HSD was suspending payments effective immediately pursuant to 42 C.F.R. §455.23(a)(1).[79] Each letter advised the provider that the payment suspension would be "temporary" and in effect until: "(1) the prosecuting authorities determine that there is insufficient evidence of fraud, or alleged fraud or willful misrepresentation by the provider; or (2) legal proceedings related to the provider's alleged fraud or willful misrepresentation are completed."[80] Just two weeks before the meeting with the providers, the last signature had been inked on another amendment to Optum's contract with the state, giving OptumHealth a percentage of the non-federal (i.e. state) share recovered for false or fraudulent claims identified by OptumHealth.[81] This would give OptumHealth a share of any funds recovered from the fifteen suspended

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[74] *Behavioral Health Provider Audits Executive Summary*, STATE OF N.M., HUM. SERVS. DEP'T (conducted by Pub. Consulting Group), https://s3.documentcloud.org/documents/726527/ag-disclosure-redacted-behavioral-health-audit.pdf (In February 2013, the New Mexico Human Services Department (HSD) contracted with Public Consulting Group, Inc. to audit fifteen mental health and substance providers state wide. HSD published Public Consulting Group's findings).

[75] Border Area Mental Health Servs., Inc. v. Squier, 524 F. App'x 397 (10th Cir. 2013), (D.N.M. July 25, 2013).

[76] *Id*. at 2.

[77] State of New Mexico Professional Services Contract Amendment No. 15 (Contract No. 09-630-7903-0063 A 15), Art. 46.4 (executed by OptumHealth's CEO on May 17, 2013 and by HSD's CFO on May 22, 2013) (on file with the author).

[78] Border Area Mental Health, 524 F., at 2.

[79] *Id.*

[80] *Id.* at 6.

[81] *See* Amendment No. 15, *supra* note 77.

behavioral health providers. The PCG audit and this amendment would be raised in yet a third whistleblower lawsuit filed by an HSD attorney who alleged that she was fired for questioning HSD's: 1) hiring of PCG to conduct auditing that OptumHealth was contractually obligated to perform; 2) failure to seek return of funds paid to OptumHealth for these unperformed program integrity services; and 3) award of a sole source contract to PCG in violation of the state's Procurement Code.[82]

Following the June 24 meeting with providers, HSD announced in a press release that it had suspended payments to the fifteen providers.[83] Responding to a public records request, HSD released the names of the suspended providers to the *Albuquerque Journal*, which ran an article on June 26, 2013 identifying the accused providers by name and reporting that they were suspended "after an audit the state Human Services Department said showed widespread mismanagement and possible fraud" on the part of "some of the biggest New Mexico players in behavioral health."[84]

After the suspensions, a legislative behavioral health subcommittee convened to look into "the fallout."[85] According to the meeting minutes, "One subcommittee member expressed great concern about reports that hospitals in Las Cruces and Silver City [were] being flooded with clients who had been turned away" [86] by one of the Arizona replacement providers. Another legislator reported hearing that the transition from one behavioral health provider to an Arizona replacement agency was "chaotic."[87] Yet another expressed concern about employees who lost jobs and benefits when their agencies were replaced.[88]

A year later, in the course of conducting its fiscal 2013 financial audit of HSD and responding to concerns of a legislative committee about the suspension of payments to the majority of the state's behavioral health providers, the state auditor was forced to go to court to obtain a copy of

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[82] Steve Terrell, *Suit: State attorney fired after audit complaint*, SANTA FE NEW MEXICAN (Aug. 31, 2013), https://www.santafenewmexican.com/news/local_news/suit-state-attorney-fired-after-audit-complaint/article_2a2d1396-8c94-521e-9f58-55ab628fd3f8.html.

[83] Border Area Mental Health Servs., Inc. v. Squier, 524 F. App'x 387, 388 (10th Cir. 2013).

[84] *Id*.

[85] *Minutes of the Second Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee,* BEHAV. HEALTH SUBCOMM. OF THE LEGIS. HEALTH & HUMAN SERV. COMM. (Sept. 3, 2013) [hereinafter *Minutes of the Second Meeting*].

[86] *Id* at 4.

[87] *Id.* at 5.

[88] *Id*. at 4-5.

the PCG audit from HSD.[89] A troubling discovery made by the state auditor's staff was the existence of an earlier draft of the audit which stated that PCG "did not uncover what it would consider to be credible allegations of fraud nor any significant concerns about consumer safety."[90] This statement had been removed by HSD from the PCG audit report that was produced to the State Auditor pursuant to court order.[91] It led the State Auditor to comment that he was "troubled by HSD's alteration of a state record referred to law enforcement authorities, its noncompliance with a court order, and its general lack of transparency related to the PCG report."[92]

Equally troubling, the State Auditor identified a "significant deficiency" regarding HSD's procedures for investigating allegations of fraud.[93] In brief, the lead-up to the behavioral provider suspensions deviated from HSD's own written procedures, circumventing its "established process for receiving, evaluating, concluding or referring allegations of fraud to the Attorney General's MFCU."[94]

E. The pitfalls of extrapolation[95]

Legal counsel for providers should be aware that the use of extrapolation in Medicaid recovery audits such as that conducted by PCG is an accepted approach to estimate overpayments based on a sampling of a subset of claims from a larger population of claims.[96] As one commentator notes, "with extrapolated results, auditors allege millions of

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[89] Letter from Hector H. Balderas, State Auditor, Off. of the State Auditor to State Rep. Elizabeth "Liz" Thomson, Chair, and State Sen. Benny Shendo, Vice-Chair, Behav. Health Subcomm. (July 24, 2014), https://www.nmlegis.gov/(X(1)S(ddmpmqsfmr0ydr3i2f0djbdl))/handouts/BHS%20072414%20Item%201%20Hector%20H.%20Balderas,%20Report%20from%20the%20Office%20of%20the%20State%20Auditor.pdf.

[90] *Id*. at 3.

[91] *Id*.

[92] *Id*.

[93] *Id.* at 4.

[94] *Id*.

[95] Extrapolation could easily be the topic of an article all its own, and the author does not intend to provide an exhaustive treatment of this subject. Rather, it is discussed to the extent that the amount of extrapolated overpayments ($36 million) was a driving force behind the actions of the Martinez administration in suspending payments based on CAF, and in the administration's dogged pursuit of inflated amounts of overpayments from the New Mexico providers in later administrative proceedings, even after the New Mexico Attorney General's investigations found no evidence of fraud.

[96] Knicole C. Emanuel, *CMS Revises and Details Extrapolation Rules*, MEDICAID & MEDICARE: A LEGAL BLOG (Nov. 26, 2019, 12:11 PM), https://medicaidlawnc.com/2019/11/26/cms-revises-and-details-extrapolation-rules/.

dollars of overpayments against healthcare providers — sometimes a sum of more than the provider . . . made during the relevant time period . . . ."[97] However, it goes without saying that mistakes in the audit process itself or sampling errors necessarily invalidate any extrapolations based upon them.

On the agenda of one of the early meetings of the legislative behavioral health subcommittee following the suspensions was a presentation from a North Carolina attorney with first-hand experience with PCG's Medicaid provider recovery audits.[98] Knicole Emanuel, a specialist in Medicaid appeals, explained the use of extrapolation by Medicaid recovery audit contractors such as PCG, and gave specific examples of problems with a PCG audit of one of her clients, conducted at approximately the same time as the PCG audits of the New Mexico providers.[99] In that case, PCG's extrapolated overpayment amount of $702,611 was reduced to $336.84 on appeal.[100] Ms. Emanuel advised the committee that nationally, 72% of denied payments, such as those withheld from the New Mexico providers, are overturned on appeal.[101] However, she added, it was up to states to provide those appeal rights under state law.[102] As noted earlier, in 2013 New Mexico had no law affording a timely appeal to providers whose Medicaid payments had been suspended.

Six years later, after numerous administrative proceedings and ten lawsuits filed by the suspended providers, not only were there no findings of fraud, but PCG's $36 million in extrapolated overpayments, and later extrapolations performed by the state after it abandoned the PCG audit findings,[103] were a fraction of original estimates.[104] Examples include: a $2.8 million demand to one provider, reduced to $484.71;[105] another

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[97] *Id.*
[98] *Minutes of the Second Meeting, supra* note 85.
[99] *Id.*
[100] *Id.*
[101] *Id.*
[102] *Id.*
[103] *Minutes of the Second Meeting*, *supra* note 85 at 7.
[104] Robert Nott, *Behavioral health groups settle with state of New Mexico*, SANTA FE NEW MEXICAN (Dec. 4, 2019), https://www.santafenewmexican.com/news/health_and_science/behavioral-health-groups-settle-with-state-of-new-mexico/article_8075db49-20b4-50a7-8bb4-d14ba977c881.html.
[105] Trip Jennings & Sylvia Ulloa, *State's 'credible allegations of fraud' charge against health providers falls apart,* NMPOLITICS.NET (July 1, 2017), https://nmpolitics.net/index/2017/07/states-credible-allegations-of-fraud-charge-against-health-providers-falls-apart/.

provider's alleged overbilling of $856,745 was reduced to zero;[106] and another provider's alleged overpayments went from a high of $12 million to $896.00.[107]

F. Four million dollars

While one purpose of pay suspensions is to protect a state's ability to recover lost funds while an investigation is ongoing, "for a provider dependent on Medicaid reimbursements, the withholding power could be used as a cudgel to force settlement without the need for the State to prove its case in a legal proceeding."[108] One of the accused New Mexico behavioral health providers was a federally qualified health center that employed 230 employees statewide and provided services to approximately 5,400 clients at the time of the suspensions.[109] Following its pay suspension, Presbyterian Medical Services (PMS) filed a request with HSD for a "good-cause exception not to suspend payments."[110] While HSD did not formally deny the request, HSD representatives told PMS that no exception would be granted until the attorney general's office completed its investigation.[111] However, HSD was willing to discuss a settlement.[112]

The PCG audit concluded that PMS had overbilled the state by $4.3 million.[113] Apparently, a factor in PCG's findings were missing documents (such as PMS employee credentials and training records) in the files that PCG reviewed.[114] PMS looked for and located the documents in question and had the resources to conduct its own audits, which did not

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[106] Sylvia Ulloa, *With agreement in hand, behavioral health CEO believed vindication was inevitable*, N.M. IN DEPTH (July 17, 2017), https://nmindepth.com/2017/07/17/with-agreement-in-hand-fyi-leader-knew-vindication-was-inevitable/.
[107] Jennings & Ulloa, *supra* note 105.
[108] Matter of Able Health Servs., Inc. v. N.Y. State Off. of the Medicaid Inspector Gen., 67 N.Y.S. 3d 755, 772 (N.Y. 2017).
[109] Doug Smith & Bill Belzner, Presentation to Presbyterian Medical Services: Report on Behavioral Health Services and Capacity, (Oct. 2014), https://www.nmlegis.gov/handouts/BHS%20100814%20Item%203%20Doug%20Smith%20EVP%20and%20Bill%20Belzer%20Dir%20BH,%20Presbyterian%20Medical%20Services%20Report%20on%20Behavioral%20Health%20Services%20and%20Capacity.pdf.
[110] *Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee,* BEHAV. HEALTH SUBCOMM. OF THE LEGIS. HEALTH & HUM. SERV. COMM. (Oct. 8, 2014) [hereinafter *Minutes of the Third Meeting*].
[111] *Id*.
[112] *Id*.
[113] Trip Jennings, *State refused evidence that refuted audit, health provider says*, N.M. IN DEPTH (Oct. 10, 2014), http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/.
[114] *Id*.

support PCG's findings.[115] PMS offered the missing documents to PCG for review, but HSD would not allow PCG to consider this exculpatory evidence.[116] In fact, PMS staff had "worked regularly" with OptumHealth and "regular audits" by OptumHealth gave PMS scores of between 88 to 97%.[117] Of note, similar favorable dealings with, and previous high audit scores from, OptumHealth were reported by the other suspended providers.[118]

To avoid letting hundreds of employees go and to continue serving its behavioral health clients, PMS's management made a painful but pragmatic decision to compromise and settle with the state, without believing or admitting that it was liable for any overpayments.[119] However, there was no negotiating when it came to the amount of the settlement. According to Presbyterian officials, HSD refused to settle for less than $4 million.[120] PMS and HSD entered into a settlement of disputed claims in the amount of $4 million approximately four months following the suspensions.[121] OptumHealth's chief executive officer was involved in settlement discussions, according to a PMS executive who appeared before a legislative subcommittee.[122]

In a presentation to the legislative subcommittee, PMS officials told legislators that, under the terms of a non-disclosure agreement with the state, PMS was required to return all the documents that had been disclosed to it by the state during the course of settlement negotiations and that the state had required PMS to destroy all of its own internal review and analysis of the PCG audit.[123] The settlement also required PMS to sever

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[115] *Id.*; *see also*, *Minutes of the Third Meeting* (Oct. 8, 2014), (according to PMS, after it conducted its own internal audit, there were "zero findings . . . absolutely no fraud". Presbyterian reportedly spent approximately $300,000 on its legal defense and $1 million in internal costs to marshal evidence and conduct its self-audit).

[116] *Minutes of the Third Meeting*, *supra* note 110.

[117] *Id.*

[118] *See Minutes of the First Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee*, BEHAV. HEALTH SUBCOMM. OF THE LEGIS. HEALTH & HUM. SERV. COMM. at 6 (July 9, 2013) [hereinafter *Minutes of the First Meeting*]. The CEO of Counseling Associates, Inc. told legislators that her organization was required to pass "rigorous audits repeatedly" and had "passed these audits and reviews at a 90% or 100% pass rate."

[119] Trip Jennings, *State refused evidence that refuted audit, health provider says*, N.M. IN DEPTH (Oct. 10, 2014), http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/.

[120] Jennings, *supra* note 119.

[121] *Id.*

[122] *Minutes of the Third Meeting*, *supra* note 119, at 8.

[123] Jennings, *supra* note 119; *See* Non-Disclosure Agreement between State of New Mexico Hum. Servs. Dep't and Presbyterian Medical Servs., Inc., 3-4 (Sept. 4, 2013),

all ties to another of the suspended providers, TeamBuilders, Inc., and to TeamBuilders affiliates — including a joint venture between PMS and TeamBuilders in another nonprofit, Partners in Wellness, LLC.[124]

G. Epilogue

For years following the 2013 suspensions and resulting disruption to New Mexico's behavioral health system, the Martinez administration claimed that not only were disrupted services restored under "Centennial Care," the state's reorganized Medicaid managed care program, but that more New Mexicans were receiving behavioral health services than ever before.[125]

Even before the suspensions, LFC reported to legislators that state behavioral health services reporting was "not of good quality and does not allow a real assessment of behavioral health service needs in the state," and that "[it] is almost impossible to reconcile OptumHealth and HSD reporting."[126] Following the suspensions and anecdotal reports indicating problems with access to behavioral health services under "Centennial Care," New Mexico's congressional delegation requested the Office of Inspector General of the U.S. Department of Health and Human Services ("OIG") to look into provider shortages and the availability of behavioral health services for those enrolled in Medicaid managed care.[127]

Moving from a single statewide managed care organization (OptumHealth) for behavioral health services to "Centennial Care," in which behavioral health services were "carved back in" or "integrated" with physical health services, does not appear to have increased access to behavioral health services as the Martinez administration claimed. Four years after the suspensions, using managed care data from HSD for

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https://s3.documentcloud.org/documents/1311557/pms-non-disclosure-agreement-executed.pdf [hereinafter Non-Disclosure Agreement] (requiring in Section 8 the return or destruction of the PCG audit findings, any underlying data supporting the findings and "any other related information" including information derived from the PCG audit findings).

[124] Non-Disclosure Agreement, *supra* note 123, at 3.

[125] New Mexico's Medicaid enrollment increased significantly after the state expanded Medicaid on January 1, 2014, under the ACA. Assessments were required of Medicaid expansion recipients that would have included behavioral health diagnoses, if present, with more people eligible for Medicaid behavioral health services than previously. Jennings, *supra* note 119.

[126] *Minutes of the First Meeting, supra* note 118, at 8.

[127] Chiedi, *supra* note 3.

calendar year 2017,[128] and information from a 2017 report on the state's health care workforce,[129] the OIG found that:

- only thirty percent of active licensed behavioral health providers served Medicaid enrollees;
- more than half of New Mexico's counties had fewer than two licensed providers per 1,000 enrollees;
- only twenty-nine percent of licensed behavioral health providers were located in rural and frontier counties, where nearly half of Medicaid managed care enrollees reside; and
- "ten frontier counties with a Medicaid managed care enrollee population of 27,000 had no prescribers."[130]

Further, the OIG found that of those licensed behavioral health providers that served Medicaid enrollees, 62% worked for behavioral health organizations ("BHOs")[131] — such as the fifteen suspended providers. Over 70% of BHOs surveyed by the OIG reported "challenges with finding and retaining staff."[132] Many reported that enrollees experienced "difficulty accessing the full range of behavioral health services" as often as needed and had problems getting timely appointments, with some BHOs maintaining wait lists.[133]

Six years after the suspensions, under a new administration, HSD announced that it would pay $10 million to settle the claims of the last of the suspended behavioral health providers that had sued the state challenging the suspensions and the amounts of alleged overpayments, and that had sought damages for injuries to their businesses and reputations.[134]

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[128] Chiedi, *supra* note 3, at 2 (describing data including the total number of Medicaid managed care enrollees for each county and identifying each discrete provider of behavioral health services).
[129] *Id.* at 31.
[130] *Id.* at 7-8.
[131] *Id.* at 9.
[132] *Id*.
[133] *Id.* at 9-10.
[134] News Release, Human Services Department, New Mexico Human Services Department reaches settlement agreement with five behavioral health providers: Santa Maria El Mirador (formerly Easter Seals El Mirador), Border Area Mental Health Services, Southwest Counseling Center, Inc., Southern New Mexico Human Development, Inc. and Families and Youth, Inc. (Dec. 4, 2019) (on file with the author); *see also* Dan Boyd, *Two more mental health providers settle claims with NM*, ABQ. J. (Aug. 22, 2019) (discussing New Mexico's settlement with TeamBuilders Counseling Services for more than $1.9 million, with TeamBuilders agreeing to repay slightly more than $107,000 in disputed overpayments, and with Counseling Associates for more than $173,000, with Counseling Associates agreeing to pay nearly $11,900 in disputed overpayments), https://www.abqjournal.com/1356802/two-more-mental-health-providers-settle-claims-with-nm.html; *see also* News Release, Human

As part of the settlement, HSD agreed to release over $300,000 in remaining disputed overpayments from the registry of the court to three of the providers, with shares of the $10 million allocated among the five settling providers.[135] In a stunning reversal of HSD's unwavering defense of the suspensions and dogged pursuit of inflated overpayments, the news release issued by HSD regarding the settlement welcomed the formerly suspended and maligned providers back into the fold. According to the news release, Governor Michelle Lujan Grisham had charged HSD to "fix New Mexico's broken behavioral health system," tasking the new HSD Secretary to "work together with these providers and others" to build "a new behavioral health care system" with "new and expanded services" and to "ensure that what happened in 2013 never happens again."[136]

III. PROTECTING THOSE ACCUSED OF FRAUD

What happened to 15 Medicaid behavioral health providers in New Mexico in 2013 would not have happened if the ACA's credible allegation of fraud initiative had afforded them the same longstanding jurisprudential protections enjoyed by any other business accused of fraud.

A. Federal Rule of Civil Procedure 9(b) safeguards those accused of fraud

Federal Rule of Civil Procedure 9(b) ("Rule 9(b)") requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."[137] With respect to fraud, this rule "perpetuates the practice that existed at common law and under the codes, as well as the English procedure under the Judicature Act as it existed at the time the Federal Rules of Civil Procedure were promulgated."[138] According to *Wright & Miller*, "innumerable federal courts" have stated that Rule 9(b) "is necessary to safeguard potential defendants from lightly made claims charging the commission of acts that involve some degree of moral turpitude."[139] For business entities (such as

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Services Department, New Mexico Human Services Department reaches settlement with three behavioral health providers: Hogares, Inc [sic]; Valencia Counseling Services, Inc.; and The Counseling Center, Inc. (July 9, 2019) (on file with the author).

[135] *Id.*

[136] *Id.*

[137] FED. R. CIV. P. 9(b).

[138] 5A ARTHUR R. MILLER ET AL., FEDERAL PRACTICE & PROCEDURE §1296 (4th ed. Oct. 2020) ("*Wright & Miller*").

[139] *Id.*

health care providers) that engage "in a high volume of transactions," particularized information is critical to mounting a defense.[140]

Rule 9(b) "serves an important purpose in fraud actions by alerting defendants to the 'precise misconduct with which they are charged' and protecting defendants against spurious charges of immoral or fraudulent behavior."[141] "It is a serious matter to charge a person with fraud and hence no one is permitted to do so unless he is in a position and is willing to put himself on record as to what the alleged fraud consists of specifically."[142] This "heightened pleading requirement imparts a note of seriousness and encourages a greater degree of pre-institution investigation by the plaintiff."[143]

Rule 9(b) requirements are met "if the complaint sets forth:

> (1) precisely what statements were made in what documents or oral representations or what omissions were made, and
>
> (2) the time and place of each such statement and the person responsible for making (or, in the case of omissions, not making) same, and
>
> (3) the content of such statements and the manner in which they misled the plaintiff, and
>
> (4) what the defendant 'obtained as a consequence of the fraud.'"[144]

Health care fraud is often the subject of False Claims Act (FCA)[145] cases and the relators are typically whistleblowers with specialized insider

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[140] *Id.*

[141] Brooks v. Blue Cross and Blue Shield of Fla., 116 F.3d 1364, 1370-71 (11th Cir. 1997), *reh. denied*, 116 F. 3d 1495 (11th Cir. 1997) (citing to Durham v. Bus. Mgmt. Assocs., 847 F.2d 786, 791 (3rd Cir. 1984), *cert. denied*, 469 U.S. 1211, 105 S. Ct. 1179, 84 L Ed. 2d 327 (1985)).

[142] Gamm v. Sanderson Farms, Inc., 944 F. 3d 455, 464 (2d Cir. 2019) (holding that facts of the underlying illegal acts supporting a claim for securities fraud under the Private Securities Litigation Reform Act must be pleaded with particularity in accordance with Rule 9(b) and the Act).

[143] Miller et al., *supra* note 138.

[144] *Brooks,* 116 F.3d at 1371 (citing Fitch v. Radnor Industries, Ltd., No. 90-2084, 1990 WL 150110 at *2 (E.D. Pa. Sept. 27, 1990) (quoting O'Brien v. Nat'l Prop. Analysts Partners, 719 F. Supp. 222, 225 (S.D.N.Y. 1989); *See also* Fearrington v. Boston Sci. Corp., 410 F. Supp. 3d 794, 807 (S.D. Tex. 2019) ("[A]llegations must include the time, place, and contents of the alleged false representations, as well as the identity of the person making the representation and what was fraudulently obtained" and where plaintiff pleads no details, her fraud allegations fail as a matter of law); *see also* Holley v. Gilead Sci., Inc., 410 F. Supp. 3d 1096, 1101 (N.D. Ca. 2019) ("[A]verments of fraud must be accompanied by the who what, when, where and how of the misconduct charged.").

[145] 31 U.S.C. § 3729.

knowledge.[146] The requirement to plead fraud with particularity applies to claims made pursuant to the FCA and analogous state statutes.[147] In fact, OptumHealth raised Rule 9(b) lack of specificity as grounds to dismiss an employee whistleblower's complaint under the FCA and New Mexico's Fraud Against Taxpayers Act, discussed in Section II. The complaint alleged that OptumHealth's claims management system was inadequate to detect potentially false or fraudulent claims from behavioral health services providers.[148] OptumHealth relied upon *United States ex rel. Lacy v. New Horizons, Inc*. and *United States ex rel. Lemmon v. Envirocare of Utah, Inc*. to argue for dismissal for failure to satisfy Rule 9(b) pleading of fraud requirements.[149] In *Lacy*, the relator was a case manager for a company that operated residential long-term care facilities for persons with intellectual disabilities.[150] She alleged that the company violated the FCA by "forward-billing" for services that had not been rendered.[151] She alleged bills were submitted for every patient in all nine houses at the beginning of every month over a specific period of approximately five years.[152] Yet, the court found this information was insufficient to satisfy Rule 9(b), as "no single instance of a particular false claim is alleged that

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[146] Taylor Sample, *False Claims Act Fundamentals: What Is a Relator?*, BASS, BERRY & SIMS (Mar. 4, 2022), https://www.insidethefalseclaimsact.com/relator-false-claims-act/#:~:text=As%20the%20Acting%20Assistant%20Attorney,are%20often%20past%20or%20present.

[147] *See, e.g.,* United States *ex rel*. Ge v. Takeda Pharm. Co., 737 F.3d 116 (1st Cir. 2013) (dismissing False Claims Act action for failure to state alleged fraud with particularity); *see also* Morgan Gray, *Loosen Up: Breaking Free from Strict "With Particularity" Requirements When Pleading Fraud for Qui Tam Actions Brought Under the FCA,* 49 CREIGHTON L. REV. 415, 416 (Mar. 2016) ("The circuit courts agree that FCA qui tam actions must meet the particularity requirements of Rule 9(b), but are split on what the particularity requirement entails.").

[148] United States *ex rel.* Clark v. United Health Grp., Civ. No. 13-00372 MV/CG, 2016 2016 U.S. Dist. LEXIS 140311 (D.N.M. Sept. 22, 2016). The court later dismissed Clark's FCA claims without prejudice for lack of specificity linking OptumHealth's conduct to the submission of any particular claim for payment. Later, when OptumHealth moved unsuccessfully to amend the judgment to one of dismissal with prejudice, both the United States and the State of New Mexico opposed a dismissal with prejudice; New Mexico opposed dismissal with prejudice on grounds that it would "prevent future, potentially meritorious litigation" it could bring against the defendants. *See* Clark v. UnitedHealth Group, Inc., 2018 WL 1175088 at *2 (D.N.M. Mar. 3, 2018).

[149] *Id.*

[150] United States *ex rel.* Lacy v. New Horizons, Inc., 348 Fed. Appx. 421, 422-423 (10th Cir. 2009); United States *ex rel.* Lemmon v. Envirocare of Utah, Inc., 614 F. 3d 1163 (10th Cir. 2010).

[151] *Id.* at 424-25.

[152] *Id.* at 425.

would be representative of the class described."[153] Citing to *U.S. ex rel Sikkenga v. Regence Bluecross Blueshield of Utah*,[154] the court explained the Rule 9(b) requirements for FCA cases:

> [A] relator must provide details that identify particular false claims for payment that were submitted to the government. . . . details concerning the dates of the claims, the content of the forms or the bills submitted, their identification numbers, the amount of money charged to the government, the particular goods and services for which the government was billed, the individuals involved in the billing, and the length of time between the alleged fraudulent practices and the submission of claims based on those practices are the types of information that may help a relator to state his or her claims with particularity.[155]

In *Lemmon*, the other case cited by OptumHealth, the court approved of the relator's Rule 9(b) showing of "the who, what, when, where and how of the alleged claims."[156] As to the *who*, the relator alleged the names and positions of the "Envirocare employees who observed the contract and regulation activity, the names of supervisors to whom they reported and the names of . . . employees responsible for submitting false claims to the government."[157] Reciting a series of contractual and regulatory breaches and of specific breached obligations, coupled with dates and amounts of claims submitted for payment supplied the *what* and *when*.[158] The locations of the waste disposal sites where violations took place addressed the *where*.[159] "Extensive factual detail regarding how the violations occurred" such as "the conduct that led to the violation and the reason the result constituted a violation and a description of the effect of the violation" provided the *how*.[160] By providing these factual allegations in a "clear, organized and relatively concise manner" the court found that relators complied with Rule 9(b)'s heightened pleading requirements.[161]

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[153] *Id.*
[154] United States *ex rel* Sikkenga v. Regence Bluecross Blueshield of Utah, 472 F.3d 702, 702 (10th Cir. 2006).
[155] *Lacy*, 348 F. App'x at 425.
[156] *Lemmon,* 614 F.3d at 1171.
[157] *Id*.
[158] *Id*. at 1171-72.
[159] *Id*. at 1172.
[160] *Id*.
[161] *Id*.

B. Under changes enacted by the ACA, there are no safeguards comparable to Rule 9(b) that protect Medicaid providers suspected of fraud

Longstanding jurisprudential concerns about fairness to those accused of fraud have fallen away when it comes to today's Medicaid (and Medicare) providers. Under a program integrity scheme enacted as part of the ACA, the U.S. Department of Health & Human Services ("HHS") now deals with Medicaid providers suspected of fraud using a regulatory approach that is far more expedient than making a case against a provider in court, and that does not afford providers protections akin to those under Rule 9(b). This clearly stacks the deck against any Medicaid provider unfortunate enough to be accused of fraud.

Previously, the federal government and states used three strategies to prevent Medicaid fraud: "provider screening, prior authorization and pre-payment reviews, and post-payment review and recovery."[162] Section 6402(h)(2) of the ACA changed HHS's post-payment review and recovery model (referred to as "pay and chase"), in which the government would go to court and meet Rule 9(b) requirements to survive a motion to dismiss, to a model that is supposed to prevent and detect fraudulent activities early on by immediately suspending payments to a provider based on CAF.[163]

For purposes of the Medicaid program's integrity regulations, fraud is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the deceptions could result in some unauthorized benefit to himself or some other person."[164] It includes any act applicable under Federal or State law."[165] Note that intent is required; mistakes or sloppy record keeping do not constitute fraud under the Medicaid program integrity regulations. Common examples of Medicaid provider fraud include: billing for services not performed; billing duplicate times for a single service; falsifying a diagnosis; billing for a more costly service than that performed (upcoding); accepting kickbacks for patient referrals; billing for a covered service when a non-covered service was provided; ordering excessive or inappropriate tests; prescribing medication or tests that are not medically necessary; and prescribing medication for people who are not patients.[166]

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[162] *Medicaid Fraud and Abuse*, NAT'L CONF. OF STATE LEGS. (last updated Apr. 16, 2024), https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx (citing to a 2013 Pew Charitable Trusts report).
[163] *Id.*
[164] 42 C.F.R. §455.2 (2024).
[165] *Id*.
[166] *Medicaid Fraud and Abuse, supra* note 162.

C. Credible allegation of fraud

The ACA's proactive and more aggressive approach to fighting fraud based on CAF is a novel construct that is at odds with the well-settled and longstanding jurisprudential requirements essential to maintaining a cause of action for fraud. To align existing regulations with this new directive, HHS modified the evidentiary standard required to suspend payments to providers from "reliable evidence of fraud" to "a credible allegation" of fraud.[167] The HHS acknowledged there is a substantive difference in these terms and that the threshold to trigger a payment suspension is lower for a credible allegation of fraud.[168]

The regulations implementing Section 6402(h)(2) of the ACA purported to define credible allegation of fraud by combining examples of possible sources of an allegation with an aspirational description of the effort that a state Medicaid agency is expected to undertake to arrive at a determination that an allegation is credible. A "credible allegation of fraud" is defined as an allegation that has been verified by the state from any source, including but not limited to the following: (1) fraud hotline complaints;[169] (2) claims data mining; or (3) patterns identified through provider audits, civil false claims cases and law enforcement investigations.[170] "Allegations 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."[171]

The problem with the latter provision is it makes the state Medicaid agency the sole arbiter of what is credible,[172] what is sufficient evidence to verify hotline tips, what source or quantum or quality of evidence constitutes sufficient indicia of reliability, and whether it is acting judiciously on a case-by-case basis. Numerous commenters on the proposed final rule found the definition of "credible allegation of fraud"

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[167] 76 Fed. Reg. 5932 (Feb. 2, 2011).
[168] *Id*. at 5932, 5935. In response to comments that this evidentiary standard was too low, the HHS added the following language to the definition of a credible allegation of fraud: "and [for which] the State Medicaid agency has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis.
[169] 42 U.S.C. §1395y(o)(4). Effective October 23, 2018, without further evidence, a fraud hotline tip shall not be treated as sufficient evidence for a credible allegation of fraud. Effective March 22, 2021, 42 C.F.R. § 455.2(1) was amended to require that fraud hotline tips be verified "by further evidence."
[170] 42 C.F.R. § 455.2 (2012).
[171] *Id*.
[172] 42 C.F.R. § 455.2 (2021).

problematic.[173] Several requested CMS to provide an "exact definition . . . as well as specific standards and guidelines for providers to follow."[174] Others characterized the description of "credible allegation of fraud" under the proposed rule "as circular, that is, an allegation is credible if it has 'indicia of reliability."[175]

The HHS deflected this criticism by deferring to states to sort out what is credible, recognizing that:

> "different states may have different considerations in determining what may be a 'credible allegation of fraud.' Accordingly, we believe that States should have the flexibility to determine what constitutes a 'credible allegation of fraud' consistent with individual State law. We will neither seek to limit what States may determine qualifies as a 'credible allegation of fraud' nor will we require States to consult with HHS in making such a determination."[176]

As far as HHS is concerned, an allegation of fraud is credible if a state says so. Likewise, as this determination may be made by the state on a case-by-case basis, there is no federal requirement for uniformity in the way a state comes to its determination. Further, what might be viewed or defined as a "credible allegation of fraud" resulting in payment suspension in one state might not be the same in another part of the country.

Indeed, when CMS was provided with the New Mexico State Auditor's fiscal year 2013 HSD audit findings (which included the state auditor's concerns regarding HSD's departure from its own procedures that resulted in the behavioral health provider payment suspensions and, in the auditor's opinion, HSD's improper use of federal funds), CMS informed the auditor that it would *not* review HSD's credible allegations of fraud determinations; instead, CMS replied that it gave 'great weight to the fact that the MFCU accepted the cases and is still processing the investigation.'[177] CMS's refusal to intercede or exercise any oversight over HSD despite the state auditor's findings is another illustration of the lack of remedy or recourse faced by providers under the CAF regime.

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[173] 76 Fed. Reg. 5935 (2011).
[174] *Id.*
[175] *Id.*
[176] *Id.* Recently, Arizona's Medicaid agency has taken the position that "as long as [it] believes an allegation is credible, the suspension must stand, until a 'full investigation' has ensued . . . ". *See AHCCCS CAF Suspensions- the biggest scandal in Arizona, or did AHCCCS make its own bed?,* ADAMS & ASSOCS., PLC (Aug. 21, 2023), https://www.azwhitecollarcrime.com/blog/2023/08/21/ahcccs-caf-suspensions-the-biggest-scandal-in-arizona-or-did-ahcccs-make-its-own-bed/.
[177] Balderas, *supra* note 89.

Additionally, certain provisions of the CAF regulations appear to contradict others. While implementing regulations tie reliability to the state Medicaid agency's review of "*all* allegations, facts and evidence," under other provisions it is all but impossible for the state Medicaid agency to be in possession of *all* the facts and evidence when making its CAF determination. There is no provision in the regulations requiring the state to afford a provider the opportunity to respond to the specific allegations or provide explanatory or exculpatory information *before* the state makes its CAF determination. Further, the regulations not only authorize, but mandate the state Medicaid agency to stop payments following the determination that an allegation of fraud is credible —*before* a thorough investigation confirms that fraud has in fact taken place.[178] And unless required by state law, the provider is not entitled to any administrative or judicial review of the state Medicaid agency's CAF determination or suspension of payment.[179]

Years after the CAF laws and regulations went into effect, state Medicaid agencies and MFCUs responding to an OIG survey indicated that state administrative courts "sometimes expected the Medicaid agency to present a higher level of evidence of provider fraud, rather than basing its determination on whether the allegation of fraud was simply 'credible' as defined in Federal regulations."[180] Further, respondents reported that when the providers appealed CAF-based suspensions, courts overturned payment suspensions for want of evidence to support them.[181]

Given the broad latitude accorded state Medicaid agencies in determining what allegations are credible and the hands-off policy articulated by HHS, comments on proposed changes to 42 C.F.R. §455.23 expressed concern about false reports of fraud from competitors,

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[178] 42 C.F.R. § 455.23(a)(1). "Suspension" means that items or services furnished by a specified provider who has been *convicted* of a program-related offense in a federal, state or local court will not be reimbursed by Medicaid. [Emphasis added] 42 C.F.R. § 455.2. But note that the regulations require "suspension" of payments in cases in which fraud has not been proven in court. *See* 42 C.F.R. § 455.23(a)(1) ("the State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.").

[179] 42 C.F.R. § 455.23(a)(3). Many states do not afford administrative review for suspended providers and relief from the courts has been nearly impossible to obtain before a provider's reputation is ruined and it is bankrupted; See discussion *infra* Sections IV and V.

[180] *Challenges Appear to Limit States' Use of Medicaid Payment Suspensions*, DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN. (Sept. 2017).

[181] *Id.*

disgruntled employees or fraud hotlines.[182] As shown in the case of the New Mexico behavioral health providers, information gleaned from a managed care organization's faulty claims processing system and later "confirmed" by an irregular audit with a pre-determined outcome proved credible enough.

D. Medicaid managed care payment data is notoriously unreliable

Managed care "has become the primary delivery system for Medicaid" nationwide.[183] Georgetown University's Health Policy institute reports that 283 Medicaid MCOs were operating in forty states and the District of Columbia in the first quarter of 2022; and "of these, 118 were owned by one of the five national publicly-traded" health insurers.[184] However, the fact that many domestically incorporated Medicaid MCOs were affiliated with national health industry giants does not guarantee that systems are operating properly, or that payment and encounter data are reliable. In the instant case, OptumHealth was and is an affiliate of UnitedHealthcare.

Medicaid Managed Care Organizations (MCOs) are the source of data that states must provide to the CMS[185] on payments to providers for services rendered to Medicaid enrollees.[186] This data is relied upon by CMS and states to "detect fraud, waste and abuse."[187] However, a 2021 OIG review of payment data for January 2020 encounter claims, "for the largest managed care plan in each of the thirty-nine states that provide comprehensive, risk-based managed care" found that "most states did not provide complete or accurate payment data."[188] Further, the OIG "and others have consistently identified deficiencies in the quality" of Medicaid managed care data.[189]

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[182] *Id*. at 1.
[183] *Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate*, DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN. (Mar. 2021).
[184] *A Guide for Health Care Advocates: Medicaid Managed Care Procurement*, GEO. UNIV. HEALTH POL'Y INST., 2 (July 14, 2022).
[185] *Data on Medicaid Managed Care*, *supra* note 183 at 1. CMS's Transformed Medicaid Statistical Information System (T-MSIS) "collects data on amounts paid, billed and allowed for every service provided to Medicaid enrollees, including those services provided through managed care."
[186] *Id.*
[187] *Id*.
[188] *Id.*
[189] *Id.*

The fragmented structure of the Medicaid program itself contributes to unreliable data. "Variability…is the rule rather than the exception."[190] States are allowed to "establish their own eligibility standards, benefit packages, provider payment policies and administrative structures under broad federal guidelines."[191] An IT consultant suggests that "with the increasingly complex and dynamic state-by-state regulatory and payment environment, it has become nearly impossible [for MCOs] to keep up to date with and adopt to the constant and nuanced changes in Medicaid payment policies and fee schedules."[192] This in turn "leads to overpayments, denials and reworks, missed reimbursements, and incorrect payments."[193]

In the instant case, the state of New Mexico accepted as "credible" OptumHealth's representations that enhanced program integrity analysis of its data had identified fraud.[194] Given questions raised from many quarters about OptumHealth's data,[195] and the foregoing OSI findings of widespread problems with managed care encounter and payment data, a state should be required to first assess the reliability of an MCO's data for the specific provider and period in question before accepting any results of mined data to support a "credible allegation of fraud."

E. Suspension of payments

Under CAF regulations, the state Medicaid agency has the discretion to suspend payments with no advance notice to the provider.[196] Following the suspension, the agency must send the provider notice within five days, unless a law enforcement agency requests in writing that it temporarily withhold the notice.[197] Law enforcement can request additional delays of up to ninety days in sending the notice of suspension.[198] In contrast to the Rule 9(b) specificity requirements, the notice from the state Medicaid

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[190] *Medicaid 101*, MACPAC (last visited Mar. 12, 2024), https://www.macpac.gov/medicaid-101/.
[191] *Id.*
[192] *Medicaid MCOs: It is time for a new claims management strategy*, HEALTHEDGE SOFTWARE, INC. (Jan. 25, 2024), https://www.contentree.com/white-papers/medicaid-mcos-it-is-time-for-a-new-claims-management-strategy_410925.
[193] Jared Lorinsky, *7 Medicaid Claims Management Risks for MCOs*, HEALTHEDGE SOFTWARE, Inc. (Jan. 9, 2023), https://healthedge.com/resources/blog/7-most-common-medicaid-mco-claims-management-risks-src.
[194] *See supra* Section II(b).
[195] *See supra* Section II(b).
[196] 42 C.F.R. § 455.23(a)(2) (2011).
[197] 42 C.F.R. § 455.23(b)(1)(i) (2011).
[198] 42 C.F.R. § 455.23(b)(1)(ii) (2011).

agency is only required to "set forth the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation."[199] The notice should "specify, when applicable, to which type or types of Medicaid claims or business units of a provider" are subject to the suspension.[200] While the regulations allow a provider to submit written evidence following receipt of the notice of suspension "for consideration" by the state Medicaid agency,[201] this right is illusory if a provider has not been told what specific conduct underlies the alleged fraud, and thus lacks essential information to mount a defense.

In another Alice-in-Wonderland aspect of the CAF regulations, the suspension is supposed to be "temporary" — unless it is not. All suspensions are "temporary" but will not end until: (1) the state Medicaid agency or the prosecuting authorities determine that "there is insufficient evidence of fraud; or (2) legal proceedings related to the provider's alleged fraud are completed."[202] It would be more accurate to describe the suspension as "indefinite." The day after the state Medicaid agency suspends a provider, it must refer the provider to the state's MFCU or other law enforcement agency for investigation.[203] If the referral is accepted, "the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed."[204]

In the case of the New Mexico behavioral health providers, the state placed more than $10 million worth of claims for payment on "hold," allowing the funds to be held in a non-interest bearing account by OptumHealth.[205] Further, the state took the position that it would not consider the amounts owed "past due" until the pay hold was lifted for each provider, which effectively tolled the date on which interest would begin to accrue.[206] This meant that, by virtue of the state's refusal to

[199] 42 C.F.R. § 455.23(b)(2)(ii) (2011).
[200] 42 C.F.R. § 455.23(b)(2)(iv) (2011).
[201] 42 C.F.R. § 455.23(b)(2)(v) (2011).
[202] 42 C.F.R. § 455.23(c) (2011).
[203] 42 C.F.R. § 455.23(d) (2011).
[204] 42 C.F.R. § 455.23(d)(3)(i) (2011).
[205] Senator Mary Kay Papen, *New Mexico's behavioral health crisis demands solutions*, LAS CRUCES SUN NEWS (Jan. 28, 2017), https://www.lcsun-news.com/story/opinion/commentary/2017/01/28/new-mexicos-behavioral-health-crisis-demands-solutions/97104454/; Email from Patricia Romero, CEO and President of Santa Maria El Mirador (formerly Easter Seals El Mirador) (May 26, 2020) (on file with the author).
[206] Email No. 2 from Patricia Romero, CEO and President of Santa Maria El Mirador (formerly Easter Seals El Mirador) (April 16, 2024) (on file with the author).

adjudicate the underlying claims until all administrative and legal proceedings were concluded, providers did not receive interest on millions of dollars of payments that had been wrongfully withheld for years.[207]

The harm to an accused provider from a payment suspension is immediate. For many providers, Medicaid constitutes a large portion of their revenue stream.[208] In addition, it is common for providers to be carrying large balances due for billed Medicaid services that may be months in arrears.[209] Few providers have the financial wherewithal or reserves to stay in business for even a month or two once Medicaid payments are suspended. Government investigations can take years to complete, to which accused providers in New Mexico can attest.[210] Without a right to expedited proceedings, it can take years for a provider to exhaust administrative remedies or for a case to make its way through the courts.

In practice, many accused providers who have later been exonerated, have gone out of business and suffered significant financial and personal loss before the temporary suspension was lifted.[211] Further, in the case of the New Mexico suspensions, the providers were required to continue to provide services during the transition to replacement providers, for which the suspended providers were uncompensated.[212] One of the suspended New Mexico providers reported being told by the state that it "would be held criminally liable" if it ceased providing unreimbursed services before the replacement provider took over.[213]

F. The ripple-effect of suspension

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[207] *Id.*
[208] Letter from Easter Seals El Mirador (Apr. 19, 2016), *supra* note 71.
[209] Tony Leys, *Medicaid managers are slow to pay bills, agencies say*, DES MOINES REGISTER (July 17, 2016, 7:02 PM), https://www.desmoinesregister.com/story/news/health/2016/07/17/medicaid-managers-slow-pay-bills-agencies-say/87036754/.
[210] *Id.* Investigations of several of the suspended New Mexico behavioral health providers took approximately three years. The New Mexico attorney general concluded its investigation of the last two of the accused providers on April 5, 2016.
[211] *See* News Release, Hum. Serv. Dep't, New Mexico Human Services Department reaches settlement agreement with five behavioral health providers: Santa Maria El Mirador (formerly Easter Seals El Mirador), Border Area Mental Health Services, Southwest Counseling Center, Inc., Southern New Mexico Human Development, Inc. and Families and Youth, Inc. (Dec. 4, 2019) (stating that in the case of the accused New Mexico providers, some did not have their wrongfully suspended funds returned until more than six years later) (on file with the author).
[212] Letter from Easter Seals El Mirador (Apr. 19, 2016), *supra* note 71.
[213] Email from Brian Kavanaugh (June 4, 2020), *supra* note 16.

For most Medicaid providers, suspension of payments quickly leads to cascading events such as: losses of office space and infrastructure; the forced sale or surrender of office equipment and furnishings and company vehicles; loss of IT and telecommunications investments; and loss of access to credit and working capital.[214] To illustrate, TeamBuilders Counseling Services, Inc. ("TeamBuilders"), one of the suspended New Mexico behavioral health providers, provided services to approximately 5,000 high-risk and high-need consumers in twenty-three medically underserved New Mexico counties and several tribal areas at the time the pay suspension was initiated.[215] As a result of the suspension, it lost a nearly statewide network of offices and infrastructure at twenty-four locations, returned company and handicap-accessible vehicles to the dealer or sold them at a loss, and lost the use of a million-dollar electronic health records system.[216] TeamBuilders also had to dismantle a million-dollar telehealth network connecting approximately three dozen locations around the state, including multiple wired and cammed classrooms, group rooms, a board room, and ten desktop units in Santa Fe, plus dozens of remote units in place in offices around the state as well as in offices of other agencies to whom it provided telepsychiatry.[217]

The implosion of the provider's business also leads to layoffs of both administrative and clinical staff who, in addition to the loss of employment, typically lose benefits such as health insurance and accrued paid time off. At the time of its suspension, TeamBuilders employed more than 600 people, including eleven psychiatrists, two prescribing psychologists, one of only two board-certified pediatric neuropsychologists in New Mexico and over 100 other doctoral- and masters-licensed clinicians.[218] All were laid off, with the exception of two employees retained to wind down the business, respond to the Attorney General's investigation and shepherd the organization through the related legal proceedings.[219] It goes without saying that this loss of jobs impacted the economy of New Mexico communities served by the suspended Medicaid providers. While some employees of the suspended organizations found work with the Arizona companies brought in to

[214] Email from Shannon Freedle, former Chief Executive Officer, TeamBuilders Counseling Services, Inc. (May 26, 2020) (on file with the author).
[215] *Id.*
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id*.

replace them, many clinicians simply left the state, exacerbating New Mexico's existing shortage of behavioral health professionals.[220]

G. Professional harm arising from the fact of suspension based on CAF

While the sanction of suspension appears less draconian than exclusion from participation in federal health care programs (usually reserved for persons convicted of health care fraud offenses), there are nevertheless serious repercussions that flow from suspension. A newly promulgated federal regulation requires a state Medicaid agency to request a provider (who is not already enrolled as a Medicare provider) applying to become enrolled or to revalidate its enrollment in Medicaid or CHIP to disclose information about affiliations that it or any of its owners or managing employees or organizations has or has had in the last five years, with a currently or formerly enrolled Medicare, Medicaid or CHIP provider "that has a disclosable event."[221] A "disclosable event" with respect to an affiliation includes a provider that "has been or is subject to a *payment suspension* under a federal health care program . . . regardless of when the payment suspension occurred or was imposed."[222]

In order for a health care practitioner to become a network provider for a health plan, the practitioner must be credentialed or vetted by the health plan.[223] It is now commonplace for health plan credentialing applications to require practitioners to disclose suspensions, and the fact of suspension may jeopardize a practitioner's ability to participate in health plan provider networks.[224] A health care practitioner's ability to work for a medical

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[220] Letter from Easter Seals El Mirador (Apr. 19, 2016), *supra* note 71; Email from Patsy Romero (May 26, 2020), *supra* note 15.
[221] 42 C.F.R. § 455.107(b) (2023) (effective Nov. 4, 2019).
[222] 42 C.F.R. §455.101 (2024).
[223] *Credentialing and Recredentialing Fact Sheet*, MOLINA HEALTHCARE, (Jan. 1, 2020), https://www.molinahealthcare.com/~/media/Molina/PublicWebsite/PDF/providers/mi/medicaid/manual/3_Credentialing.pdf (listing practitioner types requiring credentialing include but are not limited to: acupuncturists; addiction medicine specialists; audiologists; behavioral health care practitioners who are licensed, certified or registered by the state to practice independently; chiropractors; clinical social workers; dentists; doctoral- or master's-level psychologists; licensed/certified midwives (non-nurse); massage therapists; master's-level clinical social workers; master's-level clinical nurse specialists or psychiatric nurse practitioners; and physicians).
[224] *See id.* (including this provision from a health plan provider manual, which typically is incorporated by reference into the provider services agreement. "**Medicare, Medicaid and other Sanctions and Exclusions**-Practitioner must not be currently sanctioned, excluded, expelled or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid

practice may be jeopardized, if not significantly impaired, if the practitioner is not able to become credentialed by health plans that insure the practice's patients.

A handful of the New Mexico suspended providers had non-Medicaid sources of revenue that made it possible to avoid shutting down.[225] One of these providers reported that it was six years following its suspension before it received its first payment as an exonerated Medicaid provider, during which time it had to rebuild its Medicaid operation from the ground up and navigate red-tape to be cleared for payment by HSD.[226]

Several of the executives of the accused New Mexico behavioral health organizations reported being unable to find employment after their businesses closed as a result of the suspensions. One executive reported being black-balled from working elsewhere in New Mexico by the Secretary of HSD herself.[227] Another reported that she retired after being unable to find a job.[228]

IV. Recovery of Funds and Suspension of Payments Before and After the ACA

A. Pre-ACA

i. Medicare

For decades, HHS has had the means to recover funds from Medicare providers through offset, recoupment and suspension of payment. Medicare could offset a non-Medicare debt such as a public health service debt or Medicaid debt recovered by CMS against future Medicare

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sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions or disqualifications under the non-procurement common rules or when otherwise declare ineligible from receiving federal contracts, certain subcontracts and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.").

[225] Letter from Easter Seals El Mirador (Apr. 19, 2016), *supra* note 71. Easter Seals El Mirador was also a provider of services to persons with developmental disabilities.

[226] Email from Brian Kavanaugh, Chief Executive Officer, Families and Youth, Inc. (Jan. 20, 2021) (on file with the author).

[227] Email from Shannon Freedle, former Chief Executive Officer, TeamBuilders Counseling Services, Inc. (May 26, 2020) (on file with the author). This belief appears to be supported by one of the conditions of the $4 million PMS settlement requiring PMS to cut ties with TeamBuilders, Inc. *See supra* Section II (f).

[228] Email from Nancy Jo Archer, Chief Executive Officer, Hogares, Inc. (May 25, 2020) (on file with the author).

payments.[229] "Recoupment" is the recovery of any outstanding Medicare debt by reducing present or future Medicare payments.[230] Until March 2011, "suspension of payment" was defined as the withholding of payment by a fiscal intermediary or carrier from a provider or supplier of an approved Medicare payment amount before there was a determination of the amount of the overpayment.[231] The ACA amended and expanded the definition of "suspension of payment" to include the withholding of payment "until the resolution of an investigation of a credible allegation of fraud."[232]

The previous regulation authorized suspension based upon HHS's possession of "reliable information that an overpayment or fraud or willful misrepresentation exists or that the payment to be made may not be correct."[233] Suspension of payments on this basis was limited to 180 days, with allowance for extensions at the request of Medicare contractors, the OIG, law enforcement or DOJ under certain circumstances.[234]

ii. Medicaid

Similarly, "state Medicaid agencies have long been authorized to withhold provider payments in cases of fraud or willful misrepresentation."[235] Note that the authority to withhold payments to a provider in whole or in part was discretionary and not mandatory."[236] According to the HHS notice of proposed rulemaking for new CAF suspension authority, previous federal regulations promulgated in 1987 were designed to encourage state Medicaid agencies to withhold program payments "without first granting administrative review where the state agency had *reliable evidence* of fraudulent activity by the provider."[237] [Emphasis added.] Such regulations were the result of concern on the part of the HHS OIG's Office of Investigations that administrative review could interfere with ongoing investigations or jeopardize criminal cases.[238]

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[229] 42 C.F.R. § 405.370(a) (Nov. 16, 2009).
[230] *Id*.
[231] *Id.*
[232] 42 C.F.R. § 405.370(a) (March 25, 2011).
[233] 76 Fed. Reg. 22, at 5928 (Feb. 2, 2011).
[234] *Id*.
[235] *Id.* at 5931.
[236] *Id.* ("This current rule provides that a State Medicaid agency *may* withhold payments to a provider in whole or in part based upon receipt of reliable evidence that the need for withholding payment involves fraud or willful misrepresentation under the Medicaid program.") (emphasis added).
[237] *Id*.
[238] *Id*.

Whether evidence was reliable was for the state Medicaid agency to determine "looking at all the factors, circumstances, and issues at hand, and acting judiciously on this information."[239]

In its notice of proposed CAF rulemaking, HHS often referred to the infrequency with which pay holds have been imposed in the twenty years leading up to the ACA's new CAF provisions and implementing regulations.[240] However, HHS admitted that it anticipated more suspensions because under new ACA requirements, states risked losing the federal share of their Medicaid funding if payments were not suspended once a provider was referred for investigation—unless good cause existed not to suspend them.[241]

B. Post-ACA

As one commentator has observed, interest in combating health care fraud and abuse was an example of "rare bipartisanship" during the debate on health care reform.[242] "For many members of Congress (and others) health care fraud enforcement is something of a panacea."[243] While the ACA included "some of the most important and extensive changes in health care fraud and abuse [enforcement] ever enacted,"[244] the sheer breadth of the ACA may have contributed to an apparent lack of awareness on the part of most health care providers regarding the details of new strategies to combat fraud in federal health care programs such as CAF.

In a January 24, 2011 news release, HHS Secretary Kathleen Sebelius announced that "President Obama has made it very clear that fraud and abuse of taxpayers' dollars are unacceptable. . . .[T]hanks to the President's leadership and the new tools provided by the Affordable Care Act, we can focus on *stopping fraud before it happens*."[245] [Emphasis added.] The news release highlighted "important authority to suspend

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[239] 76 Fed. Reg. 22, at 5932.
[240] *Id.*
[241] *Id.*
[242] William A. Sarraille, *The Unintended Consequences of Targeting Health Care Fraud*, BLOOMBERG L. REPS. (May 2010) https://www.sidley.com/en/insights/publications/2010/05/the-unintended-consequences-of-targeting-health-care-fraud.
[243] *Id.*
[244] *Id.*
[245] Press Release, *Health Care Fraud Prevention and Enforcement Efforts Recover Record $4 Billion; New Affordable Care Act Tools Will Help Fight Fraud,* DEP'T OF JUST., 1, 2 (Jan. 24, 2011), https://www.justice.gov/opa/pr/health-care-fraud-prevention-and-enforcement-efforts-recover-record-4-billion-new-affordable.

payments when a credible allegation of fraud is being investigated."[246] In its early 2011 notice of proposed rulemaking regarding this new suspension authority, HHS acknowledged that payment suspension could result in "dire consequences" for a provider and cautioned that payment suspension authority "must be exercised responsibly by a State at all stages, from inception to the termination of the suspension."[247] In the years since, this authority has resulted in suspensions of payments to providers based on credible allegations of fraud that have later proven unsubstantiated, with predictable dire consequences for those wrongfully accused and for the populations they formerly served.[248]

i. Medicare

Section 6402(h)(1) of the ACA added a new subsection (o) to 42 U.S.C. §1395y that pertains to *Medicare*. Current subsection (o) provides in pertinent part:

> (1) **In genera**l
>
> The Secretary may suspend payments to a provider of services or supplier under this subchapter pending an investigation of a *credible allegation of fraud* against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend payments.
>
> (2) **Consultation**
>
> The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a *credible allegation of fraud* against a provider of services or supplier.[249] [Emphasis added.]

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[246] *Id.* at 4.
[247] 76 Fed. Reg. 22, at 5934 (Feb. 2, 2011).
[248] *AHCCCS CAF Suspensions- the biggest scandal in Arizona, or did AHCCCS make its own bed?, supra* note 176 176 (suspending 200 behavioral health providers who served Native Americans enrolled in the American Indian Health Program based on credible allegations of fraud, sweeping up providers who followed the rules and appropriate care. "[T]he real victims are quickly forgotten."); Emily Ramshaw, *Approach to Medicaid Fraud Investigations Has Supporters and Critics,* THE TEX. TRIBUNE (July 20, 2012), https://www.texastribune.org/2012/07/20/medicaid-fraud- investigations- controversial- tool/#:~:text=Approach%20to%20Medicaid%20Fraud%20Investigations,say%20there's%20no%20due%20process (*see* reference to precipitous and later reversed suspension of payments to Carousel Pediatrics, which served 40,000 children in Texas, most of whom were on Medicaid).
[249] 42 U.S.C. § 1395y(o) (2018).

Of note, these Medicare payment suspensions based on CAF are not limited by the time constraints applied to suspensions based on reliable information of overpayments or incorrect payments, "both of which require a speedy… determination."[250]

In explaining the ACA's addition of a Medicare suspension based on CAF, the HHS conceded that what constituted a credible allegation of fraud would need to be "determined on a case-by-case basis by looking at all the factors, circumstances and issues at hand."[251] The HHS expressed confidence that CMS and its contractors would "act judiciously" when contemplating a suspension and be "mindful of the impact that payment suspension may have upon a provider."[252] The HHS's confidence was bolstered by the statutory requirement that CMS consult with the OIG *prior to implementing a payment suspension*, which would provide "ample opportunity for the credibility of an allegation to be assessed and for a preliminary investigation into the allegation of fraud to occur sufficient to meet a reasonable evidentiary standard."[253] No similar independent review is required for *Medicaid* suspensions based on CAF.[254]

In its notice of proposed rulemaking on the new suspension authority under the ACA, HHS acknowledged that numerous commenters had raised due process concerns.[255] The HHS responded that "due process protections are more than adequate" since:

- suspended providers are afforded "ample opportunity to submit information to [HHS] in the established rebuttal statement process [after the suspension has been imposed] to demonstrate their case for why a suspension is unjustified;"
- "the criteria for suspension of payments are clear;"
- "the evidentiary standards for payment suspensions cannot be more precisely defined;" and
- "this authority will be exercised judiciously by CMS, in consultation with the OIG, and . . . only in the most egregious cases will payment

[250] 76 Fed. Reg. 22, at 5930 (Feb. 2, 2011).
[251] *Id.* at 5929.
[252] *Id.*
[253] *Id.* (Note that no similar consultation requirement is imposed on state Medicaid agencies under post-ACA CAF regulations. Thus, a Medicaid CAF determination is made solely by the state Medicaid agency).
[254] *See* Sarraille, *supra* note 242 242 (explaining the inefficiency of current healthcare industry regulation policy of government investigations and prosecutions).
[255] 76 Fed. Reg. 22, at 5930-31 (Feb. 2, 2011).

> suspensions last longer than the previously established timeframes for suspensions."[256]

ii. Medicaid

With respect to Medicaid, Section 6402(h)(2) of the ACA amended 42 U.S.C. §1396b(i)(2)[257] to add a new subparagraph (C). Section 1396b(i) provides in pertinent part:

> (i) . . . Payment under the preceding provisions of this section [payment to states] shall not be made—
>
> . . .
>
> (2) with respect to any amount expended for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room or hospital) furnished—
>
> . . .
>
> *(C) by any individual or entity to whom the state has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1395y(o) of this title and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments.*[258]

In other words, if a state fails to suspend payments to a Medicaid provider that is being investigated based on CAF, the federal government will not pay for its share of the Medicaid services rendered by that provider. There is one exception to the requirement to suspend payments while the investigation is pending: if the state has determined that there is "good cause *not* to suspend payments."[259] This good-cause-not-to-suspend exception gives a state unfettered power to spare or harm a provider for political or other improper purposes.

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[256] *Id.*
[257] 42 U.S.C. § 1396b(i)(2) (referencing Subchapter XIX Grants to States for Medical Assistance within Chapter 7 on Social Security).
[258] The italicized text was added by the ACA. Section 1395y(o)(3), added by the ACA and since amended, directs the Secretary of HHS to promulgate regulations to carry out this subsection.
[259] 42 C.F.R.§455.23(e)(2011).

The ACA requirement to suspend payments demonstrates the power of the federal government over state Medicaid agencies through the imposition of conditions with which the state must comply to receive federal funds.[260] One commenter has suggested that it "gives state Medicaid agencies an improper incentive to aggressively deny payments to providers or risk losing Federal Financial Participation (FFP)."[261] To be clear, this provision does not mean that a state Medicaid program's *entire* FFP is at risk if it does not suspend payment to a provider while an investigation based on CAF is pending; it refers to a "deferral and/or disallowance" of the federal portion of the specific payment at issue.[262] In its notice of proposed CAF rulemaking, HHS conceded that it anticipated that state Medicaid agencies would exercise payment suspension authority more frequently, given the threatened loss of FFP.[263] Moreover, ACA-driven changes to 42 C.F.R. §455.23(a) now "make payment suspensions by a state Medicaid agency mandatory where an investigation of a credible allegation of fraud under the Medicaid program exists."[264]

1. Good Cause Not to Suspend Payments

Notwithstanding the mandate to suspend payments, awkwardly worded CAF regulations give a state Medicaid agency the discretion "to find that good cause exists *not to suspend* payments or not to continue" a payment suspension to a provider that is under investigation based on a CAF.[265] The state Medicaid agency may determine that good cause exists to not suspend, or to discontinue suspension of, payments if:

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[260] BRIAN T. YEH, CONG. RSCH. SERV., R44797, THE FEDERAL GOVERNMENT'S AUTHORITY TO IMPOSE CONDITIONS ON GRANT FUNDS (2017)("Article 1, Section 8, Clause 1 of the U.S. Constitution has been widely recognized as providing the federal government with the legal authority to offer federal grant funds to states and localities that are contingent on the recipients engaging in, or refraining from, certain activities."); Rehab Az., L.L.C. v. Az. Health Care Cost Containment System, 2019 WL 1530112 *3 (Az. App. Apr. 9, 2019) (A Tenth Amendment challenge to federal CAF regulations requiring states to withhold payments was rejected in the Court of Appeals of Arizona. While the court noted that the Tenth Amendment is only implicated if the financial inducement is so coercive as to turn pressure "into compulsion," it did not find the federal CAF provision constituted "compulsion." Since the state is not required to accept Medicaid funds and the CAF provisions give the state the discretion to find good cause not to suspend payments, the court held that there was no Tenth Amendment violation).

[261] 76 Fed. Reg. 22, at 5938 (Feb. 2, 2011).

[262] *Id.* at 5934-35 (Feb. 2, 2011).

[263] *Id.* at 5932.

[264] *Id.*

[265] 42 C.F.R. § 455.23(e)(2011).

> (1) law enforcement officials have specifically requested it because suspension may compromise or jeopardize an investigation;
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> (2) other available remedies implemented by the state more effectively or quickly protect Medicaid funds;
>
> (3) the state determines that the suspension should be lifted based on the submission of written evidence by the provider that is the subject of the suspension;
>
> (4) access to items or services would be jeopardized by a payment suspension because the suspended provider is the sole community physician or sole source of "essential specialized services" in a community or the provider serves a large number of recipients within a Health Resources and Services Administration designated medically underserved area;
>
> (5) law enforcement declines to certify that a matter continues to be under investigation by a MFCU or other law enforcement agency that accepted the referral; or
>
> (6) the state determines that payment suspension is not in the best interests of the Medicaid program.[266]

Even if the state finds good cause not to suspend payments to a provider, it must nevertheless refer any credible allegation of fraud against a provider to the MFCU or appropriate law enforcement agency for investigation.[267] "Law enforcement investigations of credible allegations of fraud continue," regardless of whether payments are suspended or not.[268]

While good-cause-not-to-suspend exceptions give states leeway to continue paying essential providers after CAF referral to law enforcement, there is no right of review for a state's denial of a provider's request for a good-cause-not-to-suspend exception unless state law so requires.[269] There is also no requirement that an objective third party evaluate requests for good cause exceptions.[270] In the case of the suspended New Mexico behavioral health providers, the same committee that decided to impose

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[266] *Id.* at (e)(1) through (6).
[267] *Id.* at (d)(1) and (5).
[268] *Challenges Appear to Limit States' Use of Medicaid Payment Suspensions,* DEP'T OF HEALTH & HUM. SERVS., OFF. OF THE INSPECTOR GEN. (Sept. 2017), https://oig.hhs.gov/oei/reports/oei-09-14-00020.pdf.
[269] 42 C.F.R. § 455.23(a)(3)(2011).
[270] 42 C.F.R. § 455.23(e) (2011)(explaining that the "State" can find good cause).

suspensions in the first place,[271] was also in charge of deciding whether good cause existed to lift a provider's suspension. There is evidence that, despite well-founded requests for exceptions, HSD kept suspensions in place to leverage settlement[272]; further, HSD had already decided to replace the suspended providers and entered into contracts with out-of-state organizations to do so.[273]

2. "Temporary" Suspensions

The CAF regulations describe the pay suspensions as "temporary," ending when the state Medicaid agency or prosecuting authorities determine that there is insufficient evidence of fraud of the part of the provider, or when "legal proceedings related to the provider's alleged fraud are completed."[274] However, state Medicaid agencies and MFCUs responding to an OIG review of state Medicaid agency suspensions based on CAF "pointed to a contradiction between the description of suspensions as 'temporary' and the reality that health care law enforcement investigations are often lengthy."[275] The respondents pointed out that investigations could involve interviewing witnesses, applying for search warrants and subpoenas and coordinating with other law enforcement agencies — all taking months if not years to complete.[276] More importantly, the respondents acknowledged that lengthy suspensions could result in providers going out of business as a result of lost revenue.[277] The OIG reported that "this outcome is particularly harmful to providers . . . [when] law enforcement ultimately decides not to prosecute."[278]

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[271] *Minutes of the Second Meeting, supra* note 54 (At its July 3, 2013 meeting, noted on page 7 in the minutes, Diana McWilliams, Executive Director of the Interagency Behavioral Health Purchasing Collaborative, told the Legislative Health and Human Services Committee that a team from the HSD consisting of herself, the cabinet secretary, deputy secretary, Medicaid director, general counsel, and deputy general counsel made the determination that there was credible evidence of fraud).

[272] *See* Section II (f) (showing how HSD denied Presbyterian Medical Services, Inc.'s request for an exception but was willing to engage in settlement negotiations).

[273] *See* Section II (c) & (d), *supra* pp. 11, 14 (describing HSD's plans to replace the New Mexico providers, which did not appear to consider any alternatives to replacement such as prepayment review, third-party monitoring or corrective action).

[274] 42 C.F.R. § 455.23(c)(2011).

[275] *Challenges Appear to Limit States' Use of Medicaid Payment Suspensions*, *supra* note 268.

[276] *Id*.

[277] *Id*.

[278] *Id*.

V. CHALLENGES TO SUSPENSIONS

Every Medicaid provider is a contracted provider, subject to a provider services agreement. Provisions in both provider agreements and other documents incorporated by reference in the provider agreements (such as provider manuals) have boilerplate provisions that are not negotiable.[279] Among these standard provisions are those making the provider agreement subject to both current, and even future, changes in state and federal laws.[280] There are also express provisions that give the state Medicaid agency and any intermediaries the right to suspend payments.[281]

With respect to what process is due to a provider in connection with the suspension of payments, the courts will look to state law to determine whether a suspended provider is entitled to a hearing and if so, when. The federal CAF regulations allow for such a hearing, if state law so requires.[282] The courts will also look to dispute resolution provisions in the Medicaid provider service agreement (another instance of boilerplate and unnegotiable terms) to determine a provider's right to a hearing.[283] In addition, a suspended provider will face the requirement to exhaust administrative remedies, notwithstanding lengthy delays as administrative proceedings play out. Challenges to suspensions will also have to overcome traditional deference to agency decision-making with sufficient evidence that agency action was arbitrary, capricious or contrary to law.[284]

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[279] *See* Excerpt from the Medi-Cal Provider Service Agreement (Mar. 15, 2015) (demonstrating the assertion in Sections 2.1 and 3.2 of the Provider Service Agreement, Section 10 of the PSA, and Section 4.0 of Exhibit E to the PSA) (agreement is on file with the author).

[280] *See id.* at 19 (referencing Section 17.2).

[281] *See* Excerpt from Medicaid Provider Agreement for Nursing Facility Services (July 2018) (referencing the Texas Medicaid Provider Agreement and demonstrating the assertion on page 4 in the sanctions requirements) (agreement is on file with the author); *see supra* note 279, at 11 (referencing Section 4.1 on reimbursement) (agreement is on file with the author).

[282] 42 C.F.R. § 455.23(a)(3) "A provider may request, and must be granted, administrative review where State law so requires."

[283] *See* McKay, *supra* note 69 (regarding motion to compel arbitration in litigation related to the suspensions and replacement of the New Mexico behavioral health providers).

[284] *See* Consumer Directed Choices, Inc. v. New York State Off. of the Medicaid Inspector Gen., 90 A.D.3d 1271, 1272-73 (2011) (holding that the Department of Health's reliance upon request from MFCU to withhold payments from provider under investigation constitutes "reliable information," does not require any independent investigation or consideration of additional factual information, and is not irrational, arbitrary or capricious. A strongly worded dissent argued that the department's disregard of later received uncontroverted evidence from the provider showing that the basis for the investigation was unfounded would allow "an unscrupulous agency" to use a "baseless investigation as a pretext for the confiscation of a provider's payments for retaliatory, political, or other

A. Injunctive relief unlikely

Obtaining injunctive relief is all but impossible for a Medicaid provider whose payments have been suspended based on a CAF. When seeking injunctive relief, the movant must prove a substantial likelihood of prevailing on the merits.[285] Medicaid providers accused based on a CAF will always face a "Catch-22" in attempting to disprove the fraud alleged. Federal CAF regulations only require the state to provide general and minimal information to the accused provider once payment is suspended.[286] The regulations also require the state Medicaid agency to immediately refer the provider for investigation after the agency makes its CAF determination.[287] Once referred, federal CAF regulations prohibit the state Medicaid agency from providing the details upon which the determination is based to the accused provider.[288] This leaves the accused provider without information specifying the who, what, when and where of any alleged fraud on its part until the completion of the investigation.

Further, a "carve out" of the right to immediate payment pending an investigation based on CAF in the provider agreement and both state and federal law has been held to defeat the required showing of a constitutionally protected property interest necessary to bring a claim for a procedural due process violation.[289] Courts will also refrain from granting injunctive relief when a suspended provider can sue for breach of the provider services agreement and collect damages.[290]

B. Due process

To succeed on the merits of a violation of due process claim, there must be a constitutionally protected liberty or property interest.[291] Protected

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improper reasons, or simply to recover payments that resulted from a good faith error or interpretive disagreement involving no fraud. . . .").

[285] Border Area Mental Health Servs., Inc. v. Squier, 2013 WL 12140453 at 4 (D.N.M., 2013); 524 Fed. Appx. 387 (10th Cir. 2013) (appeal dismissed for lack of jurisdiction, motion for injunction denied).

[286] 42 C.F.R. § 455.23(b)(2)(ii) (stating that notice must set forth "the general allegations as to the nature of the suspension action, but need not disclose any specific information concerning an ongoing investigation.")

[287] *Id.* at § 455.23(d).

[288] *Id.* at § 455.23(b)(2)(ii).

[289] *Border Area Mental Health Servs., Inc.*, 2013 WL 12140453 at 4.

[290] Zen Grp., Inc. v. Harris, 2021 WL 4441553 at 5 (S.D. Fla. Sept. 28, 2021), *aff'd on other grounds sub nom*. Zen Grp., Inc. v. Agency for Health Care Admin., 80 F.4th 1319 (11th Cir. 2023).

[291] *Border Area Mental Health Servs.*, 2013 WL 12140453 at 4.

property interests subject to due process protections "are created and defined by statute, ordinance, contract, implied contract and rules or understandings developed by state officials." [292]

It is "relatively clear that providers . . . do not have a Fourteenth Amendment property interest in continued participation in federally funded healthcare programs" (such as Medicaid).[293] Provider service agreements between Medicaid MCOs and providers allow termination of providers on any number of grounds; state Medicaid agencies are authorized to suspend or revoke contracts of Medicaid providers according to the terms of the provider contracts.[294]

Provisions in Medicaid provider services agreements that expressly reference the possibility of federal CAF suspension of payments and that recite that submission of false or miscoded claims or fraudulent misrepresentations could subject the provider to recoupments will defeat claims of a due process violation of a protected property interest when funds are withheld.[295] New Mexico's HSD regulations stated that HSD "may withhold all or a portion of provider payments on pending and subsequently received claims, to recover an overpayment, or may suspend payment on all pending or subsequently submitted claims pending a final determination of the amount of overpayment."[296] Contingent payments to Medicaid providers are not constitutionally protected property in the first instance.[297] Access to state court to litigate claims arising out of a contract will also defeat claims based on a denial of due process.[298]

However, the time over which the state may withhold suspended payments is not unlimited; both federal and state laws label suspensions as "temporary."[299] Once a suspension "crosses the line from 'temporary' to 'indefinite,'" the withheld Medicaid funds transubstantiate into a protected

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[292] Rainbow Dental, LLC v. DentaQuest of New Mexico, LLC, 2016 WL 8234539 at 2 (D.N.M. 2016) (citing to Hulen v. Yates, 322 F.3d 1229, 1240 (10th Cir. 2003)).
[293] Alexandre v. Illinois Dep't of Healthcare & Fam. Servs., 2021 WL 4206792 at 6 (N.D. Ill. 2021); *Rainbow Dental,* 2016 WL 8234539 at 3.
[294] *Rainbow Dental*, 2016 WL 8234539 at 3.
[295] *Border Area Mental Health Servs.*, 2013 WL 12140453 at 4; *see also Zen Grp., Inc*., 2021 WL 4441553 at 5 (S.D. Fla. Sept. 28, 2021), *aff'd on other grounds sub nom*; Zen Grp., Inc. v. Agency for Health Care Admin., 80 F.4th 1319 (11th Cir. 2023) for discussion of reimbursement as "contingent" upon payment determinations by Medicaid agency, and therefore not a constitutionally protected property interest that would support §1983 claim under the Fourteenth Amendment.
[296] *Border Area Mental Health Servs.*, 2013 WL 12140453 at 4.
[297] *Zen Grp. Inc.*, 2021 WL 4441553 at 5.
[298] *Id.*
[299] 42 C.F.R. § 455.23(c).

property interest entitled to due process protection.[300] "[F]ederal courts have stated that the government may not deprive a provider of such funds indefinitely without a hearing."[301]

C. Traditional challenges to agency action

As with any state agency, the actions of a state Medicaid agency are subject to challenge on grounds such as those found in state equivalents to the federal Administrative Procedures Act.[302] Generally, review is available to compel agency action unlawfully withheld or unreasonably delayed or to set aside agency action, findings and conclusions found to be: (1) arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; (2) contrary to constitutional right, power, privilege or immunity; (3) in excess of statutory jurisdiction, authority or limitations or short of statutory right; (4) without observance of procedure required by law; (5) unsupported by substantial evidence on the record of an agency hearing provided by statute; or (6) unwarranted by the facts to the extent that the facts are subject to a trial de novo by the reviewing court.[303]

In the case of suspensions based on federal CAF regulations or state analogs, Medicaid providers claiming violations of constitutional or statutory rights have not prevailed. Further, federal CAF law does not provide for a hearing or require the state Medicaid agency to provide one, nor is the state Medicaid agency required to support the suspension with substantial evidence or a quantum of facts, which rules out a challenge under either of the last two categories listed above.[304] A Medicaid provider challenging a suspension or actions related to a suspension is on firmest ground if a state Medicaid agency has not followed procedures required by law, exceeds its statutory authority or fails to act in conformance with the law. In the case of the 2013 New Mexico provider suspensions, the state auditor's findings a year later that HSD did not follow its own written process for receiving, evaluating, concluding or referring allegations of

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[300] Alexandre v. Illinois Dep't of Healthcare & Fam. Servs., 2021 WL 4206792 at 8 (N.D. Ill. 2021).

[301] Maynard v. Bonta, 2003 U.S. Dist. LEXIS 16201 at 57 (C.D. Cal. 2003). While this case arose well before the ACA and the enactment of the CAF provisions discussed herein, the withheld payments in question arose under a similar regime. This decision contains an excellent discussion and analysis of the outer bounds of the state's authority to retain provider funds while moving at a glacial pace to complete its investigation.

[302] 5 U.S.C. § 706 (1996).

[303] *Id*.

[304] *See generally* 42 C.F.R. § 455.23(a)(2) (2011).

fraud to the MFCU might have served as a basis to challenge HSD's actions.[305]

D. Mandamus

Mandamus is a remedy to compel a public official to perform a ministerial act.[306] An act is "ministerial" when the duty to be performed is clearly spelled out, leaving nothing to the discretion of the official.[307] "If an action involves personal deliberation, decision, and judgment, it is discretionary."[308] "Suits to require state officials to comply with statutory or constitutional provisions are not prohibited by sovereign immunity, even if a declaration to that effect compels the payment of money."[309] A suit for mandamus must allege and prove "that the officer acted without legal authority or failed to perform a purely ministerial act."[310]

Mandamus has been used successfully to compel a state Medicaid agency to complete its investigation of a Medicaid provider, resulting in the recission of suspension of payments and the reactivation of his Medi-Cal numbers.[311] Mandamus has also been used to compel the release of withheld funds to providers following a final administrative decision adverse to the state.[312]

VI. NEW MEXICO ENACTS PROTECTIONS FOR MEDICAID PROVIDERS

Once a state Medicaid agency has made a CAF determination, there is little timely recourse or review of the decision or suspension available to an accused provider — unless state law so provides. In 2019, New Mexico amended its Medicaid Provider Act to require greater rigor on the part of HSD *before* coming to a CAF determination, set standards for auditing and extrapolation and reduce the likelihood that a suspended provider will go broke while awaiting the results of an investigation following a CAF referral. The changes were not fashioned to address hypothetical or potential situations; they were based upon the actual experiences of the 15 New Mexico behavioral health providers.

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[305] *See* Section II(d), *supra* at p.18; Letter from Hector H. Balderas, *supra* note 89.
[306] Janek v. Harlingen Family Dentistry, 451 S.W.3d 97, 101 (Tex. App. 2014).
[307] *Id*.
[308] *Id*.
[309] *Id*. (citing to City of El Paso v. Heinrich, 284 S.W.3d 366, 372 (Tex. 2009)).
[310] *Id*.
[311] Maynard v. Bonta, 2003 U.S. Dist. 16201 at 13 (C.C.D. Cal. 2003).
[312] *Janek,* 451 S.W.3d at 101.

First, new provisions place guardrails on the state Medicaid agency's auditing and extrapolation of audit findings.[313] Medicaid auditors must now be approved by the state auditor and claims must be reviewed by a licensed, certified, registered or otherwise credentialed individual in New Mexico as to the matters being reviewed, including coding or specific clinical practice.[314] Further, extrapolation is not allowed unless a Medicaid provider's error rate exceeds 10% based on valid statistical methods "in accordance with the most recently published Medicare Program Integrity Manual," using statistical software approved by HHS.[315]

Before reaching "a final determination of overpayment or credible allegation of fraud," HSD must provide the Medicaid provider with a "*preliminary* finding of overpayment" ("PFO")[316] The PFO must state the factual and legal basis for each claim forming the basis of the alleged overpayment, and include a copy of the final audit report if the overpayment is based on an audit.[317] These provisions are intended to give the provider sufficient information to enable it to marshal explanatory or exculpatory information to resolve or dispute the PFO. In addition, within 30 days of receipt of the PFO, a provider may request an informal conference with an HSD representative "knowledgeable about" the PFO and "with a member of the audit team, if an audit formed the basis of any alleged overpayment to informally address, resolve or dispute" the PFO.[318] Ideally, disputes can and should be resolved promptly, with corrective action if necessary, without the state or provider incurring unnecessary expense and with little or no interruption in services.

In addition, a Medicaid provider is now afforded the opportunity to request an expedited adjudicatory proceeding following receipt of a final determination of overpayment.[319] A Medicaid provider may challenge HSD's preliminary or final determination of overpayment as: "(1) exceeding statutory authority; (2) arbitrary or capricious;" (3) not following the department's procedure; "or (4) not supported by substantial evidence."[320] The provider may also challenge the credentials of the persons participating in the audit or claims review or the methodology or

[313] N.M. Stat. Ann. § 27-11-7(A)-(B) (1978).
[314] *Id.* at (A).
[315] *Id*. at (B).
[316] *Id.* at (C).
[317] *Id.* at (D).
[318] *Id.* at (D)(3)).
[319] *Id.* at §27-11-9 (providing procedural due process to providers with respect to alleged overpayments).
[320] N.M. Stat. Ann. §27-11-12(A)(1) (1978).

accuracy of the department's audit.[321] The administrative hearing officer's findings of fact and conclusions of law are binding on the HSD, constitute a final agency decision and are appealable to district court.[322]

A CAF determination is now deemed a final agency decision that may be appealed to a district court.[323] Once referred to the attorney general for investigation, a Medicaid provider is entitled to judicial review of this final HSD determination.[324] The HSD is required to show by "substantial evidence" that it has followed its own procedures and that the evidence relied upon to make its CAF determination was relevant, credible and material to the issue of fraud.[325] In addition, the court may not consider evidence acquired by HSD *after* it made its CAF determination.[326]

To ensure that HSD does not unreasonably deny a request for a "good cause" exception to suspension, new provisions specifically direct HSD to accept a surety bond in the amount of the suspended payment and to deem the posting of the bond as "good cause not to suspend payment."[327] To ensure suspensions are not for indeterminate periods of time, new provisions mandate release of suspended payments within ten days of the *earlier* of: (1) the posting of a surety bond; (2) notice from the attorney general that it will not pursue action against the Medicaid provider arising out of the CAF referral; (3) the date on which an administrative decision favorable to the provider as to the basis of the suspension becomes final; or (4) the date on which a judicial decision favorable to the provider as to the basis of the suspension becomes final.[328]

Status as a Medicaid provider will not change following a CAF referral or during the pendency of a dispute with HSD regarding an alleged overpayment, if the provider: submits to prepayment review of claims for ongoing services; demonstrates that employees have completed remedial training or education to prevent the submission of claims for payment to which the provider is not entitled; and engages a third party approved by

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[321] *Id.* at §27-11-12(A)(2)-(3).
[322] *Id.* at §27-11-9(E).
[323] *Id.* at §27-11-16(A) (providing procedural due process to providers whose payments have been suspended based on a CAF).
[324] *Id.* at (B).
[325] *Id*.
[326] N.M. Stat. Ann. §27-11-16(C) (1978).
[327] *Id.* at §27-11-13(A).
[328] *Id.* at (C) (creating a statutory entitlement to reimbursement for previously performed Medicaid services while a fraud investigation is pending, under conditions that protect the government's ability to recoup funds if fraud is found); *see* Shire v. Harpstead, No. 19-0807, 2019 Minn. App. Unpub. LEXIS 1221, at *4 (stating that the statute authorizing payment withholds pending investigation does not confer an entitlement to reimbursements for services already rendered).

HSD to temporarily manage or provide technical assistance to the Medicaid provider after referral or during the pendency of the dispute.[329] Further, a provider that complies with the foregoing requirements will be promptly reimbursed for each clean claim for ongoing services.[330]

Changes to the Medicaid Provider Act provide an award to a prevailing provider of reasonable administrative costs and reasonable litigation costs, capped at the lesser of 30 % of the settlement or judgment or $100,000; in addition, the prevailing provider is entitled to interest on amounts owed to the provider for clean claims.[331] Of note, HSD is prohibited from entering into a contract to pay any portion of funds recovered from a Medicaid provider, "a managed care organization or a subcontractor to any person unless expressly authorized or required to do so by state or federal law."[332]

VII. CONCLUSION

Throughout the transition to the Arizona providers, there was abundant anecdotal evidence of significant disruption in Medicaid behavioral health services.[333] According to *La Frontera*, OptumHealth could not provide a list of Medicaid enrollees for each facility for which it was expected to assume services.[334] By requiring La Frontera to retain but re-credential existing employees, OptumHealth made it impossible for La Frontera to bill for services rendered by these employees until they were re-credentialed.[335] The transition to the Arizona providers was anything but seamless,[336] which meant a reduction in services overall.

According to La Frontera, the formula for determining the amount of the capitated payments that OptumHealth received per member per month was heavily weighted to account for estimated payments that OptumHealth was contractually required to make to Medicaid providers for services.[337] La Frontera argued that OptumHealth realized a windfall during the transition as it continued to receive and retain its full monthly capitation

[329] N.M. Stat. Ann. §27-11-14(A) (1978).
[330] *Id.* at (C) (intending to prevent the state from requiring a provider to continue providing services without reimbursement, thus depleting the provider's reserves and making it likely that the provider will have to close its doors once drained of funds).
[331] *Id.* at §27-11-17.
[332] *Id.* at §27-11-15.
[333] La Frontera Ctr, Inc. v. United Behavioral Health, Inc. 268 F. Supp. 3d 1167, 1179-1180 (2017).
[334] Complaint, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al., No. D-202-CV-2016-00857 (D.N.M. Feb. 9, 2016).
[335] *Id*.
[336] *Id*.
[337] *Id*.

payment for every Medicaid enrollee during a period in which services were: (1) severely disrupted (i.e., not taking place); (2) provided but could not be billed by the replacement providers for want of required licensing or certification; or (3) provided by suspended providers who were not being reimbursed for Medicaid services that the state ordered them to provide pending transition of clients to replacement providers.[338] Whether HSD has ever attempted to recoup these apparent overpayments from OptumHealth remains unknown.

It would be difficult to track the true cost of the 2013 behavioral health provider suspensions to the taxpayers of New Mexico, but there is no doubt that the state's return on investment did not warrant the expense. The state paid approximately $24 million to the five Arizona providers for start-up costs,[339] $3 million for the flawed PCG audit[340] and $10 million to the last five of the falsely accused providers who filed administrative appeals and lawsuits against the state.[341] These amounts do not include the dollar value of the time spent by state employees across different agencies as part of the transition and disruption of services.[342] Nor do they include the dollar value of time spent by HSD legal and other staff on administrative and legal proceedings arising out of the suspensions.[343] The author estimates that the cost to taxpayers of the 2013 suspensions could reach $50 million or more. As laid out in the Section II discussion on extrapolation, *supra*, the state's original claim of $36 million in overpayments was grossly

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[338] *Id.*; *News Release - UnitedHealth Group Continues Efforts to Combat COVID-19 — Reports Second Quarter Performance*, UNITEDHEALTH GRP. (Jul. 15, 2020), https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/investors/2020/UNH-Q2-2020-Release.pdf (demonstrating the phenomenon of greater profit for a health insurer as a result of deferred care during the COVID-19 pandemic (or care not provided or unreimbursed care as in the case of the 2013 New Mexico provider suspensions) is shown by UnitedHealth Group's 48% increase in earnings for the second quarter of 2020).

[339] HSD Summary of Voucher Amounts by Vendor Name Report and Letters of Direction Nos. 190, 191, 192, 192-A, 193, 194, 198 (cost contained in summary of voucher amounts), 199, 199-A (on file with the author).

[340] N.M. LEGIS. FIN. COMM., HUM. SERV. DEP'T COST & OUTCOMES OF SELECTED BEHAV. HEALTH GRANTS & SPENDING, REP. #13-04 5, at 8 (May 16, 2013).

[341] *Id.* (stating the state returned $300,000 of remaining withheld overpayments to three of the five).

[342] *BHS Contract, supra* note 6, at 122. Recall that OptumHealth was managing behavioral health funds for the Department of Health; the Human Services Department; the Children, Youth and Families Department; the Aging and Long-Term Services Department; the Department of Finance and Administration; the Public Education Department; the New Mexico Corrections Department; and the Administrative Office of the Courts. January 22, 2009, Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract.

[343] *BHS Contract, supra* note 6, at 92.

inflated. The most that the state has claimed that it recovered because of the suspensions is "about" $4.4 million, most of which was extracted from PMS in its early settlement with the state.[344]

As shown from the 2013 suspensions of the New Mexico behavioral health providers, an accusation that results in suspended payments and the rapid destruction of a Medicaid provider's business can come from any source: a managed care organization, a competitor, a former partner or a disgruntled employee — or state officials acting in bad faith. Political or commercial considerations may improperly influence a state's CAF determination or its failure to find that good cause exists not to suspend payments. Years later, questions remain about the destruction of New Mexico's behavioral health system and whether those responsible have been, or ever will be, held accountable to New Mexican families or taxpayers.

Nearly a decade later, there are reports that Arizona's use of CAF has caused a catastrophic interruption in behavioral health services for indigenous patients.[345] In 2023, the Arizona Health Care Cost Containment System (AHCCCS) suspended payments to over 220 behavioral health providers serving primarily indigenous patients through the American Indian Health Plan (AIHP).[346] As in the case of the ill-advised 2013 CAF suspensions by New Mexico's Medicaid agency, Arizona's Medicaid regulators have been criticized for "[failing] to adequately anticipate the impact of widespread suspensions among behavioral health providers [putting] members of an already susceptible population at further risk of relapse, abuse, homelessness and even death as operators shut down." While there is no doubt that a reported $615 million increase in AIHP behavioral health claims over a three-year period strongly suggests fraud,[347] the use of CAF as a blunt instrument has apparently "swept up" many legitimate and innocent providers.[348]

One astute commentator has observed:

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[344] McKay, *supra* note 69 (referencing Section II (f) discussion entitled "*Four million dollars,*" on page 20). Recall that $4 million was paid by Presbyterian Medical Services in a business-decision settlement that admitted no fault on its part.

[345] Hannah Bassett & Maria Polletta, *Patients, advocates describe 'pure chaos' in state response to AHCCCS fraud*, ARIZ. CTR. FOR INVESTIGATIVE REPORTING (Nov. 2, 2023), https://azcir.org/news/2023/11/02/state-response-medicaid-fraud-creates-patient-chaos/.

[346] *AHCCCS CAF Suspensions- the biggest scandal in Arizona, or did AHCCCS make its own bed?*, *supra* note 176.

[347] Bassett & Polletta, *supra* note 345.

[348] *AHCCCS CAF Suspensions—the biggest scandal in Arizona, or did AHCCCS make its own bed?*, *supra* note 176.

> AHCCCS has accepted little responsibility for its own role in the downfall of the AIHP program. Rather than addressing the problems methodically, remedying the lack of oversight and carelessly drafted rules, AHCCCS elected to, in effect, close the program completely. The problem AHCCCS faces now, however, is that all the suspended providers are entitled to due process, no matter how toothless the processes may be. There are simply not enough AHCCCS investigators to adequately investigate 220 fraud cases. Similarly lacking are the number of administrative law judges and hearing days for these providers to be afforded any, much less adequate, due process. AHCCCS has also "referred" every single one of its suspensions to law enforcement, as a matter of course, which even further delays any possible resolution. Because of delays inherent in the suspension "review' process, many innocent providers will most likely eventually give up, and close their doors—a fact about which AHCCCS is certainly aware, and most certainly is counting on.[349]

AHCCCS is clearly taking the political heat for what Arizona's Attorney General has dubbed "one of the largest scandals in state history."[350] Very recently, Arizona's Governor Katie Hobbs has revealed that the suspected fraud is not limited to AIHP as previously reported, but also extends to managed care.[351] Over 90% of AHCCCS's services are overseen by MCOs, "meaning the crisis ultimately affected the agency's entire provider ecosystem, not just [AIHP]."[352] The alleged reason for "at least $2 billion" in fraud in both AIHP and managed care is AHCCCS's waiver of Medicaid provider vetting and screening requirements during the COVID public health emergency. [353] This "allowed nefarious providers to more easily enter [the Medicaid program] and remain active" as Medicaid providers.[354] Given this latest disclosure, AHCCCS has been accused of "lack of transparency [raising] questions about how effectively they are addressing the root causes" of the scandal.[355]

VIII. RECOMMENDATIONS

[349] *Id.*
[350] Hannah Bassett, *Arizona leaders misled public about scope of Medicaid fraud crisis,* ARIZ. CTR. FOR INVESTIGATIVE REPORTING, (Mar. 14, 2024), https://azcir.org/news/2024/03/14/state-leaders-misled-public-about-scope-of-medicaid-fraud-crisis/.
[351] *Id.*
[352] *Id.*
[353] *Id.*
[354] *Id.*
[355] *Id.*

In addition to having legal counsel review Medicaid participating provider agreements and before agreeing to participate in Medicaid, a provider should ascertain whether laws in its state provide protections such as those enacted in New Mexico. If not, then the state legislature should be lobbied to enact them. Serving over 85.3 million Medicaid beneficiaries nationally *before* the 2020 Covid-19 pandemic, Medicaid is already challenged in finding physicians to participate in the program due to its lower-than-Medicare reimbursement rates.[356] As this article has revealed, the high risk posed to a Medicaid provider's livelihood and reputation under current federal CAF laws and regulations will only increase providers' reluctance to participate in Medicaid.

The federal government should encourage, support and reward providers who serve the nation's Medicaid population. It is wrong to emphasize and normalize zealous prosecution of *providers* as a standard funding mechanism for Medicaid or to generate support for expansion of Medicaid programs.[357] Of no little significance, the OIG's 2021 report on the widespread unreliability of MCO payment and encounter data calls into question whether data mining is a legitimate basis for a CAF.[358] The OIG should follow up its 2021 report with a transparent investigation into the number of CAF referrals based on MCO data mining that have proved unfounded, and quantify the collateral damage to accused providers and their patients.

Unfortunately, state governments have "surrendered direct control" [359] of their Medicaid programs to MCOs that are paid hundreds of millions of dollars to manage each state's program and detect fraud. Greater independent oversight and consequences must be imposed upon Medicaid MCOs to maintain reliable encounter and payment data that is used to flag potential fraud. The New Mexico behavioral health providers were low-hanging fruit and paid a terrible price to defend and eventually exonerate themselves. To fight fraud, waste and abuse, far greater focus needs to be *upstream*, on Medicaid MCOs and the state regulators responsible for overseeing them.

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[356] Kayla Holgash & Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters & What Doesn't*, HEALTH AFF. BLOG (Apr. 10, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full/.

[357] J. STUART SHOWALTER, THE L. OF HEALTHCARE ADMIN. 59 (9th ed. 2020) (stating the ACA strengthened and promoted aggressive enforcement of fraud, waste, and abuse laws to "help recoup some of the costs of new [ACA] programs.").

[358] *Data on Medicaid Managed Care Payments to Providers Are Incomplete and Inaccurate*, U.S. DEP'T OF HEALTH & HUM. SERV., OFF. OF INSPECTOR GEN. (Mar. 2021).

[359] SHOWALTER, *supra* note 357 at 47 (citing to PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 375 (1982)).

Finally, before suspending payments to Medicaid providers based on mere "credible allegations of fraud," state Medicaid regulators should carefully weigh both short- and long-term impacts on the system of care, the potential for unintended consequences, the limitations of their own workforce to conduct investigations and hearings, and the true cost to taxpayers of pursuing providers in court and administrative proceedings. Only providers "who engaged in egregious conduct, not those who misunderstood or operated within the bounds of the rules, should be prosecuted."[360] Putting providers out of business instead of imposing corrective action or settling cases "defeats the purpose" of programs that provide services to vulnerable populations."[361]

[360] *AHCCCS CAF Suspensions—the biggest scandal in Arizona, or did AHCCCS make its own bed?*, *supra* note 176.
[361] *Id.*