JOURNAL OF HEALTH CARE FINANCE

Summer 2021

Unsubstantiated "Credible Allegations of Fraud" Pose A High Risk to Medicaid Providers: A Lesson from New Mexico

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I. INTRODUCTION

A new 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[1] the greater part of New Mexico's behavioral health system in 2013. 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. 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 15 New Mexico behavioral health provider organizations[2] accused of Medicaid fraud soon 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.[3] 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.

OptumHealth New Mexico[4] (OptumHealth), the state's behavioral health managed care organization, instigated the suspensions. The administration of Governor Susana Martinez suspended payments and referred the 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 the 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. By the time they were exonerated by the attorney general, 13 of the providers had gone out of business.[5] Of the five Arizona-based

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[1] One commentator characterized this as a "Kafka-esque Purge." Ruth McCambridge, *10 [sic] New Mexico Nonprofits Punished out of Existence in Kafka-esque Purge*, NONPROFIT QUARTERLY, February 8, 2016.

[2] While outpatient behavioral health services can be provided by individual licensed practitioners or group practices of licensed individuals, "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." U.S. DEP'T OF HEALTH § HUMAN SERV. OFFICE OF INSPECTOR GENERAL, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE, OEI-02-17-00490, at 4-5 (September 2019).

[3] The fifteen suspended providers were "Partners in Wellness LLC, Santa Maria 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." Letter from Brent Earnest, Deputy Cabinet Secretary, Human Services Department to Senator Mary Kay Papen (Apr. 3, 2014)(on file with the author)("Earnest Letter").

[4] United HealthCare Insurance Company and United Behavioral Health through their joint venture OptumHealth New Mexico. Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract (" BHS Contract") at 1, (January 22, 2009).

[5] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE, OEI-02-17-00490, at 2 (September 2019).

behavioral health providers[6] brought in to replace the 15 suspended providers, only two remain in the state as of this writing.[7]

At the time of the suspensions, New Mexico's annual total behavioral health spending approached $250 million,[8] all of it managed by OptumHealth. Of this, more than 65% was spent on those under the age of 18; two-thirds of the state's behavioral health expenditures were for those under the age of 21[9]; and two-thirds of the suspended providers' clients were under the age of 21.[10] These clients were "particularly vulnerable" and included "individuals with homicidal and suicidal ideation, children in foster care homes, and individuals dependent on psychotropic drugs."[11] The disruption of services[12] would lead many clients to disengage with treatment and lose access to medication — increasing the number of incarcerations, hospitalizations, overdoses and suicides.[13] According to many, New Mexico's behavioral health system has not recovered to this day.[14]

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 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.

A review of decisions from proceedings 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 in the absence of a state statute that gives Medicaid providers a right of expedited review and other protections. In the near term, the most expedient

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[6] 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.; Supplemental Affidavit 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").

[7] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE, OEI-02-17-00490, at 2 (September 2019).

[8] Figures are for fiscal year 2012. NEW MEXICO HUMAN SERVICES DEP'T, ANNUAL REPORT, at 3 (2012).

[9] *Id.*

[10] NEW MEXICO HUMAN SERVICES DEP'T, ANNUAL REPORT, at 3 (2012).

[11] Border Area Mental Health Serv., Inc. v. Squier, No. 13-cv-00613, 2013 WL 12140453, *8 (D.N.M. July 25, 2013). 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. Email from Patsy Romero, Chief Executive Officer, Easter Seals El Mirador (May 26, 2020) (on file with the author).

[12] 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. Email from Brian Kavanaugh, Chief Executive Officer, Families and Youth, Inc. (June 4, 2020) (on file with author).

[13] Email from Patsy Romero, Chief Executive Officer, Easter Seals El Mirador (May 26, 2020) (on file with author).

[14] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, "PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE," OEI-02-17-00490, at 2 (September 2019). (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").

approach is for Medicaid providers to lobby their state legislatures to enact laws that expressly afford accused Medicaid providers due process and that set limits on the state's power to retain suspended payments while providers are being investigated or when no fraud is found. The New Mexico legislature passed such legislation by bipartisan unanimous vote, and it was signed into law by Governor Michelle Lujan Grisham in 2019.[15] Change in CAF laws and regulations at the federal level will require a coordinated effort on the part of Medicaid providers, professional societies and provider organizations. As the Biden administration endeavors to provide health care to the growing numbers of uninsured and Medicaid-eligible individuals, the time is right to incorporate due process protections in CAF laws and regulations that incentivize providers to participate in Medicaid.

II. BACKGROUND

a. OptumHealth becomes the statewide entity for behavioral health

For years, New Mexico has had a shortage of mental health professionals.[16] This shortage is keenly felt in rural areas where approximately a quarter of New Mexicans live.[17] 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.[18] To do this, the state "carved out Medicaid funds for behavioral healthcare" from the state's existing Medicaid managed care program.[19] As part of this initiative, the state reformed its behavioral health policy to emphasize recovery as a process in which consumers would be fully integrated into their communities with "the ability to live a fulfilling and productive life despite a disability."[20] Frontline service providers were to "assist" rather than "direct" consumers; various "initiatives were to promote recovery through a wraparound approach to planning services that were holistic, based on client and family strengths, culturally appropriate, highly individualized, and flexible enough to address a person's needs across multiple domains — home, school and community."[21]

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.[22] Beginning in 2009, OptumHealth served as the "statewide entity" under a four-year contract, to have ended June 30, 2013. Among its provisions,

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[15] NMSA 1978 §§27-11-1 through 27-11-18. S.B. 41, 54th Leg., Regular Sess. (N.M. 2019) was sponsored by Senate President Pro Tempore Mary Kay Papen and signed into law by Governor Michelle Lujan Grisham, after Susana Martinez left office.

[16] Rural Health Information Hub, https://www.ruralhealthinfo.org/charts/7?state=NM (Last visited June 6, 2021).

[17] U.S. CENSUS BUREAU, URBAN AND RURAL DATA, 2010 AND 2020.

[18] Cathleen E. Willging, et al, *The Transformation of Behavioral Healthcare in New Mexico*, ADMIN. POLICY MENTAL HEALTH, 2015 May: 42(3): 343-355, doi: 10.1007/s10488-014-0574-0.

[19] *Id.*

[20] Willging, et al, *supra*.

[21] Willging, et al, *supra*.

[22] The state agencies that funded behavioral health services administered under this contract included, among others: 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. Interagency Behavioral Health Purchasing Collaborative Statewide Behavioral Health Services Contract ("BHS Contract") (January 22, 2009).

OptumHealth was paid a capitated rate[23] for Medicaid managed care, whereby OptumHealth assumed "full financial risk for all medical and administrative expenditures" for the applicable Medicaid cohort.[24] 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.[25] 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."[26] The LFC determined that in fiscal 2010, OptumHealth was paid "$243 million in capitation payments based on this alternate formula."[27] 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.[28]

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). Of note, this amendment also required OptumHealth to comply with the new suspension of payments provisions of the ACA based on CAF. [29] The amendment provided that recouped Medicaid funds were to be returned to the State.[30]

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 claims payments, which put providers under financial strain and jeopardized consumer access to services.[31] As a result, OptumHealth was sanctioned $1 million for failure to timely pay claims.[32] According to the monitor overseeing the corrective action,

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[23] A capitation payment is a fixed monthly payment to a Medicaid managed care organization (MCO) for every member enrolled in the MCO's Medicaid plan. The federal government reimburses a state for the federal share ("federal medical assistance percentage" or "FMAP") of the capitation payments. " In return for the capitated payment, the MCO is responsible for arranging for and paying providers' claims for all covered services provided to Medicaid beneficiaries." U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-18-528, MEDICAID MANAGED CARE: IMPROVEMENTS NEEDED TO BETTER OVERSEE PAYMENT RISKS (July 2018). The FMAP for fiscal year 2010 was 71.35%. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP), FISCAL YEAR 2010 (11/26/2008)("GAO Report"), last accessed at https://aspe.hhs.gov/basic-report/federal-medical-assistance-percentages-fmap-fiscal-year-2010

[24] BHS Contract, Article 6.14 (B).

[25] BHS Contract, Article 6.14 (G).

[26] LEGISLATIVE FINANCE COMMITTEE, REPORT ON HUMAN SERVICES DEPARTMENT AND OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD, WASTE, AND ABUSE CONTROLS, at 27 (July 14, 2011).

[27] *Id*.

[28] 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. GAO Report, p.9.

[29] Amendment 11 to BHS Contract, at 3 (August 24, 2012).

[30] *Id*. at p.12.

[31] *Update on OptumHealth NM* (11/18/09 presentation by the Interagency Behavioral Health Purchasing Collaborative to the New Mexico Legislative Finance Committee), pp. 2, 5, 6-9.

[32] McWilliams Affidavit, ¶22.

OptumHealth relaxed several system audits (described as "wild card edits") to address the nonpayment issues but this "had tremendous side effects in claims accounting, including incorrect fund sources, inaccurate encounter data and significant overpayments."[33] Claims processed under the wild card edits would require reprocessing and in some cases recoupment.[34] As of June 29, 2011, the monitor reported that OptumHealth had recouped $18.1 million out of $22.2 million in overpayments caused by its effort to expedite claims payments.[35] 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."[36]

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."[37] 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.[38] 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.[39] 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.[40]

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.[41] 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 15 behavioral health providers that is the subject of this article.

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

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[33] Memo from Alicia Smith & Associates, LLC to HSD Secretary Sidonie Squier and other members of the IBHPC (June 30, 2011). *See also* note 28, *supra*, regarding how inaccurate encounter data and unadjusted overpayments lead to inaccurate capitated rates.

[34] *Id*.

[35] *Id*.

[36] HEALTHINSIGHT NEW MEXICO, INDEPENDENT ASSESSMENT OF NEW MEXICO'S MEDICAID PROGRAM—BEHAVIORAL HEALTH STATEWIDE ENTITY, FINAL REPORT, at 7 (June 28, 2013).

[37] BHS Contract, Article 3.17 "Program Integrity."

[38] BHS Contract, Article 23.2.

[39] Complaint, State of New Mexico *ex rel* Tafoya v. OptumHealth, Inc. et al; No. D-101-CV-2012-01391; 1st Dist. Santa Fe County, New Mexico (5/16/12)("*Tafoya*"); U.S. *ex rel* Clark v. UnitedHealthGroup, Inc. et al, No. 1:13-CV-00372; U.S. Dist. Ct., District of New Mexico.

[40] *Tafoya* Complaint at ¶7. Note that this is approximately the amount of unrecouped overpayments reported by the monitor overseeing the corrective action.

[41] 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 re*l Tafoya v. OptumHealth, Inc. et al; No. D-101-CV-2012-01391; 1st Dist. Santa Fe County, New Mexico. The *Clark* lawsuit only became public in July of 2015. Order (July 10, 2015) U.S. *ex rel* Clark v. UnitedHealthGroup, Inc. et al, No. 1:13-CV-00372; U.S. Dist. Ct., District of New Mexico (lifting seal).

that OptumHealth looked at its data.[42] She gratuitously added that OptumHealth had "always been in compliance" with previous protocols.[43] 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 corrective action monitor's findings of inaccurate encounter data and significant overpayments to providers — data elements 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.[44] 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.[45] 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.[46] The compliance manager eventually pleaded no contest to two of the 10 counts in "a deal with the Attorney General's office that went largely unnoticed" until after OptumHealth's contract expired.[47]

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. 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. A plan is hatched

Following the separate firings of its own fraud investigators in January and April of 2012, OptumHealth's management must have been 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 15 nonprofits that served the mentally ill and addicted" by contending that "it found questionable billing practices involving the providers."[48] According to La Frontera, one of the Arizona providers brought in to take over

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[42] Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, "Update on Behavioral Health Services," presentation by Diana McWilliams, Director of the Behavioral Health Services Division of the New Mexico Human Services Department and Chief Executive Officer of the Interagency Behavioral Health Purchasing Collaborative (September 30, 2013).

[43] *Id*.

[44] State of New Mexico v. Debra K. Gonzales; No. D-202-CR-201402433; Dist. Ct. Albuquerque, NM; (May 28, 2014).

[45] Colleen Heild, *AG: Behavioral health boss falsified records*, ABQ. JOURNAL, Oct. 10, 2014, last accessed at https://wwww.abqjournal.com/477521/ag-behavioral-heallth-records-falsified.html.

[46] *Id*.

[47] *OptumHealth accused of fraud in three lawsuits*, THE SANTA FE NEW MEXICAN, March 28, 2016, last accessed at http://insurancenewsnet.com/0article/OptumHealth-accused-of-fraud-in-three-lawsuits.

[48] Colleen Heild, *AG: Behavioral health boss falsified records*, ABQ. JOURNAL, October 10, 2014, last accessed at https://wwww.abqjournal.com/477521/ag-behavioral-heallth-records-falsified.html ; Minutes of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, p. 2 (September 3, 2013)(Deputy

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'."[49]

It was no doubt easy for OptumHealth to convince Governor Martinez and her HSD Secretary to initiate a special program integrity project to follow up on so-called suspicious findings made by Optum for the 15 behavioral health providers. Susana Martinez became New Mexico's Governor on January 1, 2011. She was a former prosecutor and was considered a rising GOP star, garnering national attention when she spoke at the Republican National Convention in late August of 2012.[50] 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.[51] In its report, LFC urged HSD to do a better job of identifying and stopping Medicaid fraud.[52] 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."[53]

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.[54] A behavioral health policy analyst observed:

> Unburdened by the state's past experience with reform, new political appointees [of the Martinez administration] recruited from outside New Mexico set out to 'modernize' the Medicaid system to increase administrative efficiencies and decrease state spending on recipients . . . . Notably, the language of recovery and transformation, so prominent in the framing of the previous [behavioral health] reform in New Mexico is largely absent in the official discourse concerning Centennial Care, which is instead focused on the neoliberal ideals of cost containment and efficiency . . . .[55]

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

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Secretary of HSD Brent Earnest tells committee members that OptumHealth referred 15 provider agencies to HSD for "suspicious billing activity" in November of 2012).

[49] Complaint, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al; No. D-202-CV-2016-00857 (February 9, 2016) at ¶45.

[50] Amber Phillips, *Once hailed as the GOP's ideal VP pick, Susana Martinez finds herself clashing with Donald Trump*, THE WASHINGTON POST, May 25, 2016; NATIONAL GOVERNOR'S ASSOCIATION https://www.nga.org/governor/susana-martinez/; Video of the governor's full speech at: https://www.youtube.com/watch?v=_b0yuSTVARc.

[51] LEGISLATIVE FINANCE COMMITTEE, HUMAN SERVICES DEPARTMENT AND OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD, WASTE, AND ABUSE CONTROLS, at 2 (July 14, 2011).

[52] *Id.* at 29.

[53] *Id.*

[54] NEW MEXICO HUMAN SERVICES DEPARTMENT, ANNUAL REPORT 2012, at 1 and 3. The new Medicaid program, called "Centennial Care" was to be fully implemented by January 1, 2014.

[55] Willging, et al., *supra.*

organizations chosen by HSD's Medicaid division to implement "Centennial Care," the state's re-imagined Medicaid program.[56]

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.[57]

Among its duties as the statewide entity, OptumHealth (in conjunction with the HSD Inspector General) was responsible for conducting program integrity activities for the state's behavioral health services that OptumHealth administered.[58] Despite OptumHealth's existing program integrity obligations, HSD executed a contract in early February 2013 with Public Consulting Group ("PCG") for an intensive audit[59] of the 15 behavioral health providers flagged by OptumHealth.[60] 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. It is clear that, 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.[61]

On February 25, 2013, HSD requested approval to enter into emergency procurement contracts with two Arizona behavioral health providers (including La Frontera) from March 11, 2013 (before the PCG audits were concluded) through December 31, 2013, 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.[62] Soon, HSD would bring in a total of five Arizona companies to replace the 15 New Mexico behavioral health providers.[63]

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

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[56] Julie Weinberg, Director, Medical Assistance Division, New Mexico Human Services Department; *Presentation to the Legislative Health and Human Services Committee on Centennial Care Implementation*; at 2-3 (November 6, 2013).

[57] Complaint, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al; No. D-202-CV-2016-00857 (February 9, 2016) at ¶51.

[58] LEGISLATIVE FINANCE COMMITTEE, HUMAN SERVICES DEPARTMENT COST AND OUTCOMES OF SELECTED BEHAVIORAL HEALTH GRANTS AND SPENDING, REPORT #13-04, at 8 (May 16, 2013).

[59] *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.

[60] Professional Services Contract No. 13 630 8000 0026. The state paid PCG $3 million to conduct the audit. *See* LEGISLATIVE FINANCE COMMITTEE, HUMAN SERVICES DEPARTMENT COST AND OUTCOMES OF SELECTED BEHAVIORAL HEALTH GRANTS AND SPENDING, REPORT #13-04, at 8 (May 16, 2013).

[61] In an appearance before the Legislative Health and Human Services Committee on 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." Behavioral Health Provider Audit Results (6/24/13) (on file with author).

[62] Supplemental Affidavit of Diana McWilliams (8/2/13), Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453 (D.N.M.) (on file with author).

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

become a replacement behavioral services provider by misrepresenting 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."[64]

> "PCG said we overbilled more than $9 million, HSD increased that to over $12 million and the HSD ALJ ruled that we owed less than $900." Shannon Freedle, Teambuilders CEO

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 had even 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.[65] 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.[66]

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.[67] 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 15 providers over a three-year

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[64] Complaint, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al; No. D-202-CV-2016-00857 (February 9, 2016) at ¶97(d) and (g) (on file with author). 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. United Healthcare moved to compel arbitration. In a lengthy opinion, the district court granted the motion, finding that the arbitration clause was enforceable and applied to every claim raised in La Frontera's suit against the United Healthcare/OptumHealth defendants. La Frontera Center, Inc. v. United Behavioral Health, Inc., 268 F. Supp. 3d 1167 (D.N.M. 2017); *cp*: Clark v. UnitedHealth Group, Inc., 2018 WL 2932735 (D.N.M. June 6, 2018) in which a federal magistrate found that an arbitration clause in a UnitedHealth employment agreement with an at-will employee lacked consideration since "an offer of at-will employment is illusory." The district court adopted the magistrate's proposed findings and denied UnitedHealth's Motion to Compel Arbitration of Clark's whistle-blower and retaliatory discharge claims. Clark v. UnitedHealth Group, Inc., 2018 WL 3539817 (July 23, 2018) Not reported in Fed. Supp.

[65] April 19, 2016 letter from Easter Seals El Mirador to Senator Mary Kay Papen, Senator Michael Sanchez and Representative Brian Egolf (on file with author).

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

[67] Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453, *1 (D.N.M.).

period (2009-2011) and 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.[68]

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.[69] Based on its determination that the audit findings were "credible allegations of fraud," HSD referred the 15 providers to the MFCU and the MFCU accepted the referrals for investigation.[70]

On June 24, 2013, HSD and PCG met with the 15 providers to advise them of the referrals to the MFCU based on CAF.[71] 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). [72] 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."[73]

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.[74] This would give OptumHealth a share of any funds recovered from the 15 suspended 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.[75]

Following the June 24 meeting with providers, HSD announced in a press release that it had suspended payments to the 15 providers.[76] 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."[77]

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[68] Public Consulting Group, State of New Mexico, Human Services Department, Behavioral Health Provider Audits Executive Summary ("Redacted"), p. II, https://www.documentcloud.org/documents/726527-ag-disclosure-redacted-behavioral-health-audit.html

[69] Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453, *1 (D.N.M.).

[70] *Id*. at *2.

[71] *Id*.

[72] *Id*.

[73] *Id*.

[74] State of New Mexico Professional Services Contract (No. 09-630-7903-0063 A 15), Contract Amendment No. 15, Article 46.4 (6/11/13).

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

[76] Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453, *3 (D.N.M.).

[77] *Id*.

A year later, in the course of conducting its fiscal 2013 financial audit of HSD and responding to concerns of a legislative committee[78] 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 the PCG audit from HSD.[79] 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."[80] This statement had been removed by HSD from the PCG audit report that was produced to the State Auditor pursuant to court order.[81] 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."[82]

Equally troubling, the State Auditor identified a "significant deficiency" regarding HSD's procedures for investigating allegations of fraud.[83] 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."[84]

After six years of administrative proceedings and 10 lawsuits, there were no findings of fraud, and overpayments were a fraction of the amount originally claimed by the state; a $2.8 million demand to one provider was reduced to $484.71.

e. The pitfalls of extrapolation[85]

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. As one commentator notes, "with extrapolated results, auditors allege millions of dollars of overpayments against healthcare providers — sometimes a sum of more than the provider . . . made during the relevant

[78] The Behavioral Health Subcommittee of the Legislative Health and Human Services Committee.
[79] Letter from Hector H. Balderas, State Auditor, Office of the State Auditor to State Representative Elizabeth "Liz" Thomson, Chair, and State Senator Benny Shendo, Vice-Chair, Behavioral Health Subcommittee (July 24, 2014) (on file with author).
[80] *Id*. at 3.
[81] *Id*.
[82] *Id*.
[83] *Id*. at 4.
[84] *Id*.
[85] 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.

time period . . . ."[86] However, it goes without saying that mistakes in the audit process itself or sampling errors necessarily invalidate any extrapolations based upon them.

Soon after the suspensions, a legislative behavioral health subcommittee convened to look into "the fallout."[87] "One subcommittee member expressed great concern about reports that hospitals in Las Vegas[88] and Silver City [were] being flooded with clients who had been turned away" [89] 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."[90] Yet another expressed concern about employees who lost jobs and benefits when their agencies were replaced.[91]

A North Carolina attorney with first-hand experience with PCG's Medicaid provider recovery audits was also on the subcommittee's agenda. 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.[92] In that case, PCG's extrapolated overpayment amount of $702,611 was reduced to $336.84 on appeal. Ms. Emanuel advised the committee that nationally, 72 % of denied payments, such as those withheld from the New Mexico providers, are overturned on appeal.[93] However, she added, it was up to states to provide those appeal rights under state law.[94] 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 10 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,[95] were "a fraction" of original estimates.[96] Examples include: a $2.8 million

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[86] Knicole Emanuel, *CMS Revises and Details Extrapolation Rules*, MEDICAID & MEDICARE: A LEGAL BLOG, last accessed at https://medicaidlawnc.com/2019/11/26/cms-revises-and-details-extrapolation-rules/

[87] Minutes of the Second Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, September 3, 2013.

[88] Las Vegas, New Mexico is where the state's only behavioral health hospital is located.

[89] Minutes of the Second Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, September 3, 2013, p. 4; last accessed at https://www.nmlegis.gov/minutes/BHSminSept03.13.pdf

[90] *Id*. at 5.

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

[92] Knicole Emanuel, *North Carolina's Medicaid Audit*, September 3, 2013; last accessed at https://www.nmlegis.gov/handouts/BHS%20090313%20Item%203%20Knicole%20C.%20Emanuel's%20presentation%20regarding%20North%20Carolina's%20Medicaid%20Audit%20Experience.pdf

[93] Minutes of the Second Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, September 3, 2013, p. 7; last accessed at https://www.nmlegis.gov/minutes/BHSminSept03.13.pdf

[94] *Id*.

[95] After paying PCG $3 million for the audit, HSD "threw PCG's audit in the trash," according to defense counsel for some of the suspended New Mexico providers. Trip Jennings and Sylvia Ulloa, *State's 'credible allegations of fraud' charge against health providers falls apart*, NEW MEXICO IN DEPTH, July 1, 2017, last accessed at https://nmpolitics.net/index/2017/07/states-credible-alllegations-of-fraud-charge-against-health-providers-falls-apart/

[96] Robert Nott, *Behavioral health groups settle with state of New Mexico*, SANTA FE NEW MEXICAN, December 4, 2019, last accessed at https://www.santafenewmexican.com/news/health_and_science/behavioral-health-groups-settle-with-state-of-new-mexico/article_8075db49-20b4-50a7-8bb4-d14ba977c881.html

demand to one provider, reduced to $484.71;[97] another provider's alleged overbilling of $856,745 was reduced to zero;[98] and another provider's alleged overpayments went from a high of $12 million to $896.00.[99]

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."[100] 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.[101] Following its pay suspension, Presbyterian Medical Services (PMS) filed a request with HSD for a "good-cause exception not to suspend payments."[102] 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.[103] However, HSD was willing to discuss a settlement.[104]

The PCG audit concluded that PMS had overbilled the state by $4.3 million.[105] Apparently, a factor in PCG's findings were missing documents (such as PMS employee credentials and training records) in the files that PCG reviewed.[106] PMS looked for and located the documents in question and had the resources to conduct its own audits, which did not support PCG's findings.[107] PMS offered the missing documents to PCG for review, but HSD would not allow PCG to consider this exculpatory evidence.[108]

According to PMS executives, in the five years before the suspensions, PMS had not received any notices from OptumHealth of "program integrity problems," overbilling or other

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[97] Dan McKay, *State settles for $484 after $2.8M demand*, ABQ. JOURNAL, June 23, 2017, last accessed at https://www.abqjournal.com/1022848/nms-overpayment-demand-falls-from-2-8m-to485.html

[98] Sylvia Ulloa, , *With agreement in hand, behavioral health CEO believed vindication was inevitable*, NEW MEXICO IN DEPTH, July 17, 2017, last accessed at https://nmindepth.com/2017/07/17/with-agreement-in-hand-fyi-leader-knew-vindication-was-inevitable/

[99] Trip Jennings and Sylvia Ulloa, *State's 'credible allegations of fraud' charge against health providers falls apart*, NEW MEXICO IN DEPTH, July 1, 2017, last accessed at https://nmpolitics.net/index/2017/07/states-credible-alllegations-of-fraud-charge-against-health-providers-falls-apart/

[100] In re Able Services, Inc., 59 Misc. 3d 171, 192-93 (2017).

[101] Presbyterian Medical Services, Report on Behavioral Health Services and Capacity to the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (October 2014), Slide 13;

[102] Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (October 8, 2014), p.8.

[103] *Id*.

[104] *Id*.

[105] Trip Jennings, *State refused evidence that refuted audit, health provider says*, NEW MEXICO IN DEPTH, October 10, 2014, last accessed at http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/

[106] *Id*.

[107] *Id*. *See also*, Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (October 8, 2014), p.8 (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.

[108] Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (October 8, 2014), p.8.

performance issues.[109] In fact, PMS staff had "worked regularly" with OptumHealth and "regular audits" by OptumHealth gave PMS scores of between 88 to 97%.[110] Of note, similar favorable dealings with, and previous high audit scores from, OptumHealth were reported by the other suspended providers.[111]

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. 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.[112] PMS and HSD entered into a settlement of disputed claims in the amount of $4 million approximately four months following the suspensions.[113] OptumHealth's chief executive officer was involved in settlement discussions, according to a PMS executive who appeared before a legislative subcommittee.[114]

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.[115] The settlement also required PMS to sever 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.[116]

In April 2014, when asked by a state legislator whether OptumHealth or any of its affiliates received any settlement proceeds from HSD's settlement with PMS or any other of the 15 behavioral health providers, the Deputy Secretary of HSD stated that it had not; he indicated that the state had used approximately one-third of the PMS settlement proceeds to reimburse two of

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[109] *Id*.

[110] *Id*.

[111] 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," Minutes of the First Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (July 9, 2013), p.6.

[112] Trip Jennings, *State refused evidence that refuted audit, health provider says*, NEW MEXICO IN DEPTH, October 10, 2014, last accessed at http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/

[113] Settlement Agreement between the State of New Mexico and Presbyterian Medical Services, Inc. (October 30, 2013). To see the PCG allegations against it to enable it to evaluate settlement with the state, PMS was obliged to enter into a non-disclosure agreement to expire on the earlier of one year (September 4, 2014) or at the conclusion of the attorney general's investigation. Non-Disclosure Agreement between the State of New Mexico and Presbyterian Medical Services, Inc. (September 4, 2013). *Links to these documents embedded in* Trip Jennings, *State refused evidence that refuted audit, health provider says*, NEW MEXICO IN DEPTH, October 10, 2014. last accessed at http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/

[114] Minutes of the Third Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, (October 8, 2014), p.8.

[115] Trip Jennings, *State refused evidence that refuted audit, health provider says*, NEW MEXICO IN DEPTH, October 10, 2014. last accessed at http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/ (*See embedded link to* "Non-disclosure Agreement between State of New Mexico Human Services Department and Presbyterian Medical Services, Inc." Section 8 of the NDA requires 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)

[116] Settlement Agreement between the State of New Mexico and Presbyterian Medical Services, Inc. (October 30, 2013) (Section 3), *Link to this document embedded in* Trip Jennings, *State refused evidence that refuted audit, health provider says*, NEW MEXICO IN DEPTH, October 10, 2014. last accessed at http://nmindepth.com/2014/10/10/state-refused-evidence-that-refuted-audit-heath-provider-says/

the Arizona replacement providers and had remitted the federal share of the PMS settlement to CMS.[117] He added that, "It remains HSD's position that Optum is not entitled to any portion of the settlement funds."[118] While the representation that settlement proceeds were not paid to OptumHealth may have been technically correct, if a portion of the settlement proceeds was used to pay the replacement providers for behavioral health services performed in 2013, this would inure to OptumHealth's benefit as it was responsible for paying for these services in exchange for its capitated rate.

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.[119]

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."[120] 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.

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 calendar year 2017,[121] and information from a 2017 report on the state's health care workforce,[122] the OIG found that:

- only 30% 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;

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[117] Earnest Letter, p. 3-4.

[118] *Id*. at 4. This appears to walk back from Amendment No. 15 to Article 46.4 of the State of New Mexico Professional Services Contract (No. 09-630-7903-0063 A 15) (6/11/13) that gave OptumHealth a share of any funds recovered from the 15 suspended behavioral health providers. See Section II (d), *supra*.

[119] 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.

[120] Minutes of the First Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, "Legislative Finance Committee Program Evaluation of Behavioral Health Services 2013," (July 9, 2013), p. 8.

[121] This data included the total number of Medicaid managed care enrollees for each county and identified each discrete provider of behavioral health services. U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, "PROVIDER SHORTAGES AND LIMITED AVAILABILITY OF BEHAVIORAL HEALTH SERVICES IN NEW MEXICO'S MEDICAID MANAGED CARE," OEI-02-17-00490 at 2 (September 2019).

[122] *Id*. at Appendix A, p. 31.

- only 29% 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.[123]

Further, the OIG found that of those licensed behavioral health providers that served Medicaid enrollees, 62% worked for behavioral health organizations ("BHOs") — such as the 15 suspended providers.[124] Over 70% of BHOs surveyed by the OIG reported "challenges with finding and retaining staff."[125] 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.[126]

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.[127] 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.[128] 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."[129]

III. PROTECTING THOSE ACCUSED OF FRAUD

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[123] *Id*. at 7-8.
[124] *Id*. at 9.
[125] *Id.*
[126] *Id*. at 9-10.
[127] 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. (December 4, 2019) (on file with author). Earlier in 2019, the state settled 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. Dan Boyd, *Two more mental health providers settle claims with NM*, ABQ. JOURNAL, Aug. 22, 2019, last accessed at: https://www.abqjournal.com/1356802/two-more-mental-health-providers-settle-claims-with-nm.html ; *see also* News Release, Human 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 author).
[128] 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. (December 4, 2019) (on file with author).
[129] *Id.*

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."[130] 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."[131] 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."[132] For business entities (such as health care providers) that engage "in a high volume of transactions," particularized information is critical to mounting a defense.[133]

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." [134] "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."[135] This "heightened pleading requirement imparts a note of seriousness and encourages a greater degree of pre-institution investigation by the plaintiff."[136]

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.'"[137]

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[130] FED. R. CIV. PRO. 9(b).
[131] ARTHUR R. MILLER, MARY KAY KANE & A. BENJAMIN SPENCER, 5A FEDERAL PRACTICE & PROCEDURE §1296 (4th ed., October 2020 Update) ("*Wright & Miller*").
[132] *Id*.
[133] *Id*.
[134] Brooks v. Blue Cross and Blue Shield of Florida, Inc., 116 F. 3d 1364, 1370-71(11th Cir. 1997), *reh. denied* 116 F. 3d 1495 (11th Cir. 1997) (citing to Durham v. Business Management Associates, 847 F.2d 786, 791(3rd Cir. 1984), *cert. denied*, 469 U.S. 1211, 105 S. Ct. 1179, 84 L Ed. 2d 327(1985)).
[135] 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.)
[136] *Wright & Miller*.
[137] *Brooks*, at 1371(citing to Fitch v. Radnor Industries, Ltd., No. 90-2084, 1990 WL 150110 at *2 (E.D. Pa. Sept. 27, 1990)(quoting O'Brien v. National Property Analysts Partners, 719 F. Supp. 222, 225 (S.D.N.Y. 1989). *See also* Fearrington v. Boston Scientific Corp., 410 F. Supp. 3d 794 (S.D. Tex. 2019)("allegations 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)

Health care fraud is often the subject of False Claims Act (FCA) [138] cases and the relators are typically whistleblowers with specialized insider knowledge. The requirement to plead fraud with particularity applies to claims made pursuant to the FCA and analogous state statutes.[139, 140] 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, *supra*. The complaint alleged that OptumHealth's claims management system was inadequate to detect potentially false or fraudulent claims from behavioral health services providers.[141] OptumHealth relied upon *U.S. ex rel Lacy v. New Horizons, Inc*.[142] and *U.S. ex rel Lemmon v. Envirocare of Utah, Inc*.[143] to argue for dismissal for failure to satisfy Rule 9(b) pleading of fraud requirements.

In *Lacy*, the relator was a case manager for a company that operated residential long-term care facilities for persons with intellectual disabilities. She alleged that the company violated the FCA by forward-billing for services that had not yet been rendered. She alleged that bills were submitted for every patient in all nine houses at the beginning of every month over a specific period of approximately five years. 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 would be representative of the class described."[144] Citing to *U.S. ex rel Sikkenga v. Regence Bluecross Blueshield of Utah*,[145] 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

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and Holley v. Gilead Sciences, Inc., 410 F. Supp. 3d 1096 (N.D. Ca. 2019)("averments of fraud must be accompanied by the who what, when, where and how of the misconduct charged.").

[138] 31 U.S.C. § 3729.

[139] U.S. ex rel Ge v. Takeda Pharm. Co., Ltd., 737 F. 3d 116 (1st Cir. 2013)(False Claims Act action dismissed for failure to state alleged fraud with particularity).

[140] See 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 (March 2016) (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").

[141] Defendant's Motion to Dismiss, p. 2 (Jan. 22, 2016) U.S. ex rel Clark v. United Health Group, Inc. et al, No. 13-CV-00372-KBM-CG; U.S. Dist. Ct., District of New Mexico; 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. Clark v. UnitedHealth Group, Inc., 2018 WL 1175088 *2 (D.N.M. March 3, 2018), not reported in F. Supp.

[142] U.S. ex rel Lacy v. New Horizons, Inc., 348 F. App'x 421 (10th Cir. 2009).

[143] U.S. ex rel Lemmon v. Envirocare of Utah, Inc., 614 F. 3d 1163 (10th Cir. 2010).

[144] *Lacy*, 348 F. App'x at 425.

[145] U.S. ex rel Sikkenga v. Regence Bluecross Blueshield of Utah, 472 F. 3d 702 (10th Cir. 2006)

claims based on those practices are the types of information that may help a relator to state his or her claims with particularity.[146]

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."[147] 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."[148] 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*.[149] The locations of waste disposal sites where violations took place addressed *where*.[150] "Extensive factual detail regarding how the violations occurred" including "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*.[151] "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.[152]

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 for that matter, 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, that does not afford providers protections akin to those under Rule 9(b) and that 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."[153] 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 have to 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. [154]

For purposes of the Medicaid program integrity regulations, "fraud" is defined as "an intentional deception or misrepresentation made by a person with the knowledge that the

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[146] *Lacy*, 348 F. App'x at 425.
[147] *Lemmon*, 614 F. 3d at 1172.
[148] *Id*.
[149] *Id*.
[150] *Id*.
[151] *Id*.
[152] *Id*.
[153] Medicaid Fraud and Abuse, National Conference of State Legislatures, last found at https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx , citing to a 2013 Pew Charitable Trusts report.
[154] Medicaid Fraud and Abuse, National Conference of State Legislatures, last found at https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx

deceptions could result in some unauthorized benefit to himself or some other person."[155] It includes "any act that constitutes fraud under applicable federal or state law."[156] 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.[157]

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 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.[158] The HHS has acknowledged that 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.[159]

State Medicaid agencies are the sole arbiter of what is "credible." New Mexico's Medicaid agency found allegations of fraud against behavioral health providers made by an MCO known to have faulty encounter data, and whose corrective action response led to further accounting errors and overpayments to be credible.

The regulations implementing Section 6402(h)(2) of the ACA purport 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" may be an allegation that has been verified by the state from any source, including but not limited to the following: (1) fraud hotline complaints;[160] (2) claims data mining; or (3) patterns identified through

[155] 42 C.F.R. §455.2 (Electronic Code of Federal Regulations 2/20/20).
[156] *Id*.
[157] Medicaid Fraud and Abuse, National Conference of State Legislatures, last found at https://www.ncsl.org/research/health/medicaid-fraud-and-abuse.aspx
[158] 76 Fed. Reg. at 5932, and 5935.
[159] *Id*. at 5932. In response to comments that this evidentiary standard was too low, the HHS added the following language to the definition of "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. *Id*. at 5935.
[160] Effective October 23, 2018, without further evidence, a fraud hotline tip shall not be treated as sufficient evidence for a credible allegation of fraud. 42 U.S.C. §1395y(o)(4).

provider audits, civil false claims cases and law enforcement investigations.[161] 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."[162]

The problem with this latter provision is that it makes the state Medicaid agency the sole arbiter of what is credible,[163] of what source or quantum or quality of evidence constitutes sufficient indicia of reliability and of whether it is acting judiciously on a case-by-case basis. Numerous commenters on the proposed final rule expressed concern about the definition of "credible allegation of fraud."[164] Several requested CMS to provide an "exact definition . . . as well as specific standards and guidelines for providers to follow."[165] 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.'"[166]

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.[167]

Thus, it would appear that, 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 as a credible allegation of fraud resulting in payment suspension in one state might not be 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.'"[168]

Additionally, certain provisions of the CAF regulations appear to contradict others. While the 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

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[161] 42 C.F.R. § 455.2
[162] *Id*.
[163] 42 C.F.R. § 455.2.
[164] 76 Fed. Reg. 5935 (Feb. 2, 2011).
[165] *Id*.
[166] *Id*.
[167] 76 Fed. Reg. at 5935.
[168] July 24, 2014 letter from Hector H. Balderas, State Auditor, Office of the State Auditor to State Representative Elizabeth "Liz" Thomson, Chair, and State Senator Benny Shendo, Vice-Chair, Behavioral Health Subcommittee.

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 — but *before* a thorough investigation confirms that fraud has in fact taken place. [169] 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.[170]

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."[171] Further, respondents reported that when providers appealed CAF-based suspensions, courts "sometimes ruled in favor of providers by overturning the payment suspension, citing a lack of evidence to support [it]."[172]

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, disgruntled employees or fraud hotlines.[173] 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.

Under CAF regulations, the state Medicaid agency has the discretion to suspend payments with no advance notice to the provider.[174] 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.[175] Law enforcement can request additional delays of up to 90 days in sending the notice of suspension.[176] In contrast to the Rule 9(b) specificity requirements, the notice from the state Medicaid 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."[177] The notice should "specify, when applicable, to which type or types

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[169] 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.").

[170] 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 Sections IV and V, *infra*.

[171] *Challenges Appear to Limit States' Use of Medicaid Payment Suspensions*, Department of Health and Human Services Office of Inspector General (September 2017) OEI-09-14-00020, at 8.

[172] *Challenges Appear to Limit States' Use of Medicaid Payment Suspensions*, Department of Health and Human Services Office of Inspector General (September 2017) OEI-09-14-00020, at 8.

[173] *Id*.

[174] 42 C.F.R. § 455.23(a)(2)(Electronic Code of Federal Regulations 2/20/20).

[175] 42 C.F.R. § 455.23(b)(1)(i) (Electronic Code of Federal Regulations 2/20/20).

[176] 42 C.F.R. § 455.23(b)(1)(ii) (Electronic Code of Federal Regulations 2/20/20).

[177] 42 C.F.R. § 455.23(b)(2)(ii) (Electronic Code of Federal Regulations 2/20/20).

of Medicaid claims or business units of a provider" are subject to the suspension.[178] While the regulations allow a provider to submit written evidence following receipt of the notice of suspension "for consideration" by the state Medicaid agency,[179] 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.

> CAF laws state that payment suspensions are "temporary" but they are really indefinite, continuing until investigations, enforcement and other legal proceedings related to the provider's alleged fraud are completed. This can take years.

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.[180] 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.[181] If the referral is accepted, "the payment suspension may be continued until such time as the investigation and any associated enforcement proceedings are completed."[182]

In the case of the New Mexico behavioral health providers, HSD represented that approximately $15 million worth of claims for payment were placed on "hold" for payment and held in a non-interest bearing account by OptumHealth.[183] Further, HSD 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.[184] This meant that, by virtue of the state's refusal to 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.

The harm to an accused provider from a payment suspension is immediate. For many providers, Medicaid constitutes a large portion of their revenue stream. In addition, it is common for providers to be carrying large balances due for billed Medicaid services that may be months in arrears. 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

[178] 42 C.F.R. § 455.23(b)(2)(iv) (Electronic Code of Federal Regulations 2/20/20).
[179] 42 C.F.R. § 455.23(b)(2)(v) (Electronic Code of Federal Regulations 2/20/20).
[180] 42 C.F.R. § 455.23(c) (Electronic Code of Federal Regulations 2/20/20).
[181] 42 C.F.R. § 455.23(d) (Electronic Code of Federal Regulations 2/20/20).
[182] 42 C.F.R. § 455.23(d)(3)(i) (Electronic Code of Federal Regulations 2/20/20).
[183] Earnest Letter, pp. 1-3.
[184] *Id*. at 2.

to complete, to which accused providers in New Mexico can attest.[185] 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.[186] 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. 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.[187]

d. *The ripple-effect of suspension*

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. 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 23 medically underserved New Mexico counties and several tribal areas at the time the pay suspension was initiated. As a result of the suspension, it lost a nearly statewide network of offices and infrastructure at 24 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. 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 10 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.[188]

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 11 psychiatrists, two prescribing psychologists, one of only two board-certified pediatric neuropsychologists in New Mexico and over 100 other doctoral- and masters-licensed clinicians. 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.[189] It goes without saying that this loss of jobs impacted the

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[185] 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.

[186] In the case of the accused New Mexico providers, some did not have their wrongfully suspended funds returned until more than six years later. *See* 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. (December 4, 2019) (on file with author).

[187] Email from Brian Kavanaugh, Chief Executive Officer, Families and Youth, Inc. (June 4, 2020) (on file with author).

[188] Email from Shannon Freedle, former Chief Executive Officer, TeamBuilders Counseling Services, Inc. (May 26, 2020) (on file with author).

[189] *Id*.

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 replace them, many clinicians simply left the state, exacerbating New Mexico's existing shortage of behavioral health professionals.[190]

e. *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."[191] 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."[192]

Under federal law, state Medicaid agencies must require providers applying to become enrolled or revalidated in Medicaid to disclose information about affiliations with any provider that has been or is subject to a payment suspension, regardless of when the suspension occurred.

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.[193] 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.[194] A health care practitioner's ability to work for a medical practice may be jeopardized,

[190] Email from Patsy Romero, Chief Executive Officer, Easter Seals El Mirador (May 26, 2020) (on file with author).
[191] 42 C.F.R. §455.107(b) (effective November 4, 2019).
[192] 42 C.F.R. §455.101 (effective November 4, 2019).

[193] 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. *Credentialing and Recredentialing Fact Sheet*, Molina Healthcare of Michigan Medicaid Provider Manual (last updated January 1, 2020); last accessed at https://www.molinahealthcare.com/providers/mi/medicaid/manual/PDF/3_Credentialing.pdf

[194] The following provision is 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

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. 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.[195]

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.[196] Another reported that she retired after being unable to find a job.[197]

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 payments.[198] "Recoupment" is the recovery of any outstanding Medicare debt by reducing present or future Medicare payments.[199] 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.[200] The ACA amended and expanded the definition of "suspension of payment" to

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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 sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. The 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." *Credentialing and Recredentialing Fact Sheet*, Molina Healthcare of Michigan Medicaid Provider Manual (last updated on January 1, 2020); last accessed at https://www.molinahealthcare.com/providers/mi/medicaid/manual/PDF/3_Credentialing.pdf

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

[196] Email from Shannon Freedle, former Chief Executive Officer, TeamBuilders Counseling Services, Inc. (May 26, 2020) (on file with 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* Section II, supra.

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

[198] 42 C.F.R. § 405.370(a)(November 16, 2009).

[199] *Id*.

[200] 42 C.F.R. § 405.370(a)(November 16, 2009).

include the withholding of payment "until the resolution of an investigation of a credible allegation of fraud."[201]

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."[202] 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.[203]

ii. Medicaid

Similarly, state Medicaid agencies have long been authorized to withhold provider payments in cases of fraud or willful misrepresentation.[204] Note that the authority to withhold payments to a provider in whole or in part was discretionary and not mandatory.[205] 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."[206] [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.[207] 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."[208]

In its notice of proposed CAF rulemaking, HHS often refers to the infrequency with which pay holds have been imposed in the 20 years leading up to the ACA's new CAF provisions and implementing regulations.[209] This infrequent historic use of pay holds formed the basis for HHS's assurances that government agencies would act judiciously in using the new CAF suspension sanction.[210]

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.[211] "For many members of Congress (and others) health care fraud enforcement is something of a panacea."[212] While the ACA included "some of the most important and extensive changes in health care fraud

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[201] 42 C.F.R. § 405.370(a)(March 25, 2011).
[202] 76 Fed. Reg. 22, at 5928 (Feb. 2, 2011).
[203] *Id*.
[204] 76 Fed. Reg. 22, at 5931 (Feb. 2, 2011).
[205] *Id*. A state Medicaid agency "*may* withhold payments to a provider in whole or in party based upon receipt of reliable evidence that the need for withholding payment involves fraud or willful misrepresentation under the Medicaid program." [Emphasis added.]
[206] *Id*.
[207] *Id*.
[208] *Id*. at 5932.
[209] *Id*.
[210] *Id*.
[211] William A. Sarraille, *The Unintended Consequences of Targeting Health Care Fraud*, Bloomberg Law Reports, Vol. 3, No. 5 (2010).
[212] *Id*.

and abuse [enforcement] ever enacted,"[213] 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 . . . . Thanks to the President's leadership and the new tools provided by the Affordable Care Act, we can focus on *stopping fraud before it happens*."[214] [Emphasis added.] The news release highlighted "important authority to suspend payments when a credible allegation of fraud is being investigated."[215] 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."[216] In the years since, this authority has resulted in many suspensions of payments to providers based on credible allegations of fraud that have later proven unsubstantiated, with predictable dire consequences for those wrongfully accused.

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.[217] [Emphasis added.]

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."[218]

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."[219] The HHS expressed confidence that CMS and its contractors would "act judiciously" when contemplating a

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[213] *Id*.
[214] News Release, Department of Justice, Health Care Fraud Prevention and Enforcement Efforts Recover Record $4 Billion; New Affordable Care Act Tools Will Help Fight Fraud (January 24, 2011) (on file with author). Indeed, CAF regulations punish a provider by suspending payments *before* fraud has been proven.
[215] *Id*.
[216] 76 Fed. Reg. 22, at 5934 (Feb. 2, 2011).
[217] 42 U.S.C. § 1395y(o) (2018).
[218] 76 Fed. Reg. 22, at 5930 (Feb. 2, 2011).
[219] 76 Fed.Reg. 22, at 5929 (Feb. 2, 2011).

suspension and be "mindful of the impact that payment suspension may have upon a provider."[220] 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."[221] No similar independent review is required for *Medicaid* suspensions based on CAF.

In its notice of proposed rulemaking on the new suspension authority under the ACA, HHS acknowledged that numerous commenters had raised due process concerns. 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 suspensions last longer than the previously established timeframes for suspensions."[222]

ii. Medicaid

With respect to Medicaid, Section 6402(h)(2) of the ACA amended 42 U.S.C. §1396b(i)(2)[223] 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.*[224]

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[220] *Id*.

[221] *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.

[222] 76 Fed. Reg. 22, at 5930-31 (Feb. 2, 2011).

[223] This is in Subchapter XIX (Grants to States for Medical Assistance Programs) of Chapter 7 (Social Security).

[224] 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.

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." This good-cause-not-to-suspend exception gives a state unfettered power to spare or harm a provider for political or other improper purposes.

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.[225] 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)."[226] 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.[227] 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.[228] 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."[229]

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.[230] The state Medicaid agency may determine that good cause exists to not suspend, or to discontinue suspension of, payments if:

(1) law enforcement officials have specifically requested it because suspension may compromise or jeopardize an investigation;

(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;

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[225] The Spending Clause, Article 1, Section 8, Clause 1 of the United States 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." BRIAN T. YEH, CONGRESSIONAL RESEARCH SERVICE, THE FEDERAL GOVERNMENT'S AUTHORITY TO IMPOSE CONDITIONS ON GRANT FUNDS, Summary (March 23, 2017). A Tenth Amendment challenge to federal CAF regulations requiring states to withhold payments was rejected in Rehab Arizona, L.L.C. v. Arizona Health Care Cost Containment System, 2019 WL 1530112 *3 (Az. App. April 9, 2019) (Not reported in Pacific Reptr.). 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.

[226] 76 Fed. Reg. 22, at 5938 (Feb. 2, 2011).

[227] 76 Fed. Reg. 22, at 5934-35 (Feb. 2, 2011).

[228] *Id*. at 5932.

[229] *Id*. at 5932.

[230] 42 C.F.R. § 455.23(e).

(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.[231]

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.[232] "Law enforcement investigations of credible allegations of fraud continue," regardless of whether payments are suspended or not.[233]

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.[234] There is also no requirement that an objective third party evaluate requests for good cause exceptions. In the case of the suspended New Mexico behavioral health providers, the same committee that decided to impose suspensions in the first place[235] 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;[236] further, HSD had already decided to replace the suspended providers and entered into contracts with out-of-state organizations to do so.[237]

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."[238] 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

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[231] 42 C.F.R. § 455.23(e)(1) through(6).

[232] 42 C.F.R. § 455.23(d)(1) and (5).

[233] DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-09-14-00020, CHALLENGES APPEAR TO LIMIT STATES' USE OF MEDICAID PAYMENT SUSPENSIONS, (September 2017), at 4.

[234] 42 C.F.R. § 455.23(a)(3).

[235] At its July 3, 2013 meeting, Diana McWilliams, Executive Director, 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.

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

[237] *See* Section II (c) and (d), *supra*, 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.

[238] 42 C.F.R. § 455.23(c).

investigations are often lengthy."[239] 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.[240] More importantly, the respondents acknowledged that lengthy suspensions could result in providers going out of business as a result of lost revenue.[241] The OIG reported that "this outcome is particularly harmful to providers . . . [when] law enforcement ultimately decides not to prosecute."[242]

In *Families & Youth, Inc. v. New Mexico*, one of the suspended New Mexico behavioral health providers disputed "that a suspension of Medicaid payments lasting over twenty months could be considered 'temporary' under the governing federal and state regulations."[243] Families & Youth, Inc. (FYI) based its underlying 42 U.S.C §1983 claim on the state's failure to provide it with administrative review following suspension of payments based on CAF.[244] New Mexico regulations did not require HSD to establish a hearing process for referrals for credible allegations of fraud,[245] and did not provide for a hearing to challenge a *temporary* payment suspension based on CAF.[246] In fact, a hearing to challenge a temporary payment suspension based on CAF was expressly excluded from an HSD regulation that otherwise afforded a hearing to a provider that disagreed with a decision "with respect to recovery of overpayments due to provider billing error, including incorrect billing . . . or imposition of a sanction or other remedy."[247]

Families & Youth, Inc. argued that it was entitled to a hearing for a suspension that was indefinite and *not* "temporary" under the HSD regulation at issue. [248] The trouble was, there was no New Mexico statutory or regulatory definition of what constituted a "temporary" suspension.[249] The federal court reasoned that "the question of whether a suspension is "temporary" would appear to be made solely by reference to 42 C.F.R. §455.23(c) (the federal CAF regulation)," noting the absence of any authority from other jurisdictions defining "temporary" in the context of anything other than the federal CAF regulations.[250, 251] Applying rules of statutory construction to the HSD regulation in question, FYI argued alternatively that a provider would have a right to a hearing under 8.352.3.10(C)(1)(c) NMAC for suspensions that were *not* temporary.[252] Neither of these arguments swayed the court to abstain and remand the case back to state court, or to certify

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[239] DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-09-14-00020, CHALLENGES APPEAR TO LIMIT STATES' USE OF MEDICAID PAYMENT SUSPENSIONS, (September 2017), at 9.
[240] *Id*.
[241] *Id*.
[242] *Id*.
[243] Families & Youth, Inc. v. New Mexico, 2015 WL13662870 *1 (D.N.M.) ("*FYI*") (on motion to remand to state court).
[244] *Id*.
[245] 8.352.3.9 NMAC.
[246] 8.352.3.10(C)(1)(c) NMAC.
[247] *Id*.
[248] *FYI* at *4; See 8.352.3.10(C)(1)(c) NMAC.
[249] *FYI* at *3.
[250] *Id*., noting that two New Mexico state district courts had looked only to the federal credible allegation of fraud regulation to determine whether a suspension was "temporary". *See* Easter Seals El Mirador v. Human Serv. Dep't, No. D-101-CV-2014-01784, slip op. at 1 (N.M. 1st Judicial Dist. Ct. Mar.3, 2015); N.M. Psychiatric Services Corp. v. Human Serv. Dep't, No. D-101-CV-2012-02787, slip. op. at 1-2 (N.M. 1st Judicial Dist. Ct. Nov. 25, 2013).
[251] *See* ABA, Inc. v. Dist. of Columbia, 40 F. Supp. 3d 153, 167 (D.D.C. 2014)("All circuits that have addressed the issue have determined that a temporary suspension of Medicare or Medicaid payments does not implicate due process and no pre-suspension hearing is required").
[252] *FYI* at *4. These arguments were made as part of a motion to remand following removal to federal court. FYI's motion was denied.

underlying state law questions to the New Mexico Supreme Court: "FYI has failed to show that the question of whether its payment suspension is temporary constitutes an uncertain issue of *state* law . . . ."[253]

V. INJUNCTIVE RELIEF

The June 2013 suspension of payments to the 15 New Mexico behavioral health providers spawned nearly a dozen legal proceedings as the providers sought help from the courts to save their businesses and reputations in the face of CAF determinations by HSD. The review below discusses the success or, more often, failure of Medicaid providers in seeking injunctive relief from state agency actions based on CAF.

a. Border Area Mental Health Services, Inc. v. Squier

In *Border Area Mental Health Services, Inc. v. Squier*, nine of the suspended behavioral health providers filed suit in federal district court to enjoin HSD from continuing to impose and publicize the payment suspensions and allegations of wrongdoing unless each of the providers was furnished with a meaningful name-clearing hearing.[254] Plaintiff providers asserted two claims: (1) a claim that suspension of payments constituted a denial of due process with respect to their property interest in the suspended payments; and (2) a "stigma-plus" claim that the suspension coupled with HSD's past and continuing publicity about the alleged fraud denied plaintiffs a liberty interest without due process.[255]

A movant seeking a temporary restraining order (TRO) has the burden of showing that: (1) it has a substantial likelihood of prevailing on the merits; (2) it will suffer irreparable injury if denied injunctive relief; (3) the threatened injury outweighs the injury that will be suffered by the opposing party from the injunctive relief; and (4) the injunction will not be adverse to the public interest.[256] To succeed on the merits of a violation of due process claim, there must be a constitutionally protected liberty or property interest.[257] Protected 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." [258]

Under federal law, state Medicaid agencies must require providers applying to become enrolled or revalidated in Medicaid to disclose information about affiliations with any provider that has been or is subject to a payment suspension, regardless of when the suspension occurred.

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[253] *FYI* at 83.
[254] Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453 (D.N.M.); 524 Fed. Appx. 387 (10th Cir. 2013) (appeal dismissed for lack of jurisdiction, motion for injunction denied).
[255] *Id*. at *3.
[256] *Id*. at *4.
[257] *Id*.
[258] Rainbow Dental, LLC v. Dentaquest of New Mexico, LLC, 2016 WL 8234539 *2 (D.N.M.), citing to Hulen v. Yates, 322 F. 3d 1229, 1240 (10th Cir. 2003).

i. Protected Property Interest

The *Border Area* court looked to the provider service agreements, to state Medicaid regulation 8.351.2.13(c) NMAC and to 42 C.F.R. §455.23(a) to determine whether the providers had a protected property interest.[259] The provider services agreement expressly referenced the possibility of federal CAF suspension of payments and stated that submission of false or miscoded claims or fraudulent misrepresentation could subject the provider to recoupments.[260] 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."[261] Since the contract as well as state and federal law had "carved out" the right to immediate payment pending an investigation based on CAF, the court found that providers failed to show a likelihood of success on the merits required for a TRO.[262]

The court also found a second basis for rejecting the providers' claim of a denial of property without due process. Since the providers' right to payment was derived from the provider services agreement, this property interest could be protected by an ordinary breach of contract suit.[263] The court relied on *Lujan v. G & G Fire Sprinklers*, in which the plaintiffs argued that a suit for breach of contract against the state did not provide sufficient due process because the state would withhold payment for several years pending the outcome of the suit.[264] There, the U.S. Supreme Court held that state law remedies "provided all the due process" the plaintiffs were due.[265]

The *Border Area* court also cited to its decision in *Gannett Fleming West, Inc. v. Village of Angel Fire*.[266] There, the contractor plaintiff claimed that the Village engaged in an intentional pattern of conduct to avoid making payment, inducing Gannett to continue performing services, extend payment dates and refrain from filing suit.[267] As a result, Gannett accrued hundreds of thousands of dollars of charges, including amounts owed to subcontractors.[268] The court held that Gannett's claim was one for breach of contract and not due process, stating that "adding more details about the way in which the contract was purportedly breached does not change the cause of action, nor does it convert it into a civil rights action."[269]

Finally, the *Border Area* court noted that New Mexico law afforded the providers a hearing pursuant to 8.353.2 NMAC and the right to bring a breach of contract action pursuant to NMSA 1978 §37-1-23(A) (waiving the state's immunity from suit for actions based on a written contract).[270] Accordingly, the court held that one or both of these provisions afforded all the process to which providers were entitled.[271]

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[259] *Border Area*, at *4.
[260] *Id*.
[261] *Id*.
[262] *Id*.
[263] *Border Area*, at *5.
[264] Lujan v. G & G Fire Sprinklers, 532 U.S. 189 (2001).
[265] *Border Area*, at *5.
[266] Gannett Fleming West, Inc. v. Village of Angel Fire, 375 F. Supp. 2d 1104 (D.N.M. 2004).
[267] *Id*. at 1110.
[268] *Id*.
[269] *Id*. at 1111.
[270] *Border Area*, at *5.
[271] *Id*.

ii. *Stigma-Plus Liberty Interest*

Employees and officials of HSD spread and, in the opinions of many, unnecessarily sensationalized allegations of fraud on the part of the behavioral health providers.[272] The *Border Area* plaintiffs argued that without a name-clearing hearing they were deprived of a liberty interest without due process.[273] The court had no difficulty in drawing an analogy from the employment context to find that a cause of action for deprivation of liberty exists where a state agency: (1) makes statements that impugn the honesty or integrity of a Medicaid provider; (2) the statements are untrue; (3) the statements occur in the course of terminating the provider or foreclose other business opportunities; and (4) the statements are published.[274] Each of these elements must be satisfied to demonstrate a deprivation of the liberty interest.[275]

The court found that the providers made a substantial showing of elements (1) and (4), above.[276] However, they faced a "Catch-22" as to proving that the allegations of fraud were false, since the specific details of the alleged fraud had not been disclosed to them.[277] The best the providers could do at the time was to call into question PCG's audit of the New Mexico providers based on PCG's documented dismal performance of audits of unrelated providers in another state.[278]

With respect to element (3), HSD never terminated the providers from the Medicaid program. Further, as the TRO was filed shortly after the fraud accusations were made public and payments suspended, the providers were not yet in possession of sufficient proof that other opportunities to engage in providing behavioral health services had been foreclosed to them.[279] Looking to 10th Circuit authority, the court noted that "this is an extremely demanding showing, requiring the plaintiff to show that the plaintiff has been excluded from its occupation in both public and private sectors."[280] Provider affidavits offered the following to show harm to their ability to continue providing behavioral health services: contacts from consumers inquiring whether they would continue receiving services; contacts from referral sources to determine whether they should continue to refer patients; notification from a county program that the provider agency would not receive funding for services the provider had been providing for two previous years; the loss of business as fiscal agent; the likely impact on the provider's ability to raise funds through grants; and the likely loss of future Medicaid business.[281] While the court felt that this evidence fell short of showing that the providers' ability to provide behavioral health services had been foreclosed, it was willing to find that providers had made "a colorable, albeit weak, showing" on the stigma-plus claim.[282] Despite this, the court held that providers still failed to establish a

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[272] *See* Section II, *supra*.
[273] *Id*. at *6.
[274] *Id*. citing to Erickson v. U.S. *ex rel* Dep't of Health and Human Serv., 67 F.3d 858, 862-63 (9th Cir. 1995)(analyzing deprivation of liberty claim brought by excluded Medicare providers).
[275] Sandoval v. City of Boulder, 388 F.3d 1312, 1329 (10th Cir. 2004), citing to Workman v. Jordan, 32 F.3d 475, 481 (10th Cir. 1994).
[276] *Border Area*, at *6.
[277] *Id*.
[278] *Id*.
[279] *Id*.
[280] *Id*., citing to Sandoval v. City of Boulder, 388 F.3d 1312, 1329 (10th Cir. 2004) (relying on four-part test to demonstrate deprivation of liberty interest enunciated in Workman v. Jordan, 32 F.3d 475, 481 (10th Cir. 1994)).
[281] *Border Area*, at *6.
[282] *Id*. at *7.

likelihood of success on the merits of the stigma-plus claim that was required for injunctive relief.[283]

With respect to the requirement to show irreparable injury if injunctive relief wasn't granted, the providers argued that the 11th Amendment and other potential immunity defenses could prevent them from ever collecting damages from HSD.[284] While acknowledging that this fact alone might be sufficient to constitute irreparable harm, the court found that the providers failed to show that they would not be able to recover damages in a 42 U.S.C. §1983 lawsuit against individual HSD employees and officials responsible for publishing the allegedly libelous statements.[285]

Finally, the court weighed whether a name-clearing hearing before the MFCU completed its investigation was adverse to the public interest.[286] The court acknowledged that "there clearly exists a public interest in the uninterrupted delivery of behavioral health services to a population of particularly vulnerable Medicaid beneficiaries."[287] However, since the MFCU investigation was ongoing, the court reasoned that the only inquiry at a name-clearing hearing would be whether there was reliable evidence at the time the CAF determination was made, not whether the providers actually committed fraud.[288] In the court's opinion, even if later developed evidence cast doubt on the accuracy of PCG's auditing, if PCG's audit appeared reliable to HSD initially, this would leave the providers in the same position — suspended based on CAF.[289] Further, the court found that since the providers did not establish a likelihood of success on the merits, the scales tipped in favor of the state's interests in avoiding the cost of an additional hearing and premature disclosure of its fraud case.[290] The motion for a TRO was denied.

b. ABA, Inc. v. District of Columbia

A TRO was granted in *ABA, Inc. v. District of Columbia*, in which the underlying events parallel those that befell New Mexico's suspended behavioral health services providers.[291] Without prior warning, the D.C. Department of Health Care and Finance ("DHCF") suspended payment to 52% of the home health care providers serving 70% of the city's Medicaid home health

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[283] *Id*.
[284] *Id*.
[285] *Id*. *See* Section VI. on Qualified Immunity, *infra.*
[286] *Id*. at *8.
[287] *Id*.
[288] *Id*.
[289] *Id*. *Border Area* was filed shortly after the suspensions took place. Months later it was revealed that the original PCG audit stated that it "did not uncover what it would consider to be credible allegations of fraud." State Auditor Hector Balderas's office discovered that HSD altered the PCG audit by removing this statement after a court ordered HSD to provide the "report that was being used as the basis for the suspension of funding." "The only reason Balderas' office found the discrepancy was because the Attorney General released certain pages of [the PCG audit] due to lawsuits filed by media outlets . . .[w]hen those pages were released, the State auditor identified discrepancies." *See* Tristan Ahtone, *The Case Of New Mexico's Altered Audit*, PUBLIC HEALTH NEW MEXICO (December 2, 2013) http://publichealthnm.org/2013/12/18/the-case-of-new-mexicos-altered-audit/ Had this information been known and developed at a name-clearing hearing, albeit limited to what HSD knew at the time it made its CAF determinations, it might have been sufficient to clear the providers or at least counter the harmful publicity coming from the HSD. Had this information been before the *Border Area* court, it might have found that providers had a likelihood of success on the merits as to whether the HSD had reliable evidence of fraud at the time it made its CAF determinations.
[290] *Border Area*, at *8.
[291] ABA, Inc. v. Dist. of Columbia, 40 F. Supp. 3d 153 (D.D.C. 2014).

care recipients based on CAF.[292] As was the case in New Mexico, the suspended home health care providers were contractually obligated[293] to continue to perform uncompensated services until their patients were transferred to a new provider.[294] After a month of providing services without compensation, the home health providers sued to require DHCF to resume payments "before each Plaintiff literally ran out of money and was run out of business."[295]

After hearing testimony and arguments, the court determined that DHCF "intended to terminate Plaintiffs' contracts and to substitute itself and other providers in their places, not merely to suspend payments temporarily."[296] The court found that DHCF's suspension of payments, insistence that the providers continue providing uncompensated services and the agency's lack of a permanent plan for alternative providers and a fixed timetable to implement it "put [the providers] in a crushing vise that would inevitably drive them out of business."[297] On the basis of this evidence, the court concluded that the providers had demonstrated a likelihood of success on their due process claim, because DHCF could not terminate a provider without prior notice and hearing.[298] The court issued a TRO requiring DHCF to pay the providers "for Medicaid services rendered on and after the dates of their termination." [299]

The *ABA* providers' victory was short-lived; pertinent facts had changed when they later sought to convert the TRO to a preliminary injunction. There, the plaintiffs faced the same challenges to show entitlement to injunctive relief: the likelihood of success on the merits; irreparable harm if injunctive relief was not granted; that the balance of equities tipped in their favor; and that injunctive relief was in the public interest. Facts presented at the hearing on the preliminary injunction showed that DHCF had adequate capacity for the transfer of patients to other providers, so providers would not be required to provide uncompensated services indefinitely.[300] In addition, DHCF presented evidence that the suspensions were "temporary" and that the plaintiffs were still being paid for other types of Medicaid services such as skilled nursing and case management and, thus, had not been terminated from the Medicaid program. Further, provisions in the Medicaid Provider Agreement gave DHCF broad authority to withhold payments or terminate the agreement and did not require any notice for suspension of payments.[301] In addition, the court determined that DHCF complied with 42 C.F.R. §455.23(b)'s requirement to give suspended providers written notice within five days after the suspension.[302] Plaintiffs' claims for unjust enrichment also failed because "there can be no recovery for unjust enrichment when

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[292] *Id*. at 157.
[293] Provisions requiring a provider to continue providing services to a patient who is transitioning to another provider are standard in provider services agreements.
[294] ABA, Inc. v. Dist. of Columbia, 40 F. Supp. 3d at 157.
[295] *Id*.
[296] *Id*. Plaintiffs proffered evidence that Medicaid services comprised a major portion of their revenues, that they had exhausted company reserves and would not be able to fund company payrolls. *Id.* at 161. "Plaintiffs provided evidence of the imminent and complete collapse of their businesses." *Id*. at 162. "While economic loss alone does not constitute irreparable harm, it becomes irreparable if the loss "threatens the very existence of the movant's business." " *Id*.
[297] *Id*. at 162.
[298] *Id.* at 162-163.
[299] *Id*.
[300] *Id*. at 169. There was also evidence that the plaintiffs had been uncooperative in facilitating the transfer of patients to other providers.
[301] *Id*. at 171.
[302] *Id.* at 172.

there is an express contract between the parties" as here, with the Medicaid Provider Agreement.[303] The court also noted that plaintiffs were in the process of exhausting their administrative remedies.[304]

All these facts weighed against the likelihood of success on the merits. The court denied the motion for preliminary injunction, dismissing the case without prejudice to allow the plaintiffs to exhaust administrative remedies.[305]

> Federal CAF law prohibits the state Medicaid agency from disclosing the specific allegations to the provider, preventing the provider from demonstrating a substantial likelihood of success on the merits when seeking injunctive relief.

c. Chances of obtaining injunctive relief are slim

As shown by the cases above, obtaining injunctive relief is all but impossible for a Medicaid provider suspended based on a CAF. To show a substantial likelihood of prevailing on the merits means being able to make a strong showing that the provider will not be found to have committed fraud. Federal CAF regulations only require the state to provide general and minimal information to the accused provider once payment is suspended.[306] The regulations also require the state Medicaid agency to immediately refer the provider for investigation after the agency makes its CAF determination.[307] Further, once referred, federal CAF regulations prohibit the state Medicaid agency from providing the details upon which the determination is based to the accused provider.[308] 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. How can a provider demonstrate a likelihood of success on the merits if it does not know of what it stands accused?

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. Among these standard provisions are those making the provider agreement subject to both current, and even future, changes in state and federal laws. There are also express provisions that give the state Medicaid agency and any intermediaries the right to suspend payments.[309] As shown above,

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[303] *Id*.
[304] *Id*.
[305] Id. at 173.
[306] 42 C.F.R. § 455.23(b)(2)(ii) (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.")
[307] 42 C.F.R. § 455.23(d).
[308] 42 C.F.R. § 455.23(b)(2)(ii).
[309] "If [the U.S. Department of Health and Human Services, including CMS] suspends payments to a provider while governmental authorities investigate a credible allegation of fraud (as determined by [HHS]), then Health Plan may

the courts will refrain from finding irreparable injury and awarding injunctive relief when a suspended provider has access to a state court to litigate issues arising from the provider services agreement. This access to state court to litigate claims arising out of a contract will also defeat claims based on a denial of due process.

Damage to reputation and a provider's business are the inevitable result of a suspension based on a CAF. New Mexico providers reported that grants and health plan credentialing applications asked whether the applicant was the subject of payment suspensions.[310] Unfortunately, an adverse impact (even going out of business as a result of the suspension) on a provider's ability to pursue its business or profession may fall short of the quantum of harm (such as the loss of a professional license) needed to make a claim based on a state's deprivation of a liberty interest. If the state Medicaid agency has not terminated the provider, or if the provider is still receiving payment for other lines of Medicaid services or non-Medicaid services, the courts are unlikely to find that the provider's opportunity to pursue its profession has been "foreclosed." While exclusion from federal health care programs is clearly a death sentence for a provider, a court may not view a temporary payment suspension in the same light, even if it is likely that the provider could go out of business before the completion of the investigation into the CAF.

For procedural due process claims, the courts will look to state law to determine whether a suspended provider is entitled to a hearing. The federal CAF regulations provide room for such a hearing, if state law so requires.[311] 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.[312] If no right to a hearing is found, there is no substantial likelihood of success on the merits of a claim of entitlement to a hearing.

The *Border Area* court created some daylight for a provider to challenge whether the state Medicaid agency had reliable evidence at the time it made its CAF determination.[313] In such case, a suspended provider will have to overcome traditional deference to agency decision-making with sufficient evidence that agency action was arbitrary, capricious or contrary to law.[314]

VI. 42 U.S.C. §1983 Claims

a. Suspension of payments

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suspend Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments." Excerpt from Participating Provider Agreement of Health Connections, Inc.

[310] Email from Patsy Romero, Chief Executive Officer, Easter Seals El Mirador (May 26, 2020) (on file with author).

[311] 42 C.F.R. § 455.23(a)(3) "A provider may request, and must be granted, administrative review where State law so requires."

[312] See Footnote 63, supra, regarding motion to compel arbitration in litigation related to the suspensions and replacement of the New Mexico behavioral health providers.

[313] *Border Area* at *8.

[314] *But see* Consumer Directed Choices, Inc. v. New York State Office of the Medicaid Inspector General, 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 improper reasons, or simply to recover payments that resulted from a good faith error or interpretive disagreement involving no fraud. . . ." *Id.* at 1276-77.

In *Southwest Counseling Center, Inc. v. New Mexico*, the suspended behavioral health providers filed 42 U.S.C. Section 1983 ("Section 1983") claims against individual state actors, including the current and former HSD secretaries, and the deputy director of HSD's Medical Assistance Division.[315] The providers alleged that by indefinitely withholding their suspended Medicaid payments without properly determining whether there was a CAF and without proper administrative review, the individual defendants violated the providers' federal statutory rights under 42 C.F.R. §§455.1- 455.3 and §§455.12- 455.23 and their constitutional rights under the 14th Amendment.[316]

Section 1983 civil rights claims may be brought against "any person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects or causes to be subjected, any citizen of the United States . . . to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws."[317] Injured parties are entitled to bring a suit at law or equity for redress of their damages.[318] Section 1983 generally provides a cause of action for a violation of a federal statute, provided the statute creates enforceable rights, privileges or immunities within the meaning of Section 1983, or unless Congress has foreclosed a private right of action in the statute itself.[319] The mere violation of a federal law does not necessarily give rise to a Section 1983 action.[320] Whether a Section 1983 action may be used to remedy a statutory or constitutional violation involves a two-step inquiry: the plaintiff must assert a violation of a federal right, and the provision in question must be intended to benefit the injured plaintiff.[321]

In *Southwest Counseling*, the district court undertook to determine whether the federal program integrity regulations at 42 C.F.R. §§ 455.1- 455.3 and §§455.12- 455.23 created a federal right enforceable under Section 1983.[322] The providers argued that the regulations were intended to benefit Medicaid providers by protecting them from abuse of power and arbitrary payment suspensions.[323] The court looked to two earlier decisions in the same federal district that held that the regulations at issue did not create such a right: *New Mexico Psychiatric Services Corp. v. New Mexico* and *Morrow v. New Mexico*.[324] Plaintiffs in these earlier cases made the same arguments as in *Southwest Counseling* to urge the court to find a federal right in the CAF regulations.[325] These arguments were unsuccessful, as the court relied on authority that holds that "an

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[315] Southwest Counseling Center, Inc. v. New Mexico, 2016 WL 9777240, *2 (D.N.M.).
[316] *Id*.
[317] 42 U.S.C. § 1983.
[318] *Southwest Counseling*, at *4.
[319] *Id*.
[320] *Id*., citing to Wilder v. Virginia Hospital Ass'n, 496 U.S. 498, 509 (1990).
[321] Golden State Transit Corp. v. City of Los Angeles, 493 U.S. 103, 106 (1989).
[322] *Southwest Counseling*, at *4.
[323] *Id*.
[324] *Id*.; New Mexico Psychiatric Services Corp. v. New Mexico, 2016 WL 2995757 (D.N.M.); Morrow v. New Mexico, 2016 WL 2995634 (D.N.M.). In these cases, plaintiffs' Medicaid payments had been suspended based on a credible allegation of fraud for 44 and 42 months, respectively. *See also* NSCH Rural Health Clinic v. Snyder, 2020 WL 5905045 at *5 (Miss. App.) (Slip Opinion Oct. 6, 2020)(holding that neither federal nor state law entitled the provider to Medicaid reimbursement payments during a pending CAF investigation).
[325] The CAF regulations were promulgated pursuant to Section 6402(h)(2)(B) of the Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010). See Section III, supra (on the origins of the CAF antifraud initiative.)

administrative regulation alone cannot create an enforceable Section 1983 interest not already implicit in the enforcing statute."[326]

b. Network termination

In an unrelated New Mexico federal court case involving a Medicaid provider's Section 1983 claim, a terminated dental practice sued a managed care organization ("MCO") that administered Medicaid dental services.[327] The grounds for termination were the contracted provider's alleged failure to comply and cooperate with the MCO's credentialing requirements "resulting in the submission of false claims and fraudulent billing."[328] The provider argued that terminating it from the MCO's network violated the provider's due process rights under both the state and federal constitutions.[329] New Mexico's state Medicaid agency moved to dismiss on the grounds that the provider failed to plead a necessary element of a Section 1983 cause of action: a protected property interest giving rise to the claim.[330]

In deciding whether continued participation in the MCO's network was a protected property interest subject to due process protections, the court noted that such interests "are created and defined by statute, ordinance, contract, implied contract and rules or understandings developed by state officials."[331] Further, this property interest must be one that cannot be eliminated except for cause.[332] The terminated dental practice argued that its protected property interested derived from three sources: 1) the contract and previous course of dealings under the provider services agreement with the MCO; 2) 8.352.3.9 NMAC; or 3) 42 C.F.R. §455.23.[333]

The court found that 8.352.3.9 NMAC only applied to Medicaid fee-for-service providers, and not to a contracted managed care provider such as the dental practice.[334] Turning to rules applicable to managed care providers, the court found that while MCOs are required to provide a grievance procedure and process to a contracted provider, there is no provision creating an entitlement to continued provider status in an MCO's provider network.[335] Nor did the court find that 42 C.F.R. §455.23 (pertaining to notice of suspension of payments to Medicaid providers based on a CAF) spoke to continued provider status or created a constitutionally protected property interest.[336]

New Mexico's HSD argued that it was expressly authorized by statute to suspend or revoke the contract between a Medicaid provider pursuant to the terms of the contract.[337] Reviewing NMSA 1978 §27-11-3, the court found no provisions indicating that a Medicaid provider's contract could only be terminated for cause, nor did the statute characterize the provider's interest

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[326] *New Mexico Psychiatric Services Corp.*, at *2; *Morrow*, at *2; both citing to Alexander v. Sandoval, 532 U.S. 275, 286-87.
[327] Rainbow Dental, LLC v. Dentaquest of New Mexico, LLC, 2016 WL 8234539 (D.N.M.).
[328] *Id*. at *1.
[329] *Id*.
[330] *Id*. at *2.
[331] *Id*., citing to Hulen v. Yates, 322 F.3d 1229,1240 (10th Cir. 2003).
[332] *Rainbow Dental*, at *2.
[333] *Id*. at *3.
[334] *Id*.
[335] *Id*.
[336] *Id*. citing to Levin v. Childers, 101 F. 3d 44, 46 (6th Cir. 1996) ("an expectation of receiving process is not, without more, a liberty interest protected by the Due Process Clause"), *abrogated on other grounds by* Johnson v. City of Detroit, 446 F.3d 614, 628 (6th Cir. 2006).
[337] NMSA 1978 §27-11-3(C)(3).

in continuing reimbursement as an entitlement.[338] The court also refused to find an implied right of action under New Mexico's Medicaid Provider and Managed Care Act, NMSA 1978 §27-11-1 et seq.[339] The court concluded that the New Mexico legislature defined the Medicaid provider's interest as its interest in the contract.[340]

The only contract referenced in the providers' complaint was the MCO's provider manual.[341] Language in the manual's credentialing section gave the MCO the sole right to determine which dentists it would "accept and continue as" participating providers; nor was there language restricting the MCO from terminating the provider in accordance with the network provider agreement.[342] The court noted that the manual referred to a dispute resolution process; however those provisions did not discuss any rights or entitlements.[343] Finally, it found that nothing in the manual created a reasonable expectation that a provider's status as a participating provider could not be terminated at any time or could only be terminated for cause.[344] The court found that network provider status was not a protected entitlement if it could be granted or denied in the MCO's discretion.[345] In *dicta*, the court also rejected finding a protected property interest in continued Medicaid reimbursements.[346]

c. Qualified Immunity

As laid out in Section II, *supra*, various New Mexico state officials appeared to go out of their way to harm the businesses and reputations of the 15 behavioral health providers. The chief executive officer of one accused provider told legislative committee members that HSD had branded her organization and her colleagues and employees as "criminals and liars." [347] Taking legal action seeking damages for injury to businesses and reputations — and even the resulting injury to a provider's physical and mental health as a consequence — against any of the state officials involved would necessarily implicate the doctrine of "qualified immunity."

Qualified immunity balances "the need to hold public officials accountable when they exercise power irresponsibly and the need to shield officials from harassment, distraction and liability when they perform their duties reasonably."[348] Further, the defense of qualified immunity can be raised at any time.[349] This doctrine protects public officials not only from being subjected

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[338] *Rainbow Dental*, at *4.
[339] *Supra*,note 4.
[340] *Id*. at *4.
[341] *Id*. at *5.
[342] *Id*.
[343] *Id*.
[344] *Id*.
[345] *Id*. citing to Geriatrics, Inc. v. Harris, 640 F. 2d 262, 264-65 (10th Cir. 1981)("stating that a nursing home whose Medicaid contract was not renewed did not have a constitutionally protected property interest" where the contract would not be renewed without a showing that the nursing home was a qualified provider).
[346] *Rainbow Dental*, at *6. The court called attention to Starko, Inc. v. New Mexico Human Services Department, 333 P. 3d 947 (N.M. 2014) in which the New Mexico Supreme Court held that a statute expressly guaranteeing reimbursement rates to fee-for-service pharmacists did not impliedly guarantee reimbursement rates to pharmacists participating in Medicaid managed care.
[347] Minutes of the First Meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee, "Legislative Finance Committee Program Evaluation of Behavioral Health Services 2013," (July 9, 2013), p. 6.
[348] Four Winds Behavioral Health, Inc. v. New Mexico Dep't of Health, 2019 WL 2327618, *1 (D.N.M.)
[349] *Id*.

to trial, but also from having to participate in discovery.[350] When defendant public officials file a dispositive motion based on qualified immunity, they are entitled to a stay of discovery.[351]

Qualified immunity shields a state official from money damages unless (1) the official violated a statutory or constitutional right and (2) the right was "clearly established" at the time of the challenged conduct.[352] The decisions discussed previously in this article do not support: a right under CAF regulations to assert a 42 U.S.C. §1983 cause of action for violation of a Medicaid provider's civil rights;[353] a constitutionally protected property interest in continued provider status for a Medicaid provider;[354] or a statutory entitlement to continuing reimbursement from Medicaid.[355] As stated previously, there was no New Mexico law in place at the time of the suspensions guaranteeing accused providers expedited review to challenge a suspension or granting a provider other rights beyond those set forth in the Medicaid provider services agreement. Thus, it would be difficult for a suspended Medicaid provider to defeat the defense of qualified immunity unless there was a violation of a clearly established right in state law at the time of the challenged conduct.

Successful challenges to suspensions have been based on traditional challenges to agency action.

VII. SUCCESSFUL CHALLENGES TO AGENCY PAYMENT HOLDS

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.[356] 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.[357]

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[350] *Id*.
[351] *Id*.
[352] Ashcroft v. Al-Kidd, 131 S. Ct. 2074, 2080; 563 U.S. 731, 735 (2011). *See* Tanzin v. Tanvir, 592 U.S. _ , 141 S. Ct. 486 (2020)(holding that the Religious Freedom Restoration Act of 1993's express remedies provision permits litigants to obtain money damages from federal officials in their individual capacities).
[353] Southwest Counseling Center, Inc. v. New Mexico, 2016 WL 9777240 (D.N.M.); New Mexico Psychiatric Services Corp. v. New Mexico, 2016 WL 2995757 (D.N.M.); Morrow v. New Mexico, 2016 WL 2995634 (D.N.M.).
[354] Rainbow Dental, LLC v. Dentaquest of New Mexico, LLC, 2016 WL 8234539 (D.N.M.).
[355] *Id*. Border Area Mental Health Services, Inc. v. Squier, 2013 WL 12140453 (D.N.M.).
[356] 5 U.S.C. § 706.
[357] *Id*.

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. 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 fraud to the MFCU might have served as a basis to challenge HSD's actions.[358]

a. Mandamus

Following an administrative decision that the agency had failed to sufficiently demonstrate misrepresentation or fraud on the provider's part, a state Medicaid agency's refusal to release suspended provider funds was the subject of *Janek v. Harlingen Family Dentistry*. There, the Texas Health and Human Services Commission ("HHSC") and Office of Inspector General ("OIG") opened a fraud investigation and suspended 100% of the provider's orthodontia billings, "which constituted 40% of the dental group's total Medicaid reimbursements."[359] Under Texas law, the provider was entitled to, and requested, an expedited administrative hearing to determine whether there was a credible allegation of fraud to support the pay hold.[360]

The administrative law judge ("ALJ") presiding over the hearing found that the state did not make a sufficient showing to support the payment hold based on suspected fraud or misrepresentation.[361] However, the ALJ also found that the provider "had billed for non-reimbursable services or made other billing errors in 9%" of the services at issue.[362] The ALJ's proposed decision included a recommendation that "any payment hold against [the Dental Group] be reduced to 9 percent of . . . total Medicaid reimbursement related to orthodontics."[363] The HHSC adopted the ALJ's findings, conclusions of law and decision, incorporating them into a final administrative order. The order required that the pay hold "be reduced to 9% of the [Dental Group's] total Medicaid reimbursement that is related to orthodontic services."[364] As of the date of the order, approximately $1.4 million in provider funds had been suspended.[365] The order became final and neither party appealed.[366] When the provider made demand for the return of 91% of withheld funds, a dispute arose over whether the order applied retrospectively or prospectively, with the state refusing to return any withheld funds.[367] The provider filed suit in

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[358] *See* Section II(d), supra.
[359] Janek v. Harlingen Family Dentistry, 451 S.W. 3d 97, 100 (Tex. App. 2014)("*Harlingen 1*").
[360] *Id*., TEX. GOV'T CODE § 531.102(g)(3); former TEX. HUMAN RES. CODE §32.0291(c).
[361] *Harlingen 1*, 451 S.W. 3d at 100.
[362] *Id*.
[363] *Id*.
[364] *Id*.
[365] *Id*.
[366] *Id*.
[367] *Id*.

district court seeking a writ of mandamus to compel the release of approximately $1.2 million.[368] The district court granted the petition; the state appealed.

Mandamus is a remedy to compel a public official to perform a ministerial act.[369] An act is "ministerial" when the duty to be performed is clearly spelled out, leaving nothing to the discretion of the official.[370] "If an action involves personal deliberation, decision, and judgment, it is discretionary."[371] "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."[372] A suit for mandamus must allege and prove "that the officer acted without legal authority or failed to perform a purely ministerial act."[373] Thus, here the inquiry on appeal was whether the final administrative order, read in conjunction with applicable law, "unambiguously required" withheld funds to be released to the providers.[374]

The appellate court found that HHSC had adopted the ALJ's findings of fact and conclusions of law *in toto*.[375] The ALJ's finding of facts stated that "there is no evidence that is credible, reliable or verifying, or that has indicia of reliability, that [the Dental Group] committed fraud or misrepresentation."[376] In its conclusions of law, the ALJ found that the HHSC-OIG lacked statutory authority to maintain a pay hold on the basis of the alleged fraud or misrepresentation.[377] However, the ALJ also concluded that HHSC and OIG were authorized to continue to impose a pay hold on 9% of orthodontic reimbursements based on billings that, while not fraudulent, were not in compliance with the Medicaid provider agreement or provider manual, or that were for services that were not reimbursable.[378] HHSC's final administrative order concluded by ordering that "the action imposing a payment hold on [the Dental Group] be sustained in part and be reversed in part, and that the payment hold against [the Dental Group] be reduced to 9 percent" of the provider's total Medicaid reimbursement related to orthodontics.[379]

The court also looked at state and federal regulations for guidance on whether HHSC had discretion to retain the withheld funds. Texas law stated that HHSC "*shall* discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied upon by the department in imposing the hold is relevant, credible and material to the issue of fraud or willful misrepresentation."[380] Former Section 531.102(g)(2) of the Texas Government Code "required that a hold placed by the OIG. . . be imposed in accordance with 42 C.F.R. Section 455.23."[381] The court determined that under both Texas and federal law, payment holds were supposed to be temporary and "had to end if credible evidence of fraud was lacking."[382] The court explained that the state's right to temporarily hold the funds was based "solely on the existence of credible

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[368] *Id*.
[369] *Id*. at 101.
[370] *Id*.
[371] *Id*.
[372] *Id*., citing to City of El Paso v. Heinrich, 284 S.W. 3d 366, 372 (Tex. 2009).
[373] *Id*.
[374] *Harlingen 1,* 451 S.W. 3d at 101.
[375] *Id*.
[376] *Id*.
[377] *Id*.
[378] *Id*. at 102; 1 TEX. ADMIN. CODE §§ 371.1703(b)(5), 371.161(1)(K), (5)(A) and (G).
[379] *Harlingen 1*, 451 S.W. 3d at 102.
[380] *Id*. at 103; former TEX. HUMAN RES. CODE §32.0291(c); "shall" means "must".
[381] *Id*. at 103.
[382] *Id*.

evidence of fraud. Thus, a finding of the absence of such evidence could only mean that the state's right to temporary possession of the funds no longer existed."[383]

In its effort to keep the suspended payments, the state argued that the provider's mandamus suit was a retrospective claim for monetary relief, barred by sovereign immunity.[384] Agreeing that retrospective claims are barred by sovereign immunity,[385] the Court disagreed that this suit constituted such a claim.[386] It ruled that, as the mandamus proceeding sought to enforce HHSC's existing order that imposed a ministerial duty on HHSC and OIG officials to release a portion of the withheld funds, the relief sought was prospective.[387]

b. Agency action exceeding statutory authority

In a concurrent proceeding, Harlingen Family Dentistry joined with another dental group to challenge two sets of pre-payment hold provisions in HHSC rules as exceeding the agency's statutory authority.[388] In *Harlingen Family Dentistry v. Texas Health and Human Services Commission* ("*Harlingen 2*"), the dental groups appealed a district court decision upholding the rules; the court of appeals reversed, finding the challenged provisions invalid.[389]

One of the challenged provisions granted the state Medicaid agency authority to impose a pre-notice payment hold for *any* alleged violation of the state's Medicaid program and the other allowed HHSC to retain suspended funds, even after the termination of a temporary hold, to offset any overpayments determined owed as a result of an ongoing investigation of the provider.[390] This appeal followed the trial court's finding that the rules at issue were "a valid exercise of HHSC's statutory rulemaking authority."[391]

The onus of this suit was a challenge to the facial validity of a rule, wherein the challenging party has the burden of showing the rule's invalidity.[392] To do so, the party must show that the rule: "(1) contravenes specific statutory language; (2) is counter to the statute's general objectives; or (3) imposes additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions."[393] Put plainly, "[a]n agency's rules must comport with the agency's authorizing statute." [394] The appeals court explained that "[a] state administrative agency has only the authority expressly provided by statute or necessarily implied in order to carry out the express powers the legislature has given it."[395] This is a question of law.[396]

The dental groups argued that the HHSC rule that permitted payment holds in instances that do not involve evidence of fraud exceeded the agency's statutory authority.[397] The appellate

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[383] *Id*.
[384] *Id*.
[385] *See* City of El Paso v. Heinrich, 284 S.W. 3d 366, 374 (Tex. 2009).
[386] *Harlingen 1,* 451 S.W. 3d at 103.
[387] *Id*.
[388] TEX. GOV'T CODE §2001.038 (provides for challenges to the validity or applicability of agency rules).
[389] Harlingen Family Dentistry v. Texas Health and Human Serv. Comm'n 452 S.W. 3d 479 (Tex. App. 2014), challenging 1 TEX. ADMIN. CODE §371.1709 (a) (2),(3),(4) and (e)(2).
[390] *Harlingen 2,* 452 S.W. 3d at 481.
[391] *Id.*
[392] *Id*.
[393] *Id*.
[394] *Id*. at 482.
[395] *Id*.
[396] *Id*.
[397] *Id*.

court looked at the statutes that authorized pre-payment holds that were in effect at the time the challenged rule provisions were promulgated.[398] The court found that the "plain language" of two statutes authorized payment holds if the HHSC had "reliable evidence that the provider has committed fraud or wilful [sic] misrepresentation" and "*required* the OIG to impose a payment hold to compel production of documents when requested by the state's Medicaid fraud unit."[399] The court determined that the challenged rule provisions expanded the circumstances under which a payment hold could be imposed beyond HHSC's statutory authority.[400] The challenged provisions allowed pre-payment holds for a broad and non-exclusive list of acts that constituted program violations such as: (1) submitting claims for non-reimbursable items; (2) failing to properly maintain records; and (3) failure to comply with the terms of the Medicaid program or provider agreement.[401] Included in the challenged provisions was a "catch-all" category allowing pre-payment holds "for any other reason specified by statute or regulation."[402] The court noted that this provision would allow HHSC to adopt a rule authorizing payment holds "in any conceivable circumstance" and justify the hold on the basis that it was "specified by . . . regulation."[403]

The second set of challenged provisions were amendments to the payment hold rule[404] that allowed the OIG to:

> impose a payment hold if a provider commits a program violation, is affiliated with a person who commits a program violation, or for any reason provided by statute or regulation;[405] and
>
> retain funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.[406]

Once again, the Court found no statutory basis for the expansion of pre-notice payment holds in these amended provisions.

The HHSC argued that the determining factor in an inquiry to determine whether an agency has exceeded its rule-making authority is whether a rule is "in harmony with the general objectives of the legislation at issue." [407] According to the court, to find such harmony, the rule "must not impose additional burdens, conditions, or restrictions in excess of or inconsistent with relevant

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[398] *Id*.
[399] *Id*. at 483. A 2011 amendment to one of these statutes required the OIG to impose a payment hold "on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful [sic] misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable." TEX. GOV'T CODE § 531.102(g)(2). The court noted that this was "nearly identical" to the hold that HHSC was "already authorized to impose' under TEX. HUMAN RES. CODE §32.0291(b).
[400] *Id*.
[401] *Id*. at 484.
[402] *Id*.
[403] *Id*.
[404] TEX. ADMIN. CODE § 371.1709 (e)(2)
[405] *Harlingen 2*, 452 S.W. 3d at 485; TEX. ADMIN. CODE § 371.1709 (a)(2), (3) and (4) (2014).
[406] *Id*. at 485; TEX. ADMIN. CODE §371.1709 (e)(2) (2014).
[407] *Id*. at 486.

statutory provisions."[408] The court found that relevant statutory provisions established OIG as the arm of HHSC that is responsible for the investigation of fraud and abuse.[409] However, the challenged rule provisions went much further, granting OIG and HHSC authority to:

> impose a payment hold whenever [HHSC] believes a provider has committed *any program violation, no matter how minor and irrespective of whether there is any indication of fraud or other intentional abuse*… [T]he rules significantly expand the circumstances under which a pre-notice payment hold can be imposed beyond those enumerated in [statute]. [Emphasis added.] [410]

The court expressed concern that, as written, the rules allowed OIG to impose a payment hold without notice and *in the absence of fraud* without giving providers sufficient due process protections. The court observed that providers who had committed "less serious program violations" would face more dire consequences than those accused of fraud.[411, 412] "The fact that the challenged rules lacked the due process notice and hearing requirements that are the hallmark of legislation expressly authorizing the imposition of pre-notice payment holds" led to the court's determination that they were inconsistent with relevant statutory provisions.[413]

Next, the court addressed HHSC's argument that a legislative grant of "rulemaking authority as necessary for the proper administration of the Medicaid program" gave HHSC implied authority to promulgate the challenged rules.[414 415] The court acknowledged that this language can impliedly grant authority to enforce administrative rules.[416] However, it cautioned, implied statutory authority is limited to what is necessary and reasonable:

> It is neither reasonable nor necessary . . . for HHSC to be permitted to impose a pre-notice payment hold, without the opportunity for an administrative hearing regarding the hold, on a provider who commits a Medicaid program violation merely to enforce its rules or ensure the proper and efficient operation of the program.[417]

Importantly, the court foresaw that such overreach could harm the state's Medicaid program:

> In fact, doing so could actually impair that mission, as it could result in Medicaid providers withdrawing from the program, declaring bankruptcy, or otherwise being unable to continue providing services for which they are not being paid until the matter triggering the hold has been resolved.[418]

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[408] *Id*.
[409] *Id*.; TEX. GOV'T CODE §§531.102, 531.103.
[410] *Id*. at 486.
[411] *Id*.
[412] By statute, providers accused of fraud were given procedural protections such as expedited administrative review.
[413] *Id*. at 487.
[414] *Id*.
[415] Grants of "full rulemaking authority to implement the purposes of this Act" and similar language are boilerplate language in statutes that establish state agencies.
[416] *Id*. at 487.
[417] *Id*.
[418] *Id*.

Finally, the court addressed the challenge to rule provisions permitting the state to retain seized funds notwithstanding the termination of a pay hold.[419] The court turned to the federal CAF's regulation's provisions relating to suspended payments, incorporated by reference in Section 531.102(g)(2) of the Texas Government Code as requiring the state to initiate a pay hold.[420] The federal regulation repeatedly refers to the suspension as "temporary" and expressly directs that the suspension:

> will be temporary and will not continue after agency prosecuting authorities determine there is insufficient evidence of fraud by the provider . . .or legal proceedings related to the alleged fraud are completed . . . [or if] a state Medicaid agency referral and investigation leads to a payment suspension, the payment suspension may be continued until such time as the investigation and any enforcement proceedings are completed.[421]

The court made clear that when pay holds end as prescribed by state and federal regulations, the state's right to temporary possession of the funds also ends.[422] "Once the statutory basis for imposing the hold ceases to exist, HHSC no longer has the authority to possess those funds."[423] The court held that rule provisions allowing the OIG to retain funds when the justification for the pay hold has terminated exceed the agency's authority and are invalid.[424]

Of note, the *Harlingen 2* court referred to and was clearly aware of 42 C.F.R. §455.23. However, the court did not undertake any analysis of the interplay or potential conflict between state statutes only authorizing payment holds upon receipt of "*reliable evidence of fraud* or wilful [sic] misconduct" and 42 C.F.R. §455.23, which provides that a state Medicaid agency must suspend all payments to a provider "after the agency determines there is a *credible allegation of fraud*." [Emphasis added.][425, 426]

c. Waiver of sovereign immunity

Medicaid providers who suffer damages due to malfeasance or mismanagement on the part of the state or its third-party administrator face an uphill battle when it comes to maintaining claims against these actors. A major barrier to such claims is sovereign immunity. "The common-law doctrine of sovereign immunity prohibits suits against the state unless the state consents and

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[419] *Id*.
[420] *Id*. at 488.
[421] *Id*.; 42 C.F.R. § 455.23.
[422] *Id*. at 488.
[423] *Id*.
[424] *Id*.
[425] *Id*. at 484 and 488.
[426] Later in 2013, the Texas Legislature amended both the Texas Government Code and the Human Resources Code, striking language authorizing the HHSC to impose a payment hold upon receipt of credible evidence of fraud or willful misrepresentation of the provider. *Id*. at 485. The court noted that the amendments added a requirement that OIG employ certain experts to review investigative findings before imposing payment holds without prior notice, and additional requirements to inform the provider of the basis for the payment hold and of the administrative and due process remedies available to the provider, including the right to seek an informal hearing and expedited administrative review. *Id*. at 487 , footnote 4 of the opinion.

waives its immunity."[427] Sovereign immunity from suit acts to deprive a trial court of subject-matter jurisdiction.[428] One of the "primary justifications" for sovereign immunity is to "protect the public fisc from unforeseen expenditures that could hamper governmental function,"[429] preserving taxpayer resources for their intended purpose and preventing them from being diverted to defend lawsuits and pay judgments.[430] Unfortunately, sovereign immunity can also shield the government from accountability for its mistakes and bar an aggrieved provider from seeking relief to make it whole when the government has harmed it.

Nazari v. State involves a case similar in certain respects to the one that is the focus of this article, in which a Medicaid administrative contractor's questionable performance led to trouble for the providers it was supposed to oversee.[431] There, the state of Texas alleged that dental providers had defrauded its Medicaid program through the routine submission of: (1) prior authorization requests that misrepresented the patient's diagnosis or severity of the condition; (2) claims for payment for services not rendered; and (3) claims for services that had been performed by unlicensed employees. [432]

In response, providers alleged a "scheme" on the part of the state and Xerox Corporation ("Xerox"), its third-party administrator, to maximize approval of treatments in response to longstanding federal class-action litigation against the state's Medicaid program for failure to provide health care to indigent children.[433] Providers alleged that Xerox's practice was to "rubber-stamp" prior authorization requests, leading providers to believe that their requests were in order and that their patients qualified for orthodontic services.[434] According to providers, when the state's high expenditures for these services came under public scrutiny, the state "blamed [providers] in an effort to avoid responsibility for its own actions, enrich itself, and limit its liability to the federal government for having mismanaged the [Medicaid] Program."[435] Of note, and unlike what happened in New Mexico, the state also brought fraud proceedings against Xerox for failing to properly review prior authorization requests.[436]

On appeal from the granting of both the state's plea to the jurisdiction over counterclaims and its motion to dismiss third-party claims against Xerox, the Texas Supreme Court addressed whether sovereign immunity barred the providers' counterclaims against the state. While the Court acknowledged that a governmental entity participating in litigation is bound by the same rules as a private litigant, it found that, in the absence of a statutory waiver, more was needed to find a waiver of the state's sovereign immunity.[437] The court turned its focus to "whether the scope of the state's immunity encompasses [providers'] counterclaims to begin with."[438] To guide its analysis, the court looked to its earlier decision in *Reata Construction Corporation v. City of Dallas.*[439]

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[427] Nazari v. State, 561 S.W. 3d 495, 500 (Tex. 2018).
[428] Reata Construction Corp. v. City of Dallas, 197 S.W. 3d 371, 374 (Tex. 2006).
[429] *Nazari*, 561 S.W. 3d at 508.
[430] Reata Construction Corp. v. City of Dallas, 197 S.W. 3d at 375.
[431] Nazari v. State, 561 S.W. 3d 495 (Tex. 2018).
[432] *Nazari*, 561 S.W. 3d at 498. In addition, the state alleged that providers had accepted kickbacks.
[433] *Id*.
[434] *Id*.
[435] *Id*.
[436] *Id*. *See also* Section IX, infra, regarding the state's $235 million settlement of the litigation against Xerox.
[437] *Nazari*, 561 S.W. 3d at 501.
[438] *Id*. at 502.
[439] *Reata*, 197 S.W. 3d 371 (Tex. 2006).

Reata, a City of Dallas subcontractor, hit a water main causing flooding in an office building. In the ensuing litigation, Reata made claims against the city for failing to accurately identify the location of the water main. Before answering Reata's third-party claim, the city intervened in the case, alleging negligence on the part of the general contractor and seeking damages.[440] Weeks later, the city answered Reata's third-party petition with a plea to the jurisdiction and amended its claims to assert negligence against Reata.[441] Reata responded, claiming that: (1) the city subjected itself to the court's jurisdiction by intervening and seeking affirmative relief; (2) both state law and the city charter expressly waived immunity by providing that the city could "sue and be sued" and "plead or be impleaded;" (3) under common law, the city's activity was a proprietary function; and (4) even if the Texas Tort Claims Act applied, the claims fell within the Act's waiver of immunity.[442] The trial court dismissed the city's plea to the jurisdiction. Subsequently, the court of appeals reversed the trial court, rejecting each of Reata's arguments in support of waiver and dismissing Reata's claims against the city.[443] Reata appealed on grounds (1), (2) and (4), above.

The Texas Supreme Court rejected Reata's argument that "sue and be sued" or "plead or be impleaded" language in state or municipal codes waived immunity, finding that this did not constitute a "clear and unambiguous waiver of immunity to suit."[444] It also rejected Reata's argument that the claims for property damage and mental anguish fell within the Tort Claims Act waiver of immunity for "personal injury and death caused by a condition or use of tangible personal or real property."[445] However, the Court was persuaded that:

> [W]here the governmental entity has joined into the litigation process by asserting its own affirmative claims for *monetary relief*, we see no ill befalling the governmental entity or hampering of its governmental functions by allowing adverse parties to assert, as an offset, claims germane to, connected with, and properly defensive to those asserted by the governmental entity.[446] [Emphasis added.]

The Court made clear that the trial court's subject matter jurisdiction was limited to the amount of damages sought in the counterclaim that could be offset against any recovery by the city against Reata. The court of appeals judgment was reversed and the case remanded to the trial court.

The boundaries of the *Reata* waiver were further delineated in *Nazari*, when the Texas Supreme Court considered whether counterclaims made against the state could be offset against statutory civil penalties to punish providers for "violating a public welfare statute and to deter others from doing the same."[447] *Nazari* involved a state enforcement action against a Medicaid provider under the Texas Medicaid Fraud Prevention Act, which provided for specific penalties for violations of the act.[448] The state argued that the *Reata* waiver applied only to *compensatory damages* sought by the state; the providers argued that *Reata* applied broadly, whenever the state

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[440] *Id. at* 372.
[441] *Id.* at 373.
[442] *Id.* at 373-374.
[443] *Id*. at 374.
[444] *Id*. at 378.
[445] *Id*. at 377; See also TEX. CIV. PRAC. & REM. CODE §101.021(2).
[446] Reata Construction Corporation v. City of Dallas, 197 S.W. 3d at 376-377.
[447] Nazari v. State, 561 S.W. 3d at 509.
[448] TEX. HUM. RES. CODE §36.051(a) and §36.052.

seeks a *transfer of funds*. The Court rejected both of these arguments, holding that the *Reata* waiver "does not apply when the state seeks to impose a monetary penalty to enforce a substantive prohibition against unlawful conduct."[449] The *Reata* waiver "never applies to offset a penalty."[450]

Medicaid providers should take heed of the Court's interest in protecting the state's ability to generate revenue through penalties:

> Many state programs and offices — including Medicaid, police departments, environmental agencies, etc. — depend at least in part for their continued existence on collecting revenue in the form of penalties. Hampering these entities' collections by abrogating their sovereign immunity injures the public fisc just as surely as allowing private citizens to sue them directly for damages. [451]

Medicaid providers suspended based on CAF could argue that these decisions support finding a waiver of sovereign immunity as to a Medicaid provider's counterclaims to the extent of the alleged overpayment, as the CAF regulations do not provide for any penalties, but rather recoupment. In instances in which overpayments have been inflated by extrapolation, this could work in the provider's favor.

Successful challenges to suspensions have been based on traditional challenges to agency action.

VIII. 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.

First, new provisions place guardrails on the state Medicaid agency's auditing and extrapolation of audit findings.[452] Medicaid auditors must now be approved by the state auditor and claims must be reviewed by a person who is licensed, certified, registered or otherwise credentialed in New Mexico as to the matters being reviewed, including coding or specific clinical practice.[453] Further, extrapolation is not allowed unless a Medicaid provider's error rate exceeds

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[449] *Nazari*, 561 S.W. 3d at 509.
[450] *Id*.
[451] *Id*. at 508.
[452] NMSA 1978 § 27-11-7(A) and (B).
[453] NMSA 1978 § 27-11-7(A).

10% based on an appropriate sampling and representative sample of claims computed by valid statistical methods "in accordance with the most recently published Medicare Program Integrity Manual," using statistical software approved by HHS.[454]

Next, 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")[455] The PFO must state with specificity 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.[456] 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.[457] Ideally, disputes can be resolved promptly, with corrective action if necessary, without the state or the provider incurring unnecessary expense and with little or no interruption in services.

In addition, a Medicaid provider is now afforded an expedited adjudicatory proceeding following receipt of a final determination of overpayment.[458] 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.[459] The provider may also challenge the credentials of the persons participating in the audit or claims review or the methodology or accuracy of the department's audit. 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.[460]

A CAF determination is now deemed a final agency decision that may be appealed to a district court.[461] Once referred to the attorney general for investigation, a Medicaid provider is entitled to judicial review of this final HSD determination.[462] 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.[463] In addition, the court may not consider evidence acquired by HSD after it made its CAF determination.[464]

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."[465] To ensure that suspensions are not for indeterminate periods of time, new provisions mandate release of suspended payments within 10 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

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[454] NMSA 1978 § 27-11-7(B).
[455] NMSA 1978 § 27-11-7(C).
[456] NMSA 1978 § 27-11-7(D).
[457] NMSA 1978 §27-11-7(D)(3).
[458] NMSA1978 §27-11-9. This provides procedural due process to providers with respect to alleged overpayments.
[459] NMSA 1978 §27-11-12 (A)(1).
[460] NMSA 1978 §27-11-9 (E).
[461] NMSA 1978 §27-11-16 (A). This provides procedural due process to providers whose payments have been suspended based on a CAF.
[462] NMSA 1978 §27-11-16 (B).
[463] *Id*.
[464] NMSA 1978 §27-11-16(C).
[465] NMSA 1978 §27-11-13(A).

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.[466]

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 HSD to temporarily manage or provide technical assistance to the Medicaid provider after the referral or during the pendency of the dispute.[467] Further, a provider that complies with the foregoing requirements will be promptly reimbursed for each clean claim for ongoing services.[468]

Changes to the Medicaid Provider Act provide for 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.[469] 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.[470]

IX. CUI BONO

The Martinez administration's use of the federal CAF laws and regulations to upend and replace New Mexico's behavioral health system fits squarely into a definition of one form of "crony capitalism," which is defined as:

> transactions that, while legal, come at great expense of the wider public. In other words, the benefits received by the few far outweigh the benefits received by others. In fact, it is quite likely that in these cases the public experiences significant *costs* associated with the transactions.[471]

Throughout the transition to the Arizona providers, there was abundant anecdotal evidence of significant disruption of Medicaid behavioral health services. According to La Frontera, OptumHealth could not provide a list of Medicaid enrollees for each facility for which it was

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[466] NMSA1978 §27-11-13(C). This provision creates 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, 2019 WL 7287088 (Minn. App. 2019)(Not Reported in N.W. Rptr.)(statute authorizing payment withholds pending investigation does not confer an entitlement to reimbursements for services already rendered).

[467] NMSA 1978 §27-11-14(A).

[468] NMSA 1978 §27-11-14(C). This provision is intended 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.

[469] NMSA 1978 §27-11-17.

[470] NMSA 1978 §27-11-15.

[471] The Committee for Economic Development, *Crony Capitalism, Corruption and the Economy in the State of New Mexico*, January 2016, pp. 20-21.

expected to assume services.[472] 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.[473] The transition to the Arizona providers was anything but turnkey or seamless,[474] 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.[475] La Frontera argued that OptumHealth realized a windfall during the transition as it continued to receive and retain its full monthly capitation 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.[476] 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,[477] $3 million for the flawed PCG audit[478] and $10 million to the last five of the falsely accused providers who filed administrative appeals and lawsuits against the state.[479] These amounts do not include the dollar value of the time spent by state employees across many different agencies as part of the transition and disruption of services.[480] 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. 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 inflated.

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[472] Complaint, La Frontera Center, Inc. v. United Behavioral Health, Inc. et al; No. D-202-CV-2016-00857 (February 9, 2016) at ¶73.

[473] *Id*. at ¶74.

[474] *Id*. at ¶¶72-75.

[475] *Id*. at ¶70.

[476] *Id.* As an example, 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. News Release, UnitedHealth Group, UnitedHealth Group Continues Efforts to Combat Covid-19 —Reports Second Quarter Performance (July 15, 2020), last accessed at https://www.unitedhealthgroup.com/viewer.html?file=/content/dam/UHG/PDF/investors/2020/UNH-Q2-2020-Release.pdf.

[477] Data obtained from 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 author).

[478] LEGISLATIVE FINANCE COMMITTEE, HUMAN SERVICES DEPARTMENT COST AND OUTCOMES OF SELECTED BEHAVIORAL HEALTH GRANTS AND SPENDING, REPORT #13-04 (May 16, 2013), p.8.

[479] In addition, the state returned $300,000 of remaining withheld overpayments to three of the five.

[480] 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 (" BHS Contract")(on file with author).

The most that the state has claimed that it recovered as a result of the suspensions is "about" $4.4 million, most of which was extracted from PMS in its early settlement with the state.[481]

Throughout the fallout from the suspensions, state legislators and others publicly questioned why OptumHealth had not been investigated in connection with its own performance in managing state and federal funds both before and following the 2013 suspensions. Answers were never forthcoming from the Governor, HSD or the attorney general. The *Santa Fe Reporter* has published an exhaustive exposé of United Healthcare's political contributions to, and lobbying of, the Martinez administration during the period in question.[482] In October 2014, an extensive investigative piece in the *New York Times* called attention to the influence of large donors to attorneys general associations of both the Republican and Democratic parties.[483]

Gary King was New Mexico's attorney general at the time of the behavioral health suspensions and for several years afterward. After accepting the referrals from HSD, the Office of the Attorney General investigated each of the suspended providers and eventually found no evidence of fraud on the part of any of them. The office also repeatedly moved to keep the two whistleblower lawsuits against OptumHealth under seal, which meant that they were kept from the public for years following the suspensions.[484] The office did not intervene in either of the whistleblower suits. However, in 2018, the office, now headed by former State Auditor Hector Balderas,[485] opposed United Healthcare's motion to dismiss with prejudice one of the OptumHealth whistleblower suits on the grounds that a "with prejudice" dismissal would "prevent future, potentially meritorious litigation" that the office could bring against the UnitedHealth defendants (among them OptumHealth).[486] As of this writing, New Mexico's Office of Attorney General has not publicly disclosed whether it has considered, or is still considering, taking legal action against OptumHealth for its actions while serving as the state's behavioral health managed care organization.[487]

In early 2019, the Attorney General of Texas announced a $235 million settlement with Xerox and several of its former subsidiaries arising out of Xerox's rubber-stamping of prior authorization requests for orthodontic services by dentists serving Medicaid patients, related to the

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[481] Dan McKay, *State settles for $484 after $2.8M demand*, ABQ. JOURNAL, June 23, 2017, last accessed at https://www.abqjournal.com/1022848/nms-overpayment-demond-falls-from-2-8m-to-485.html
Recall that $4 million was paid by Presbyterian Medical Services in a business-decision settlement that admitted no fault on its part. *See* Section II (f) discussion entitled "*Four million dollars*," *supra*.

[482] Justin Horwath, *Access Peak: How United Healthcare bought access to the governor, won lucrative contracts with New Mexico and avoided scrutiny in the behavioral health care shakeup*, SANTA FE REPORTER, March 17, 2015, last accessed at https://www.sfreporter.com/news/coverstories/2015/03/17/access-peak/

[483] Eric Lipton, *Courting Favor: 'The People's Lawyers'—Lobbyists, Bearing Gifts, Pursue Attorneys General*, N.Y. TIMES, October 28, 2014. The article made no reference to the State of New Mexico, or to its Attorney General.

[484] 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; No. D-101-CV-2012-01391; 1st Dist. Santa Fe County, New Mexico (all motions on file with author). The *Clark* lawsuit only became public in July of 2015. Order (July 10, 2015) U.S. ex rel Clark v. UnitedHealthGroup, Inc. et al, No. 1:13-CV-00372; U.S. Dist. Ct., District of New Mexico (lifting seal).

[485] Balderas was the state auditor who investigated the PCG audit. *See* Section II (d), *supra*.

[486] Clark v. UnitedHealth Group, Inc., 2018 WL 1175088 *2 (D.N.M. March 3, 2018), not reported in F. Supp.

[487] It could be argued that OptumHealth's conduct violated Section 27-11-3(B) NMSA 1978 of the Medicaid Provider and Managed Care Act, or provisions of New Mexico's Fraud Against Taxpayers Act, Sections 44-9-3 NMSA 1978. Both acts prescribe penalties of several thousand dollars per violation.

Nazari case discussed in Section VII, *supra*.[488] After nearly a decade of administering the Texas Medicaid program under contracts with the state's Medicaid agency, Xerox was sued by the state for misrepresenting, concealing or failing to disclose "that it was not processing orthodontic prior authorization requests in accordance with Medicaid policy, was not substantively reviewing the evaluative documentation, and was approving vast numbers of prior authorization requests for ineligible services." The Xerox litigation was brought under the Texas Medicaid Fraud Prevention Act ("TMFPA"), which provides for civil penalties of not less than $5,000 and up to $15,000 for each unlawful act.[489] The TMFPA also authorizes the state to collect two times the amount of the payment or the value of the benefit, in addition to reasonable investigation and litigation fees, expenses and costs.[490] New Mexico has several laws similar to the TMFPA: the Medicaid Fraud Act, which provides for treble the amount of excess payments, interest on the excess payment, a civil penalty of $10,000 for each false claim, legal fees and costs of investigation and enforcement;[491] the Fraud Against Taxpayers Act, which provides for treble damages, a civil penalty of not less than $5,000 nor more than $10,000 for each violation of the act;[492] and the Medicaid Provider and Managed Care Act, which provides for a penalty of not more than $5,000 for each violation.[493]

Of interest, the Texas Supreme Court rejected Xerox's attempt to join the Medicaid providers in the TMFPA suit "for purposes of shifting liability, if any, to the service providers who had directly received disputed Medicaid payments."[494] Holding that a TMFPA civil remedy is not subject to comparative fault apportionment, the court found that the Texas "Legislature did not intend to allow fraudsters to mitigate their TMFPA liability" through a comparative fault remedy.[495] The "court upheld a court of appeals ruling that Xerox — and not the dentists — was responsible for mismanaging and [improperly authorizing] payments for Medicaid dental services."[496] This decision, while not binding on New Mexico courts, is nevertheless persuasive authority for the proposition that OptumHealth cannot deflect its liability for receiving payments from the state for work that it did not perform, or performed improperly, onto the suspended behavioral health providers.

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 Martinez administration's 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.

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[488] News Release, Texas Attorney General, AG Paxton Recovers Record $236 Million for Texas in Medicaid Fraud Settlement (February 19, 2019), last accessed at https://www.texasattorneygeneral.gov/news/releases/ag-paxton-recores-record-236-million-texas-medicaid-fraud-setttlement
See Nazari v. State, 561 S.W. 3d 495 (Tex. 2018)(related case against Medicaid dental providers).
[489] TEX. HUM. RES. CODE §§ 36.001-36.132; *In re Xerox*, 555 S.W. 3d 518 (Tex. 2018).
[490] *Id*. at 525.
[491] NMSA 1978 30-44-8.
[492] NMSA 1978 §44-9-3.
[493] NMSA 1978 §27-1-3.
[494] *In re* Xerox Corp., 555 S.W.3d 518 (Tex. 2018).
[495] *Id*. at 539.
[496] Marissa Evans, *Texas Supreme Court rules Xerox responsible for fraudulent Medicaid dental payments*, THE TEXAS TRIBUNE (June 22, 2018).

X. CONCLUSION

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. On the federal front, without a unified national campaign by Medicaid providers to amend federal law to afford those suspected of fraud the same legal protections enjoyed by the wider business community, change is unlikely. 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.[497] As this article has revealed, the high risk posed to a Medicaid provider's livelihood and reputation under current federal CAF laws and regulations can only increase providers' reluctance to participate in Medicaid.

Physicians "could be a powerful force" for change in federal CAF laws and regulations, with more than 900,000 of them in active practice.[498] Unfortunately, according to one expert, "there is no single organization that unifies all" physicians, characterizing the profession as "balkanized."[499] However, the same expert notes that recent collective action by physicians and physician specialty societies advocating for gun control and lower insulin prices, and protesting immigration policies separating children from their parents has made a difference.[500] Likewise, non-physician Medicaid service providers operate in silos and do not appear to be organized when it comes to influencing federal Medicaid policy. With the number of people eligible for Medicaid likely to increase as a result of the Covid-19 pandemic and the possibility of a Medicaid "public option,"[501] the time is right for Medicaid providers (including the medical profession), professional societies and provider organizations to join in advocating for change in federal Medicaid CAF law and regulations.

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.[502] To "stop fraud before it happens" greater attention needs to be focused on the performance of third-party program administrators, to whom state governments have "surrendered direct control" [503] and who are paid hundreds of millions of dollars to manage the Medicaid program.

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[497] Kayla Holgash & Martha Heberlein, *Physician Acceptance of New Medicaid Patients: What Matters And What Doesn't*, HEALTH AFFAIRS BLOG, April 10, 2019. DOI: 10.1377/hblog20190401.678690; https://www.healthaffairs.org/do/10.1377/hblog20190401.678690/full/

[498] Eric Topol, *Why Doctors Should Organize*, THE NEW YORKER, August 5, 2019.

[499] *Id*.

[500] *Id*.

[501] Andrew Bindman, *Medicaid's Public Health Plan Options*, JAMA HEALTH FORUM, Published online August 20, 2020. doi:10.1001/jamahealthforum.2020.1067.

[502] J. STUART SHOWALTER, THE LAW OF HEALTHCARE ADMINISTRATION (9th ed. 2020) at 59. According to Showalter, the ACA strengthened and promoted aggressive enforcement of fraud, waste, and abuse laws to "help recoup some of the costs of new [ACA] programs."

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