CLIENT ALERT: March 16, 2011

NEW CMS RULE EFFECTIVE MARCH 25, 2011 INCREASES RISK THAT MEDICARE AND MEDICAID PAYMENTS WILL BE SUSPENDED DURING GOVERNMENT INVESTIGATIONS

On February 2, 2011, the Centers for Medicare and Medicaid ("CMS") issued new rules that expand the government's right to suspend payments to a provider while investigating a credible allegation of program fraud (the "Suspension Rules"). The Suspension Rules came out of the Patient Protection and Affordable Care Act of 2010, and represent an expansion of CMS and state Medicaid programs' authority to suspend payments based in whole or in part upon reliable information either (1) that an overpayment or fraud or willful misrepresentation exists, or (2) that the payments to be made may not be correct. The Suspension Rules are a strategic move on the part of CMS, as the agency changes its fraud and abuse strategy from "pay to chase" (targeting overpayments and pursing recovery after the fact) to fraud prevention.

Credible Allegation of Fraud

Under the Suspension Rules, a healthcare provider's Medicare and/or Medicaid payments can now be suspended when a credible allegation of fraud exists, unless there is good cause not to suspend.

- "Credible allegation of fraud" means: an allegation from any source, such as fraud hotline, claims data mining, patterns identified through provider audits, civil False Claims Act, and law enforcement investigations. Allegations are considered to be credible when they have "indicia of reliability".

- Good cause not to suspend exists in the following circumstances:
    - Suspension would endanger life or health by jeopardizing beneficiary access to healthcare;
    - Suspension would compromise an existing investigation;
    - Other remedies would more effectively or more quickly protect Medicare funds; or
    - Suspension is not in the best interest of the Medicare program.

18 Month Cap on Medicare Payment Suspensions

Medicare payments will be suspended until the earlier of: (i) resolution of an investigation, or (ii) expiration of 180 days. After 180 days, CMS is required to re-evaluate the allegation to determine whether there is good cause not to continue the suspension. If CMS determines that the suspension should be extended, it must request certification from a federal or state law enforcement agency that the

matter continues to be under investigation. Ultimately, CMS cannot suspend Medicare payments for more than 18 months unless the case has been referred to a government enforcement agency.

Failure to Submit Medicare Cost Reports on a Timely Basis

Failure to submit Medicare cost reports on a timely basis will result in automatic suspension of payments until the cost report is filed and determined acceptable by the Medicare contractor.

Suspension of Medicaid Payments Requires Both Notice and Coordination with the Medicaid Fraud Unit

When suspending Medicaid payments, the state Medicaid program is required to notify the provider within five days of instituting the suspension, unless requested by law enforcement to delay notice. The notice must include: (i) a statement that payments are being suspended; (ii) a general description of the allegations that are the basis of the suspension; (iii) a statement that the suspension is temporary; (iv) specification of the type of claims the suspension affects; (iv) a statement of the provider's right to submit written evidence; and (v) a statement of the provider's appeal rights.

The state Medicaid program must also refer all investigations that lead to payment suspensions to the state's Medicaid Fraud Unit. If the Medicaid Fraud Unit accepts the referral, the payment suspension may be continued until enforcement proceedings are completed by the Medicaid Fraud Unit. The State Medicaid program must also obtain a list from the Medicaid Fraud Unit of any ongoing investigations in order to continue the payment suspension. If the Medicaid Fraud Unit declines the referral, the payment suspension must be discontinued immediately, unless separate authority exists to continue.

Future Outlook

The Suspension Rules go into effect on March 25, 2011. It is unclear how CMS and Medicaid will exercise its discretion to suspend payments under these new Rules. The Suspension Rules have the potential to delay or prevent the flow of funds to healthcare providers, which could cause financial hardship even if the healthcare providers eventually prevail on the allegations at issue. Healthcare providers should update their compliance plans and take seriously any overpayment or related concerns that may be expressed by Medicare or Medicaid in order to avoid possible payment suspensions.

If you have any questions about the new CMS rule, please contact Attorney Emily Kretchmer at ekretchmer@kb-law.com or (617)482-7211.