

ISSUE

Whether the Department acted properly when it issued an Order of Summary Suspension to Petitioners on June 26, 2023, effective June 27, 2023.

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. To become Medicaid providers in Michigan, providers must sign Medicaid Provider Enrollment agreements in which they agreed to comply with all regulations, laws and policies relating to the Medicaid program. (Exhibits 1, 8; Testimony.)
2. According to Michigan Medicaid records, including the providers' CHAMPS profile, Petitioner REDACTED is the 100% owner of Petitioners, REDACTED Transportation, LLC; REDACTED Transportation, Inc.; REDACTED Transportation, LLC; and REDACTED Transportation, LLC. (Exhibits 1, 8; Testimony.)
3. In 2022, Modivcare, the transportation provider for Blue Care Complete, a Medicaid Health Plan, began an investigation into Petitioner REDACTED Transportation, Inc. (REDACTED) after reviewing REDACTED's duplicate driver report. (Exhibits 1, 2; Testimony.)
4. During the investigation, Modivcare discovered that two REDACTED drivers, REDACTED and REDACTED, were claiming to be conducting more than 40 trips/legs in one day causing overlapping pick-up and drop-off times to various locations. (Exhibits 1, 2; Testimony.)
5. Modivcare also reviewed driver packets for drivers REDACTED and REDACTED and confirmed that both drivers had forged Passenger Assistance, Safety and Sensitivity (PASS) certificates through the Community Transportation Association of America (CTAA).¹ (Exhibits 1, 2, 3; Testimony.)
6. Modivcare also confirmed that both drivers, REDACTED and REDACTED had forged physicals on file. (Exhibits 1, 2; Testimony.)
7. Modivcare also reviewed Petitioners' Auto Liability and General Liability coverage and discovered that not all of the vehicles used for transporting members for Modivcare were listed. (Exhibits 1, 2; Testimony.)

¹ Such training is required to be a driver for Modivcare and the Medicaid Health Plan.

8. Modivcare also reviewed Petitioners' Auto Liability coverage and discovered none of the listed drivers were credentialed drivers for Modivcare or covered under any active policies from January 1, 2020 through July 1, 2022. (Exhibits 1, 2; Testimony.)
9. After receiving Modivcare's investigation, Blue Cross Complete conducted its own investigation through its contractor AmeriHealth. (Exhibits 2-6; Testimony.)
10. AmeriHealth extended Modivcare's investigation to 10 additional REDACTED drivers: REDACTED and REDACTED (Exhibits 2-6; Testimony.)
11. AmeriHealth discovered that National Safety Committee Certificates for completion of Defensive Driving Certifications for all drivers were invalid and had all been altered in some way. Additionally, the PASS certificates for all drivers were determined to be fraudulent by CTAA. (Exhibits 2-6; Testimony.)
12. AmeriHealth also reviewed trip logs for three of the drivers (REDACTED, and REDACTED) and found that the drivers each used multiple vehicles on the same dates of service with overlapping pick up and drop off times. (Exhibits 2-6; Testimony.)
13. On April 26, 2023, Blue Cross Complete submitted a fraud referral regarding Petitioners to the MDHHS OIG and the Department of Attorney General Health Care Fraud Division (HCFD), Medicaid Fraud Control Unit (MFCU). (Exhibit 1; Testimony.)
14. On May 30, 2023, the HCFD-MFCU notified MDHHS OIG that they would be accepting and investigating the fraud referral from Blue Cross Complete and that a payment suspension would not compromise or jeopardize the HCFD-MFCU investigation. (Exhibit 7; Testimony.)
15. On June 26, 2023, Respondent issued an Order of Summary Suspension to Petitioners, suspending Petitioners from participation in the Michigan Medicaid Program effective June 27, 2023. (Exhibit 8; Testimony.) In support of the suspension, the Order indicated, in part:
 1. REDACTED Transportation billed for services not rendered as evidenced by:
 - a. Two REDACTED Transportation drivers billed more than 40 trips/legs in one day causing overlapping pick-up and drop-off times to various locations. Modivcare SIU also

confirmed that both drivers had forged physicals on file.

- b. Three REDACTED Transportation drivers billed trips where drivers were each using multiple vehicles on the same dates of service with overlapping pick-up and drop-off times.
2. National Safety Committee (NSC) Defensive Driving Certifications for all drivers were confirmed with the NSC organization to be not valid and had all been altered in some manner.
 3. Passenger Assistance Safety and Sensitivity Program (PASS) certificates for all drivers were determined to be fraudulent by the Community Transportation Association of America (CTAA).
 4. REDACTED Transportation did not maintain appropriate insurance for itself or its drivers while services were being rendered to Medicaid beneficiaries:
 - a. The General Liability policy did not cover all vehicles and/or drivers used for beneficiary transportation at REDACTED Transportation
 - b. The Auto Liability policy only showed two covered vehicles; however, the list of vehicles credentialed with Modivcare by REDACTED Transportation included 26 total vehicles. The scheduled driver list on the policy also included several drivers, none of whom were credentialed drivers for Modivcare.
 - c. Certificates of insurance did not cover any of the active drivers under any policies from January 1, 2020, through July 1, 2022.

(Id.)

16. On July 7, 2023, Petitioner's request for hearing was received by MOAHR.

CONCLUSIONS OF LAW

Respondent has the burden to show, by competent, material, and substantial evidence on the whole record, that it acted properly when it issued an Order of Summary Suspension to Petitioners on June 26, 2023, effective June 27, 2023. MCL 400.111f(5);

Blue Cross Blue Shield v Milliken, 422 Mich 1; 367 NW2d 1 (1985); *Dep't of Community Health v Risch*, 274 Mich App 365, (2007).

The Social Welfare Act of 1939, 1939 PA 280, (Act) as amended, provides for the summary suspension of Medicaid providers. MCL 400.111d provides, in pertinent part:

(1) Participation as a provider in the program is subject to denial, suspension, termination, or probation on the grounds specified by section 111e. The director may take 1 or more of the following actions:

(a) Refuse to enroll an applicant.

(b) Suspend a provider indefinitely or for a term certain.

* * * *

Federal regulations require the Department to suspend if there is a credible allegation of fraud and an investigation is pending. 42 CFR 455.23 provides, in pertinent part:

(a) Basis for suspension

(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.

A credible allegation of fraud is defined in 42 CFR 455.2, which provides:

Credible allegation of fraud. A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:

(1) Fraud hotline tips verified by further evidence.

(2) Claims data mining.

(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. 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.

Emphasis added.

The Act mandates suspension if a provider bills for services not rendered and allows for suspension if the Director determines a suspension is necessary to protect Medicaid beneficiaries or the funds of the program. MCL 400.111e provides, in pertinent part:

(1) The grounds for action by the director under section 111d(1) and the actions to which they may be applied shall be as follows:

(3) The director shall take action under section 111d(1)(a), (b), (c),(d), or (f) if any of the following occurs:

(b) The provider submits a claim for services, supplies, or equipment that was not provided to a recipient.

(5) In addition to or in place of the grounds specified in subsection (1), (2), or (3), the director may base an action provided for in section 111d(1)(a), (b), (c), (d), (e), or (f) on his or her judgment that the action is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

(Emphasis added)

The director may also issue an emergency suspension if there is a reasonable belief that the provider has violated the Medicaid False Claims Act or a similar statute. MCL 400.111f provides, in pertinent part:

(1) The director may issue an order incorporating a finding that emergency action is required to protect the state's interest, as the state's interest is described in this subsection by the statement of circumstances warranting emergency action, in any of the following: the public health, welfare, or safety; medically indigent individuals; or public funds of the program of medical assistance. Circumstances that warrant emergency action include, but are not limited to, any of the following:

(b) A reasonable belief that the provider has violated the medicaid false claims act, Act No. 72 of the Public Acts of 1977, being sections 400.601 to 400.613 of the Michigan Compiled Laws, the health care false claims act, Act No. 323 of the Public Acts of 1984, being sections 752.1001 to 752.1011 of the Michigan Compiled Laws, or a substantially similar statute of another state or the federal government.

(6) A hearing, conference, or similar meeting between a provider or representative of a provider and the state department shall not be required to be held or conducted before the emergency suspension of payment to the provider or the emergency suspension of participation of the provider in the program of medical assistance under this section.

(Emphasis added)

The Act also requires providers to make available any records required to be maintained, such as medical records. MCL 400.111b provides:

(1) As a condition of participation, a provider shall meet all of the requirements specified in this section except as provided in subsections (25), (26), and (27).

(7) Upon request and at a reasonable time and place, a provider shall make available any record required to be maintained by subsection (6) for examination and photocopying by authorized agents of the director, the department of attorney general, or federal authorities whose duties and functions are related to state programs of medical assistance under title XIX. If a provider releases records in response to a request by the director made under section 111a(13) or in compliance with this subsection, that provider is not civilly liable in damages to a patient or to another provider to whom, respectively, the records relate solely, on account of the response or compliance.

Suspensions extend to owners of sanctioned entities. 42 CFR 1001.1551 provides, in pertinent part:

(a) Circumstance for exclusion. The OIG may exclude any individual who -

(1) Has a direct or indirect ownership or control interest in a sanctioned entity, and who knows or should know (as defined in section 1128A(i)(7) of the Act) of the action constituting the basis for the conviction or exclusion set forth in paragraph (b) of this section; or

(2) Is an officer or managing employee (as defined in section 1126(b) of the Act) of such an entity.

Emphasis added.

While the above section applies to the federal Office of Inspector General, the authority is extended to the States in 42 CFR 1002.3, which states:

In addition to any other authority it may have, a State may exclude an individual or entity from participation in the Medicaid program for any reason for which the Secretary could exclude that individual or entity from participation in Federal health care programs under sections 1128, 1128A, or 1866(b)(2) of the Act.

Emphasis added.

Should know is defined under 42 U.S.C. 1128A(i)(7), which provides:

(7) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

In this case, the Department argues that it was required to suspend (or exclude) Petitioners because there is a credible allegation of fraud for which an investigation is pending and because there is a reasonable belief that Petitioners submitted claims for services, supplies, or equipment that were not provided to a recipient. The Department also argues that it had discretion to suspend Petitioner because there is a reasonable belief that Petitioners have violated the Medicaid False Claims Act or a substantially similar statute, and the suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

Petitioners argue that the summary suspension should be lifted because there has been no credible allegation of fraud. Petitioners argue that Petitioner REDACTED never intended to defraud the Medicaid program, so he lacked the necessary intent to prove fraud. Petitioners argue that representatives of Modivcare instructed Petitioners to bill for trips as they did because of problems with Modivcare's trip tracking and reporting software. Petitioners also argue that the false certifications on file with Modivcare were the actions of a rogue employee, and that employee has been fired and a police report was filed against her. Petitioners also argue that while business practices required them to add and remove vehicles and drivers from their insurance frequently, all drivers and vehicles were insured when services were provided.

Having considered the parties' arguments in full, the Department has established by competent, material, and substantial evidence on the whole record, that its summary suspension was proper under 42 CFR 455.23(a)(1), MCL 400.111d(1), MCL 400.111e(3)(b), MCL 400.111e(5), and MCL 400.111f(1)(b).

As indicated above, 42 CFR 455.23(a)(1) requires the Department to suspend Medicaid payments to a provider after the Department determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. Here, there is

an investigation pending by the HCFD-MCFU, so the only question is whether there is a credible allegation of fraud.

As also indicated above in 42 CFR 455.2(3), "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."

A thorough review of the evidence demonstrates that there is a credible allegation of fraud, so the Department was required to suspend (and exclude) Petitioners from Medicaid under state law and federal regulations.

Furthermore, under MCL 400.111e(3)(b), the Act requires the Department to suspend a provider if there is a reasonable belief that the provider submitted a claim for services, supplies, or equipment that was not provided to a recipient. A thorough review of the evidence demonstrates that the Department had such a reasonable belief.

Here, Modivcare discovered that two REDACTED drivers, REDACTED and REDACTED, were claiming to be conducting more than 40 trips/legs in one day causing overlapping pick-up and drop-off times to various locations. Modivcare also reviewed driver packets for drivers REDACTED and REDACTED and confirmed that both drivers had forged PASS certificates through CTAA. Modivcare also confirmed that both drivers, REDACTED and REDACTED had forged physicals on file. Modivcare also reviewed Petitioners' Auto Liability and General Liability coverage and discovered that not all of the vehicles used for transporting members for Modivcare were listed. Modivcare also reviewed Petitioners' Auto Liability coverage and discovered none of the listed drivers were credentialed drivers for Modivcare or covered under any active policies from January 1, 2020 through July 1, 2022.

After receiving Modivcare's investigation, Blue Cross Complete conducted its own investigation through its contractor AmeriHealth. AmeriHealth extended Modivcare's investigation to 10 additional REDACTED drivers: REDACTED and REDACTED. AmeriHealth discovered that National Safety Committee Certificates for completion of Defensive Driving Certifications for all drivers were invalid and had all been altered in some way. Additionally, the PASS certificates for all drivers were determined to be fraudulent by CTAA. AmeriHealth also reviewed trip logs for three of the drivers (REDACTED, and REDACTED) and found that the drivers each used multiple vehicles on the same dates of service with overlapping pick up and drop off times.

On April 26, 2023, Blue Cross Complete submitted a fraud referral regarding Petitioners to the MDHHS OIG and the Department of Attorney General HCFD-MCFU. The allegations were credible enough that the HCFD-MCFU accepted the referral and opened a criminal investigation that is still pending. The allegations are also credible on their face. Therefore, at the time Respondent issued its summary suspension, there were credible allegations of fraud.

Petitioners' arguments to the contrary are not persuasive. First, Petitioners' argument that Petitioner REDACTED lacked the required intent to prove fraud is without merit. As Respondent points out, no credible allegation of fraud was made against Petitioner REDACTED nor was Petitioner REDACTED the "provider" under MCL 400.111f that the Department reasonably believes violated the Medicaid False Claims Act. The investigation here concerned claims and documentation submitted by REDACTED and it is that information that led to the credible allegations of fraud here. If anyone bears civil or criminal liability for REDACTED's actions, that will be determined by HCFD-MCFU, not OIG.

With regard to Petitioner REDACTED, the proper question is whether he "knew or should have known" of the actions going on at his company, REDACTED. Again, "should know" is defined in Section 1128A of the Social Security Act as "(A) acts in deliberate ignorance of the truth or falsity of the information; or (B) acts in reckless disregard of the truth or falsity of the information." Based on the evidence, Petitioner REDACTED certainly acted in reckless disregard of the truth and may have acted in deliberate ignorance of the truth.

For example, Petitioner REDACTED testified that he worked in a hands-on manner in all aspects of the company, including billing and working with Modivcare on software issues. (See also Exhibit F.) And, while Petitioner REDACTED argues that he was told to bill the way that he did by a representative of Modivcare, he offered no proof to support this allegation besides his own testimony. And, while Petitioners did present proof that there were issues with Modivcare's software system, that is a far cry from proving that someone from Modivcare informed Petitioner REDACTED to commit Medicaid fraud.

Further, while Petitioner REDACTED may have fired and filed a police report against the rogue employee who was allegedly responsible for all the fake certificates in REDACTED's drivers' files, his actions demonstrate that he knew, with certainty, that REDACTED was not following Modivcare policy, and failed to report it to Medicaid. Ultimately, as owner it was Petitioner REDACTED's who was responsible to ensure that all policies and procedures were properly followed. Further, the fact that there were so many false certificates (and forged physicals) makes it difficult to believe that Petitioner REDACTED did not know before the investigation what was going on, or, at a minimum, turn a blind eye to the misconduct.

Also, while Petitioners provided additional insurance information as part of this appeal, the information submitted does not clearly show that all vehicles and drivers were covered during the period of the investigation. While it is understandable that Petitioner REDACTED had to make frequent changes to his insurance for business reasons, again, he was ultimately responsible to ensure that all vehicles and drivers were insured at all times.

Therefore, there was a credible allegation of fraud and the Department's suspension pursuant to 42 CFR 455.23(a)(1) was proper.

In addition, based on the same facts, there was a reasonable belief that Petitioners submitted claims for services, supplies, or equipment that was not provided to a recipient. The evidence shows plainly that many of Petitioners' drivers performed overlapping trips and trips at the same time in different vehicles. Clearly, that would be impossible. As such, the Department was required to suspend Petitioners under MCL 400.111e(3)(b).

Finally, also based on the same facts, the Department properly used its discretion to suspend Petitioners pursuant to MCL 400.111e(5) (the action was necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program) and MCL 400.111f(1)(b) (a reasonable belief that the provider violated the medicaid false claims act or a substantially similar statute of another state or the federal government).

The suspension of REDACTED was properly extended to the exclusion of Petitioner REDACTED and the suspension of the related entities pursuant to 42 CFR 1001.1551 and 42 CFR 1002.3. There is no dispute that Petitioner REDACTED is the owner of all related entities.

While this Administrative Law Judge understands the serious effect the Department's action has had on Petitioners'; the rationale for the lower standard of proof in an emergency suspension action is clear. A temporary suspension is often necessary to protect Medicaid while more definitive proceedings are pending, or the investigation is closed. Based on the multiple, serious allegations here, an emergency suspension was proper.

Having determined that the Department has met its burden, the Department's Order of Summary Suspension is proper and should remain in place.

IT IS THEREFORE ORDERED that:

The Order of Summary Suspension issued by the Department on June 26, 2023, effective June 27, 2023, is **AFFIRMED/UPHELD**.