

ISSUE

Whether the Department properly issued an Order of Summary Suspension to Petitioner on October 6, 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. Petitioner is an enrolled provider in the Michigan Medicaid Program. (Department's Exhibit A, pages 1-11; Department's Exhibit E, page 38).
2. On June 23, 2023, CoventBridge Group, on behalf of The Centers for Medicare & Medicaid Services (CMS), sent Petitioner a Notice of Suspension of Part B Medicare Payments. (Petitioner's Exhibit A, pages 1-4; Department's Exhibit F, pages 40-43).

3. In part, that Notice of Suspension stated:

The purpose of this letter is to notify you of our determination to suspend Medicare payments to [Petitioner] pursuant to 42 C.F.R. § 405.371(a)(2). The suspension of [Petitioner's] Medicare payments took effect on June 15, 2023. Prior notice of the suspension was not provided because it was determined it was not appropriate. See 42 C.F.R. § 405.372(a)(3) and (4).

CMS, through its Central Office, made the decision to suspend [Petitioner's] Medicare payments. See 42 C.F.R. § 405.372(a)(4)(iii). This suspension is based on credible allegations of fraud. See 42 C.F.R. §405.371(a)(2). CMS regulations define credible allegations of fraud as an allegation from any source, including but not limited to fraud hotline complaints, claims data mining, and patterns identified through audits, civil false claims cases, and law enforcement investigations. See 42 C.F.R. § 405.370(a). Allegations are considered to be credible when they have indicia of reliability. *Id.* This suspension may last until resolution of the investigation as defined under 42 C.F.R. § 405.370 and may be extended under certain circumstances. See 42 C.F.R. § 405.372(d)(3).

Specifically, the suspension of [Petitioner's] Medicare payments is based on, but not limited to, information that [Petitioner] misrepresented services billed to the Medicare program. More particularly, [Petitioner] billed Medicare for units of COVID-19 over the counter (OTC) test kits that were never requested or received by the beneficiary. Medicare pays only for expenses incurred for items or services that are "reasonable and necessary for the diagnosis or treatment of illness or injury." 42 U.S.C. § 1395y(a)(1)(A). In addition, while the public health emergency was in effect, under the OTC COVID-19 Test Demonstration, suppliers could bill Medicare for up to 8 OTC COVID-19 tests per beneficiary per month if the beneficiary requested the test kit.

Here, there have been 429 complaints filed by beneficiaries against [Petitioner], 107 of which were from beneficiaries who did not receive the COVID-19

OTC test kits billed to Medicare, 167 from beneficiaries who had not heard of REDACTED, 136 that were listed as "other", and 18 that were listed as suspected identity theft. Thus, the complaints allege that REDACTED is billing COVID-19 OTC test kits to beneficiaries who did not request, or receive them, which is contrary to the Medicare statute and CMS guidance under the OTC COVID-19 Test Demonstration.

* * *

Pursuant to 42 C.F.R. § 405.372(b)(2), [Petitioner] has the right to submit a rebuttal statement in writing to us indicating why you believe the suspension should be removed. If you opt to do so, we request that you submit this rebuttal statement to us within 15 days of receipt of this notice, and you may include with this statement any evidence you believe supports your reasons why the suspension should be removed.

Petitioner's Exhibit A, pages 1-2
Department's Exhibit F, pages 40-41

4. On July 31, 2023, Petitioner's attorney sent a letter to CoventBridge/CMS in rebuttal. (Petitioner's Exhibit B, pages 1-11).
5. In part, that rebuttal stated:

As discussed in detail below, [Petitioner] worked hard—including with a dedicated, third-party management services provider—to provide a clear, accessible, and secure platform for interested Medicare beneficiaries to order FDA-authorized OTC COVID-19 tests in compliance with applicable CMS guidance. Among other things, [Petitioner] undertook extensive efforts to inform beneficiaries about their rights under the Program, including their right to opt-out of the Program at any time if they no longer wished to receive the tests. [Petitioner] also applied stringent controls at each stage of its order fulfillment process to minimize the risk of fraudulent orders, and [Petitioner] undertook further efforts to strengthen those controls, on its own accord, as the Program progressed.

[Petitioner] also utilized a billing system that was both logistically feasible and designed to ensure that it only billed CMS for tests that were shipped and delivered to Medicare beneficiaries.

Upon receipt of the CMS Letters, [Petitioner] immediately investigated the claims CMS identified. For the vast majority of those claims, [Petitioner] consulted the documentation it maintained as part of the Program—and as required by the CMS guidance—and confirmed the validity of the claims in question including that the tests were, in fact, both requested/ordered by a beneficiary and delivered to him/her. However, [Petitioner] also came to learn that despite its numerous safeguards (discussed below), it did experience some issues in connection with a subset of claims. Of the 65 claims CMS identified, only nine were not successfully delivered (unknown to [Petitioner] until very recently, as explained further below); the rest were confirmed as delivered to a verified address of the beneficiary.

As demonstrated throughout this response, these billed-but-undelivered tests represent a small fraction of [Petitioner's] overall participation in the Program. More importantly, the evidence shows that [Petitioner's] billing of these claims to CMS was done in good faith—i.e., [Petitioner] did not know, or have any reason to know, that the tests had not been successfully delivered. To the contrary, [Petitioner] had a good faith belief that they had been or would be delivered, and the reason they were not delivered was human error outside [Petitioner's] control or knowledge—specifically, inputted addresses by the ordering individual, and false confirmations of shipment by the third-party logistics provider that was engaged to ship the tests. In short, [Petitioner's] believes that its investigation and the relevant documentation demonstrate that these errors that [Petitioner] has come to discover are stark outliers to what was by all accounts an otherwise well-run and compliant operation.

As discussed in more detail below, [Petitioner] has already taken swift action to refund each and every claim for a test it has since learned was billed to CMS

and was not successfully delivered to a beneficiary. [Petitioner] participated in the Program both effectively and compliantly. The information in this response, along with the supporting documentation attached hereto, demonstrate [Petitioner's] commitment to compliance and adherence to CMS guidance and provide a sufficient basis for CMS to conclude its investigation with a finding that [Petitioner's] did not engage in any fraud (and has already taken action to remedy any inadvertent billing for undelivered tests) and reinstate payment of [Petitioner's] Medicare claims.

Petitioner's Exhibit B, pages 1-2

6. On September 19, 2023, CoventBridge/CMS sent Petitioner a response to that rebuttal. (Petitioner's Exhibit C, pages 1-3).
7. In part, that response stated:

We have reviewed the documentation you submitted and have concluded that a basis exists to continue the suspension of payments. The beneficiary complaints referred in the Notice of Suspension as well as [Petitioner's] own investigation provide a sufficient basis for the suspension of [Petitioner's] Medicare payments. As previously explained in the Notice of Suspension, CMS received multiple complaints from beneficiaries alleging that they did not order or receive OTC COVID-19 test kits. [Petitioner's] own internal investigation confirmed that it billed Medicare for 20,166 test kits that were never shipped to beneficiaries and 6,268 test kits that were shipped, but not delivered. Even if these errors were the fault of ShipBob as [Petitioner] contends, as the supplier enrolled in Medicare, [Petitioner] is ultimately responsible for ensuring that the claims it submits to Medicare are accurate. Billing Medicare for OTC COVID-19 test kits that were not provided to beneficiaries is a sufficient basis for CMS to implement a payment suspension based on a credible allegation of fraud. As a reminder, the determination to suspend payments is not a determination that fraud in fact occurred. Rather, the suspension is a tool used by CMS to allow CMS and its contractors to investigate whether fraud occurred while protecting Medicare funds.

We also note that CMS can suspend payments even if no fraud occurred. The regulations allow CMS to suspend payments when there is reliable information that an overpayment exists. See 42 C.F.R. § 405.371(a)(1). Here, [Petitioner] admits that as a result of its billing errors, an overpayment exists totaling \$2,494,290. Thus, CMS has a sufficient basis to suspend [Petitioner's] Medicare payments while it completes its own investigation into whether an overpayment exists and the amount of that overpayment.

Petitioner's Exhibit C, page 2

8. On September 29, 2023, Petitioner's attorney emailed CoventBridge/CMS. (Petitioner's Exhibit D, pages 1-2).
9. In part, that email stated:

I want to take this opportunity to briefly clarify and reiterate a couple of items from REDACTED's July 31, 2023, Rebuttal.

First, and most importantly, your letter noted that as of August 16, 2023, REDACTED had refunded "over 11,294" claims. Since that time, REDACTED has completed the refunds. As of September 14, 2023, REDACTED has refunded all 26, 534 claims that it committed to refund in its Rebuttal, totaling \$2,494,290.00.

Second, we understand from your letter that CMS's investigation is ongoing, and that CMS is continuing to gather information. As you know, we provided detailed records with the Rebuttal, and we have also shared a detailed reporting of REDACTED's self-audit and its explanation of the claims that it has refunded. Accordingly, if there remains any additional information that would aid CMS in resolving the issue, please let us know so we can provide them.

Third, we believe that our Rebuttal (and the associated records) demonstrates that (a) there was no fraud, and (b) any reliable information that an overpay exists is limited to the COVID-19 OTC Test Demonstration program (the "Program") and HCPCS code K1034.

With respect to allegations of fraud, I want to reiterate what we stated in the Rebuttal, namely, that REDACTED had controls in place to ensure that kits were not shipped or billed without the individual making a valid order on the Verified Health Platform. This included IP address checks and other checks to guard against orders resulting from identity theft. In addition, REDACTED designed its billing protocols to ensure that REDACTED's billing process began only after it had received confirmation that shipping had been affected. Overall, this system was overwhelmingly accurate, with only two inadvertent failures: (1) the entry of incorrect addresses by beneficiaries on the Verified Health Platform (which led to orders that were shipped but not delivered), and (2) the error by third-party logistics provider ShipBob (which failed to ship product despite providing confirmation that shipment had been affected). The resulting billing errors represented a statistically insignificant percentage of all claims. REDACTED had implemented a practical and rigorous billing procedure to ensure compliance. However, an error occurred, which occurs throughout the industry and is the very reason CMS has a protocol in place to allow providers to rectify such errors upon discovery, as REDACTED did here. Such errors are not viewed as fraud.

Petitioner's Exhibit D, page 1

10. On October 6, 2023, the Department issued an Order of Summary Suspension with respect to Petitioner and others. (Petitioner's Exhibit E, pages 1-4; Respondent's Exhibit G, pages 45-48).
11. In part, that Order of Summary Suspension stated:

The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General (OIG) has determined that emergency action is necessary to protect the State's interest in medically indigent individuals and the public funds of the medical assistance program under MCL 400.111f.

MDHHS OIG has determined that evidence exists in support of the exclusion of . . . [Petitioner], NPI REDACTED . . . and such evidence includes but is not limited to:

1. On June 23, 2023, [Petitioner] was notified by CoventBridge, a contractor for the Centers for Medicare and Medicaid Services (CMS), that their Medicare payments were suspended effective June 15, 2023. Allegations from the suspension included:
 - a. This suspension was based on a credible allegation of fraud. Specifically, the suspension of [Petitioner's] Medicare payments was based on, but not limited to, information that [Petitioner] misrepresented services billed to the Medicare program.
 - b. [Petitioner] billed Medicare for units of COVID-19 over the counter (OTC) test kits that were never requested or received by the beneficiary.
 - i. Medicare pays only for expenses incurred for items or services that are "reasonable and necessary for the diagnosis or treatment of illness or injury."
 - ii. While the public health emergency was in effect, under the OTC COVID-19 Test Demonstration, suppliers could bill Medicare for up to eight OTC COVID-19 tests per beneficiary per month if the beneficiary requested the test kit.
 - c. There had been 429 complaints filed by beneficiaries against [Petitioner], 107 of which were from beneficiaries who did not receive the COVID-19 OTC test kits billed to Medicare, 167 from beneficiaries who had not heard of [Petitioner], 136 that were listed as "other" and 18 that were listed as suspected identity theft. Thus, the complaints allege that [Petitioner] is billing OTC COVID-19 OTC test kits to beneficiaries who did not

request, or receive them, which is contrary to the Medicare statute and CMS guidance under the OTC COVID-19 Test Demonstration.

* * *

Pursuant to Sections 111d, 111e and 111f of the Social Welfare Act, 1939 PA 280; MCL 400.01 et seq., participation as a provider in the Medicaid program is subject to suspension when:

- The provider is suspended or terminated as a provider from participation in the Medicaid or Medicare program, or other governmentally supported program in any jurisdiction.
- There is 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.
- The director finds that emergency action is required under subsection (1) in a clinic, corporation, partnership, or other entity with multiple providers or locations, therefore, the director may extend any emergency action to the entire legal entity and its providers.
- The suspension is necessary to protect the health of medically indigent individuals, the welfare of the public, and the funds appropriated for the program.

Pursuant to Section 111f of the Social Welfare Act, MDHHS finds that emergency action is required to protect the public funds of the Medicaid program; now therefore,

IT IS HEREBY ORDERED that [Petitioner] is summarily suspended from any direct or indirect participation in the Michigan Medicaid program commencing on October 10, 2023.

Petitioner's Exhibit E, pages 1-3
Department's Exhibit G, pages 45-47

12. On September 27, 2023, MOAHR received the request for hearing filed by Petitioner in this matter with respect to the Order of Summary Suspension.

CONCLUSIONS OF LAW

As discussed above, the Department has moved for summary disposition in this matter.

The Administrative Procedures Act (APA) allows parties "an opportunity to present oral and written arguments on issues of law and policy[.]" MCL 24.272(3). Pursuant to MCL 24.272(3), a party may also pursue a motion for summary disposition to address questions of law that do not involve factual disputes. *Smith v Lansing Sch Dist*, 428 Mich 248, 256-257; 406 NW2d 825 (1987).

The Michigan Administrative Code also allows for summary disposition under Rule 792.10129, which provides, in the pertinent part:

- (1) A party may make a motion for summary disposition of all or part of a proceeding. When an administrative law judge does not have final decision authority, he or she may issue a proposal for decision granting summary disposition on all or part of a proceeding if he or she determines that that any of the following exists:
 - (a) There is no genuine issue of material fact.
 - (b) There is a failure to state a claim for which relief may be granted.
 - (c) There is a lack of jurisdiction or standing.
- (2) If the administrative law judge has final decision authority, he or she may determine the motion for summary decision without first issuing a proposal for decision.
- (3) If the motion for summary disposition is denied, or if the decision on the motion does not dispose of the entire action, then the action shall proceed to hearing.

"A genuine issue of material fact exists when the record, drawing all reasonable inferences in favor of the nonmoving party, leaves open an issue upon which reasonable minds could differ." *West v. General Motors Corp*, 469 Mich 177, 183; 665 NW2d 468 (2003).

Moreover, with respect to the undersigned Administrative Law Judge's authority in this case, the applicable Delegation of Authority provides:

In those cases where the Director issues a summary suspension of payments to a Medicaid provider under MCL 400.111f(5), and the emergency action is based upon any one of the circumstances described in subsection 111f(1)(a) to (h), if the provider requests a contested case hearing relative to the emergency suspension, I appoint the administrative law judge to conduct the hearing and issue a final decision on the summary suspension and order as follows: The decision must be based only on a determination whether any of the circumstances in subsection 111f(1)(a) to (h) are supported by competent, material, and substantial evidence on the whole record. The presence of any of these circumstances is, as a matter of law, an emergency that warrants a summary suspension without further proof of harm. Where the Director issues a summary suspension of a provider from participation in the Medicaid program or a summary suspension of payments that is based on circumstances that are not described in subsection 111f(1)(a) to (h), the administrative law judge must issue a proposal for decision.

Delegation of Authority dated October 30, 2020

As such, the undersigned Administrative Law Judge has the authority to hear and decide preliminary dispositive motions, the authority to issue a decision on emergency actions based upon any of the circumstances described in MCL 400.111f(1)(a)-(h), and the authority to issue a proposal for decision on emergency actions based upon other circumstances.

Having considered the whole record and the parties' arguments in this case in full, the undersigned Administrative Law Judge finds that, while the remainder of the Department's motion would be denied, no genuine issue of material fact exists, and the Department is entitled to judgment as a matter of law, with respect to the determination that summary suspension is warranted based upon the circumstances described in 400.111f(1)(b).

Moreover, as the undersigned Administrative Law Judge has final decision authority order over such an action, and it is the sole grounds where he finds that summary

disposition is appropriate, the undersigned Administrative Law Judge also finds that the Department's motion should be granted by final order, and the upcoming hearing cancelled.

With respect to such summary suspensions, 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.

* * *

- (5) Upon a determination that circumstances described in subsection (1) exist, the director may issue an order for the summary suspension of payments on pending or subsequent claims, in whole or in part, or for the summary suspension of a provider from participation in the program of medical assistance. The summary suspension shall be effective on the date specified in the order or on service of a certified copy of the order on the provider, whichever occurs later, and shall remain in effect during administrative or judicial proceedings on the suspension. Upon request of a provider, a contested case hearing pursuant to chapter 4 and chapter 6 of the Administrative Procedures Act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.271 to 24.287 and 24.301 to 24.306 of the Michigan Compiled Laws, shall be commenced not later than 15 days after the summary suspension. If a contested case hearing is

requested by a provider relative to an emergency suspension under this section, a hearing shall be held to determine whether the emergency suspension is supported by competent, material, and substantial evidence on the whole record. Under appropriate circumstances, the state department may hold or institute a hearing under section 111c(1) or take an action under section 111d at the same time an action is taken under this section, while an action under this section is pending, or after a decision on an action is made. The presiding officer may consolidate the 2 hearings into a single proceeding in the interest of economy. However, the director shall not make a final decision in a contested case under section 111c(1) or 111d arising from or related to an emergency action or the circumstances upon which an emergency action was taken.

MCL 400.111f

Accordingly, in order to support summary disposition on the summary suspension in this case, the Department must show that no genuine issue of material fact exists with respect to its finding that there is a reasonable belief that Petitioner violated the Medicaid false claims act, the health care false claims act, or a substantially similar statute of another state or the federal government.

In support of its motion, the Department argues that it proceeded with the summary suspension after learning of the CMS Medicare's investigation and the finding of a credible allegation of fraud, with CMS regulations defining credible allegations as an allegation from any source having indicia of reliability, 42 CFR 405.370(a).

In response, Petitioner argues that, at the very least, there is a genuine dispute of fact as to whether the Department could currently "reasonably believe" that Petitioner violated the Michigan Medicaid false claims act or a comparable statute.

Specifically, it argues that all of the applicable false claims acts, both state and federal, require that a provider knowingly submit false claims and as demonstrated in its responses to CMS, Petitioner has since rebutted the supposed "credible allegations of fraud" and there is no evidence that Petitioner knowingly submitted false claims.

According to Petitioner, it examined every claim identified by CMS and definitively confirmed that (a) the vast majority of the billed-for COVID-19 tests were in fact ordered by the Medicare beneficiary and were delivered to that beneficiary; (b) some claims were verifiably ordered by the Medicare beneficiary but were not delivered due to error by the beneficiary in inputting the shipping address into the online ordering platform; and (c) some claims were verifiably ordered by the Medicare beneficiary but were

inadvertently not shipped due to a single error by Petitioner's 3PL, which the 3PL did not communicate to Petitioner until after CMS' June 23, 2023 letter.

Petitioner also argues that CMS essentially confirmed that no basis for fraud existed in the September 19, 2023 letter in response to Petitioner's rebuttal, where CMS switched gears and claimed both that CMS "can suspend payments even if no fraud occurred" and that "[t]he regulations allow CMS to suspend payments when there is reliable information that an overpayment exists" (Petitioner's Exhibit C, page 2).

However, Petitioner grossly misstates the September 19, 2023, letter in response to its rebuttal, and, while CMS did state that it could suspend payments even if no fraud occurred, it certainly did not confirm that no basis for fraud existed. Instead, it expressly stated that it had reviewed Petitioner's documentation and concluded that a basis existed to continue the suspension of payments, with multiple complaints from beneficiaries alleging that they did not order or receive items and Petitioner's own investigation conforming that it billed for 20,166 test kits that were never shipped and 6,268 kits that were shipped, but not delivered. According to the letter, those facts are "a sufficient basis for CMS to implement a payment suspension *based on a credible allegation of fraud.*" (Petitioner's Exhibit C, page 2 (emphasis added)).

Petitioner continues to fight those allegations of fraud, as it has a right to do, but the allegations remain, and its Medicare payments remain suspended based on a finding that they are credible.

Moreover, given the finding of credible fraud allegations with respect to Medicare payments, the Department had a reasonable belief that Petitioner has violated the health care false claims act, MCL 752.1001 et seq., or a substantially similar federal statute., as that act provides that "[a] person shall not make or present or cause to be made or presented to a health care corporation or health care insurer a claim for payment of health care benefits knowing the claim to be false." MCL 752.1003(1).

The rationale for Department's reduced burden of proof is clear - to allow the Department to take quick and temporary action to protect the Medicaid program while a full investigation takes place, and the allegations contained in the CMS Notice are more than sufficient alone to establish a reasonable belief that the applicable acts have been violated here.

Accordingly, while Petitioner did put forth evidence that might arguably weaken the Department's findings, there is no genuine issue of material fact as to whether the Department has met its low burden of establishing that there is a reasonable belief that Petitioner violated the health care false claims act, or a substantially similar federal statute, and the Department is entitled to both judgment as a matter of law and to have the summary suspension upheld.

IT IS THEREFORE ORDERED that:

- The Department's Motion for Summary Disposition is **GRANTED**.

The exclusion of Petitioner provided for in the Order of Summary

Suspension

issued by the Department on October 6, 2023 is **UPHELD**.

The hearing scheduled for October 25, 2023 is cancelled.