Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FLORIDA DID NOT SUSPEND MEDICAID PAYMENTS TO SOME PROVIDERS THAT HAD CREDIBLE FRAUD ALLEGATION CASES IN ACCORDANCE WITH THE SOCIAL SECURITY ACT

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Office of Inspector General

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EXECUTIVE SUMMARY

Florida did not suspend approximately $13.8 million ($8.1 million Federal share) and placed at risk about $70.3 million ($40 million Federal share) in Medicaid payments to some providers in cases of credible fraud allegations. In addition, it did not return $236,544 of Federal share related to restitution for one closed case.

WHY WE DID THIS REVIEW

The Social Security Act (the Act) requires a State to suspend Medicaid payments to a provider when it receives a credible allegation that the provider has submitted fraudulent claims.

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) suspended Medicaid payments to providers with credible fraud allegations in accordance with requirements of the Act.

BACKGROUND

The Patient Protection and Affordable Care Act amended portions of the Act. Under the amended Act, a State that does not suspend payments to a provider when an investigation of a credible fraud allegation is pending is not eligible for Federal reimbursement for payments made to that provider unless the State shows that it has good cause not to suspend such payments. A State may use such good-cause exceptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more effectively or quickly protect Medicaid funds.

Effective March 25, 2011, a State agency must suspend all Medicaid payments to providers when it determines that there is a credible fraud allegation. Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend such payments. The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or that legal proceedings related to alleged fraud are completed.

In Florida, two governmental offices are responsible for safeguarding Medicaid payments. The first office, within the State agency, is the Office of Medicaid Program Integrity. It audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud to the second office, the Florida Attorney General's Medicaid Fraud Control Unit (MFCU). The MFCU investigates and prosecutes providers suspected of engaging in fraudulent billing practices in the Medicaid program.

Effective March 2013, the State agency and the MFCU entered into a memorandum of understanding (MOU) that requires the State agency to refer suspected cases of civil or criminal fraud to the MFCU and incorporates the requirements of the Act to suspend payment in cases of credible fraud allegations.

Our review covered 95 cases related to provider fraud allegations that the State agency determined to be credible and formally referred to the MFCU between March 25, 2011, and December 31, 2013.

WHAT WE FOUND

The State agency did not always suspend Medicaid payments to providers that had credible fraud allegation cases in accordance with requirements of the Act. Of the 95 cases that we reviewed, the State agency applied a good-cause exception not to suspend payments for 1 case; and it either suspended, pursued recovery, or otherwise did not make Medicaid payments to providers related to 40 other cases. However, for the remaining 54 cases, the State agency did not suspend Medicaid payments as follows:

- For four cases, credible fraud investigations were ongoing as of May 2015, but the State agency did not suspend Medicaid payments totaling $13,827,876. As a result, the Federal share ($8,056,973) of these payments was not eligible for Federal reimbursement.

- For one case with a completed investigation that resulted in a civil settlement, the State agency did not provide documentation to support that it returned the Federal share of $236,544 to the Federal Government.

- For 49 cases for which the MFCU had completed its investigation and payment suspension was no longer proper, the State agency had not suspended Medicaid payments totaling $70,257,156 ($40,004,753 Federal share) when a fraud investigation was pending. As a result, the State agency put these Medicaid funds at risk.

The State agency repeatedly failed to suspend payments when there was a credible fraud allegation because it neither updated its policies and procedures to reflect the requirements of the Act nor adhered to the MOU that required the State agency to suspend payments 45 days from the referral date for cases it referred to the MFCU after March 5, 2013.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $8,056,973 to the Federal Government;

- refund $236,544 to the Federal Government related to one case for which the State agency did not provide documentation to support that it returned the Federal share to the Federal Government; and

- update its policies and procedures to ensure that it adheres to the MOU and complies with the requirements of the Act to suspend Medicaid payments to providers with credible fraud allegations, which could have prevented $70,257,156 ($40,004,753 Federal share) from being at risk.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency neither concurred with our first recommendation nor proposed any corrective actions. It stated that it had referred the providers to the MFCU because the State agency suspected that the providers' activities were suspicious and not because of credible fraud allegations. A State agency is allowed to consult with the MFCU prior to determining whether a credible allegation of fraud exists. Once this determination is made, however, the State agency must make a formal written referral to the MFCU. Based upon the evidence that the State agency provided, the only written referrals to the MFCU were these referrals upon a suspected criminal violation. Further, without any additional formal referral between the State agency and the MFCU, the MFCU (1) accepted and initiated investigations on these providers based on the State agency's referrals and (2) requested good cause exceptions pursuant to 42 CFR § 455.23. Thus, we believe these referrals constitute a credible allegation of fraud.

The State agency partially concurred with our second recommendation but did not concur with our calculation of the Federal share. Finally, the State agency did not concur with our third recommendation. The State agency said that these 49 cases did not rise to the level of credible fraud allegations and that the State agency would have had to eventually release these funds and been at risk for paying interest. The State agency did not provide documentation showing that there was good cause not to suspend payments or applied good-cause exceptions after the 45-day period allowed by the MOU for 49 cases when a fraud investigation was pending. Regulations require the State agency to suspend all Medicaid payments to a provider after it determines that there is a credible fraud allegation for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause not to suspend payments or to suspend payment only in part (42 CFR § 455.23(a), "Basis for suspension"). After considering the State agency's comments on our draft report, we maintain that all of our findings and recommendations are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Social Security Act (the Act) requires a State to suspend Medicaid payments to a provider when it receives a credible allegation that the provider has submitted fraudulent claims. Appendix A lists related Office of Inspector General reports on States' compliance with ACA requirements in reviewing cases of credible fraud allegations.

OBJECTIVE

Our objective was to determine whether the Florida Agency for Health Care Administration (State agency) suspended Medicaid payments to providers with credible fraud allegations in accordance with requirements of the Act.

BACKGROUND

Federal Requirements Related to Payment Suspensions for Providers with Credible Fraud Allegations

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Act). The Patient Protection and Affordable Care Act (ACA) amended portions of the Act. Under the amended Act, a State that does not suspend payments to a provider when an investigation of a credible fraud allegation is pending is not eligible for Federal reimbursement for payments to that provider unless the State shows that it has good cause not to suspend those payments.[1] A State may use such good-cause exceptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more effectively or efficiently protect Medicaid funds.[2]

Effective March 25, 2011, a State agency must suspend all Medicaid payments to a provider when it determines that there is a credible fraud allegation (42 CFR § 455.23(a)). Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend those payments (76 Fed. Reg. 5862, 5938 (Feb. 2, 2011)). The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or that legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)). A State agency must also refer credible fraud allegations to either a Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in States without a MFCU (42 CFR § 455.23(d)).

[1] The Act § 1903(i)(2)(C), and 42 CFR § 447.90(b).

[2] A list of good-cause exceptions is provided at 42 CFR § 455.23(e).

Florida's Medicaid Payment Safeguards

In Florida, the State agency is responsible for administration of the Medicaid program, which includes ensuring compliance with all Federal and State requirements related to operation of the program. Additionally, two governmental offices safeguard Medicaid payments. The first, within the State agency, is the Office of Medicaid Program Integrity. It audits and investigates providers suspected of overbilling or defrauding Florida's Medicaid program, recovers overpayments, issues administrative sanctions, and refers cases of suspected fraud to the MFCU.

The second office, the MFCU, is within the Florida Office of the Attorney General. It is responsible for investigating and prosecuting provider fraud, waste, abuse, and neglect in the Medicaid program. Effective March 5, 2013, the State agency and the MFCU entered into a memorandum of understanding (MOU) that requires the State agency to refer suspected cases of civil or criminal fraud to the MFCU. The MOU incorporates the requirements of the Act to suspend Medicaid payments to providers 45 days from the referral date for cases the State agency referred to the MFCU after March 5, 2013, unless it obtained a good-cause exception.

HOW WE CONDUCTED THIS REVIEW

Our review covered 95 cases related to provider fraud allegations[3] that the State agency formally referred to the MFCU between March 25, 2011, and December 31, 2013.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology, and Appendix C contains Federal and State requirements.

FINDINGS

The State agency did not always suspend Medicaid payments to providers that had credible fraud allegation cases in accordance with the Act. Of the 95 cases that we reviewed, the State agency applied a good-cause exception not to suspend payments for 1 case; and it either suspended, pursued recovery, or otherwise did not make Medicaid payments to providers related to 40 other cases.[4] However, for the remaining 54 cases, the State agency did not suspend Medicaid payments, as follows:

[3] Some providers bill under multiple Medicaid provider numbers and have several facilities. These types of providers are investigated under one MFCU case.

[4] For 5 of the 40 cases, the State agency suspended Medicaid payments after referral. For 29 cases, the State agency did not withhold payments, but it took other preventive actions such as terminating and barring providers under investigation from participating in the Medicaid program. The remaining six cases had completed investigations that resulted in a fraud conviction, plea agreement, or civil settlement for which the State agency pursued recovery of the restitution amounts ordered by the courts.

- For four cases, credible fraud investigations were ongoing as of May 2015, but the State agency did not suspend Medicaid payments totaling $13,827,876. As a result, the Federal share ($8,056,973) of these payments was not eligible for Federal reimbursement.

- For one case with a completed investigation that resulted in a civil settlement, the State agency did not provide documentation to support that it returned the Federal share of $236,544 to the Federal Government.

- For 49 cases for which the MFCU had completed its investigation and payment suspension was no longer proper, the State agency had not suspended Medicaid payments totaling $70,257,156 ($40,004,753 Federal share) when a fraud investigation was pending. As a result, the State agency put these Medicaid payments at risk.

The State agency repeatedly failed to suspend payments when there was a credible fraud allegation because it neither updated its policies and procedures to reflect the Act requirements nor adhered to the MOU that required the State agency to suspend payments 45 days from the referral date for cases it referred to the MFCU after March 5, 2013, unless it obtained a good-cause exception.

THE STATE AGENCY DID NOT ALWAYS SUSPEND PAYMENTS FOR CASES WITH CREDIBLE FRAUD ALLEGATIONS

Federal regulations, effective March 25, 2011, require a State agency to suspend all Medicaid payments to a provider when the State agency determines that there is a credible fraud allegation (42 CFR § 455.23(a)). This payment suspension is temporary and will not continue after either of the following: (1) authorities determine that there is insufficient evidence of provider fraud or (2) legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)).

Payments should not be made to any individual or entity when a credible fraud investigation is pending against the individual or entity, unless the State determines that there is good cause not to suspend such payments (the Act § 1903(i)(2)(C)). A State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud (42 CFR § 455.23(e)).

States must return the Federal share of overpayments due to fraud within 30 days of the final determination of the overpayment amount (42 CFR § 433.316(d)(2)).

Finally, no Federal financial participation (FFP) is available for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part, as required by section 455.23 (42 CFR § 447.90).

The MOU states that the State agency will promptly refer suspected cases of fraud to the MFCU and suspend Medicaid payments to the providers upon referral to the MFCU unless there is good cause not to suspend payment. Additionally, when the State agency refers a case to the MFCU,

before suspending payment the State agency will allow the MFCU a maximum of 45 days from the date of referral to request the good-cause exception.

The State agency did not suspend Medicaid payments for providers related to 60 cases when it determined that there were credible fraud allegations. The table below shows the number of cases with unsuspended Medicaid payments.

Table: Number of Cases With Ongoing and Completed Investigations

Calendar Year	No. of Cases With Ongoing Investigations	No. of Cases With Completed Investigations
2011[5]	1	27
2012	1	17
2013	2	12
Total	**4**	**56**

For 4 of the 60 cases, fraud investigations were ongoing as of May 2015, but the State agency did not suspend Medicaid payments to these providers under investigation. For these 4 cases, the State agency either did not apply a good-cause exception or applied good-cause exceptions after the 45-day period allowed by the MOU. As a result, payments totaling $13,827,876 ($8,056,973 Federal share) were not eligible for Federal reimbursement. For the remaining 56 cases, the MFCU had completed its investigations, but the State agency had not suspended Medicaid payments to the providers under investigation after the date of referral to the MFCU. For these cases, the State agency did not apply good-cause exceptions or applied good-cause exceptions after the 45-day period allowed by the MOU.[6]

Of these 56 cases, the State agency made payments totaling $70,257,156 ($40,004,753 Federal share) for 49 cases with completed investigations closed without a conviction. Examples of outcomes for the investigation of these cases included administrative referrals, lack of evidence, and referrals to another law enforcement agency. As a result, the State agency put Medicaid payments totaling $70,257,156 ($40,004,753 Federal share) at risk for these 49 cases.

Seven of the fifty-six cases with completed investigations resulted in a fraud conviction, plea agreement, or civil settlement. Restitution for these cases totaled $3,762,599[7] as follows:

[5] March 25, 2011, to December 31, 2011.

[6] For one case, before the effective date of the MOU, the State agency applied a good-cause exception not to suspend payment more than 1 year after the referral date.

[7] The State agency made Medicaid payments totaling $11,131,226 ($6,385,002 Federal share) to these providers after the date of referral to the MFCU. Restitution amounts are for Medicaid damages that occurred before or after the date of referral to the MFCU.

- For five cases, for which the courts ordered $1,390,651 in restitution, the State agency provided support that it had pursued collections in the amount of $912,180[8] and that it had returned $538,520 of the Federal share[9] to the Federal Government.

- For one case with completed investigations that resulted in a fraud conviction, the court ordered the defendant to pay $1,671,335 in restitution directly to CMS.

- For one case, for which the courts ordered $700,613 in restitution, which represents $407,273 in damages to Medicaid, the State agency did not provide documentation to support that it had returned $236,544 (Federal share) to the Federal Government.

The State agency improperly claimed Federal reimbursement and put Medicaid payments at risk because it neither adhered to the MOU nor followed the requirements of the Act regarding Medicaid payment suspensions. The State agency did not follow the requirements because it did not update its policies and procedures to reflect them.

RECOMMENDATIONS

We recommend that the State agency:

- refund $8,056,973 to the Federal Government;

- refund $236,544 to the Federal Government related to one case for which the State agency did not provide documentation to support that it returned the Federal share to the Federal Government; and

- update its policies and procedures to ensure that it adheres to the MOU and complies with the requirements of the Act to suspend Medicaid payments to providers with credible fraud allegations, which could have prevented $70,257,156 ($40,004,753 Federal share) from being at risk.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our first recommendation and, therefore, did not propose any corrective actions. It stated that it had referred the providers to the MFCU because the State agency suspected that the providers' activities were suspicious and not because of credible fraud allegations. In addition, the State agency said that the statutory requirement is a lower threshold than credible fraud allegations, and, therefore, many referrals to the MFCU are not appropriate for Federal payment restriction.

[8] The $912,180 represents the amount of the restitution that is attributable to Medicaid.

[9] For two cases, the State agency was in the process of returning the Federal share of the collections in the quarter ending on September 30, 2016. For one case, the restitution amount ordered was all Federal funds.

The State agency concurred with our second recommendation but did not concur with our calculation of the Federal share. It stated that the overpayment should be based on the FFP in effect during the period that ended on September 30, 2012, when the rate was 56.04 percent.

Finally, the State agency did not concur with our third recommendation. The State agency said that these 49 cases did not rise to the level of credible fraud allegations and that the State agency would have had to eventually release these funds to the providers and would have been at risk for paying interest on the withheld funds.

Parts of the State agency's written comments have been redacted because they contain sensitive and personally identifiable information. The State agency's written comments on the draft report are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After considering the State agency's comments on our draft report, we maintain that all of our findings and recommendations are valid. Specifically, regarding the first recommendation, we disagree with the State agency's position that the referrals to the MFCU of suspicious fraud did not constitute credible fraud allegations. A State agency is allowed to consult with the MFCU prior to determining whether a credible allegation of fraud exists. Once this determination is made, however, the State agency must make a formal written referral to the MFCU. Based upon the evidence that the State agency provided, the only written referrals to the MFCU were these referrals upon a suspected criminal violation. Further, without any additional formal referral between the State agency and the MFCU, the MFCU (1) accepted and initiated investigations on these providers based on the State agency's referrals and (2) requested good cause exceptions pursuant to 42 CFR § 455.23. Thus, we believe these referrals constitute a credible allegation of fraud.

Federal regulations, effective March 25, 2011, require a State agency to suspend all Medicaid payments to a provider when the State agency determines that there is a credible fraud allegation (42 CFR § 455.23(a)). Further, no FFP is available for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part, as required by section 455.23 (42 CFR § 447.90).

Regarding the calculation of the Federal share of the overpayment in the second recommendation, we disagree with the State agency. We calculated the overpayment based on the FFP rate in effect when the settlement agreement was executed because the damages covered several Federal fiscal years. The CMS *State Medicaid Manual* states, "When recoveries cannot be related to a specific period, compute the Federal share at the FMAP rate in effect at the time the refund was received" (chapter 2, § 2500.6 (B)).

Finally, with regard to the third recommendation, we disagree with the State agency's position that the 49 cases did not rise to the level of credible fraud allegations. It did not provide documentation showing that there was good cause not to suspend payments or applied good-cause exceptions after the 45-day period allowed by the MOU for 49 cases when a fraud

investigation was pending. Regulations require the State agency to suspend all Medicaid payments to a provider after it determines that there is a credible fraud allegation for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause not to suspend payments or to suspend payment only in part (42 CFR § 455.23(a), "Basis for suspension").

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
New Jersey Did Not Suspend Medicaid Payments to Some Providers With Credible Allegations of Fraud in Accordance With the Affordable Care Act	A-02-13-01046	5/25/16
Arkansas Complied With the Requirements of the Affordable Care Act in Its Review of Cases of Credible Allegations of Medicaid Fraud	A-06-15-00026	9/21/15
Washington State Did Not Suspend Medicaid Payments to Some Providers With Credible Allegations of Fraud in Accordance With the Affordable Care Act	A-09-14-02018	8/31/15
Ohio Did Not Always Comply With the Requirements of the Affordable Care Act in Its Review of Cases of Credible Allegations of Medicaid Fraud	A-05-14-00008	3/9/15
Minnesota Complied With the Requirements of the Affordable Care Act in Its Review of Cases of Credible Allegations of Medicaid Fraud	A-05-14-00009	11/21/14
Pennsylvania Complied With the Requirements of the Affordable Care Act in Its Review of Cases of Credible Allegations of Medicaid Fraud	A-03-14-00202	6/25/14

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 95 cases related to provider fraud allegations that the State agency determined to be credible and for which it made formal referrals to the MFCU between March 25, 2011, and December 31, 2013.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective.

We conducted our audit from September 2013 to May 2015 and performed our fieldwork at the State agency's office in Tallahassee, Florida.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes, regulations, and guidance;
- held discussions with State agency and MFCU officials;
- reviewed the State agency's policies and procedures to gain an understanding of its practices when reviewing credible fraud allegations;
- reviewed the MOU between the State agency and the MFCU;
- identified and reviewed 95 case files containing credible fraud allegations that the State agency processed and referred to the MFCU between March 25, 2011, and December 31, 2013;
- analyzed Medicaid payments made for the 95 case files to identify any payments that the State agency made after the referral of credible fraud allegations;
- determined the number of Medicaid payments that the State agency made for these 95 cases after it had referred them for credible fraud allegations when a good-cause exception was not in place;
- calculated the Federal share for the payments that we determined the State agency made to providers referred for credible fraud allegations; and
- discussed our findings with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Section 6402(h)(2) of the ACA amended section 1903(i)(2) of the Act

States are required to suspend payments if the State determines that there is a credible allegation of fraud concerning a provider's Medicaid claims. Section 1903(i)(2)(C) of the Act states that payments should not be made to any individual or entity when a credible fraud investigation is pending against the individual or entity, unless the State determines that there is good cause not to suspend such payments.

42 CFR § 433.316(d)(2)

When a State is unable to recover a debt that represents an overpayment (or any portion thereof) resulting from fraud within 1 year of discovery because no final determination of the amount of the overpayment has been made under an administrative or judicial process (as applicable), including as a result of a judgment begin under appeal, no adjustment shall be made in Federal payment to such State on account of such overpayment (or any portion thereof) until 30 days after the date on which a final judgment (including, if applicable, a final determination on appeal) is made.

42 CFR § 447.90

"FFP: Conditions related to pending investigations of credible allegations of fraud against the Medicaid program," states that no FFP is available for an item or service furnished by any individual or entity to whom a State has failed to suspend payments in whole or part, as required by section 455.23.

CMS amended its regulations (42 CFR § 455.23), effective March 25, 2011, to comply with the program integrity provision of the ACA.[10] The amended regulations include provisions relating to suspension of payments.

42 CFR § 455.23(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.

(2) The State Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.

(3) A provider may request, and must be granted, administrative review where State law so requires.

[10] "Final Rule," 76 Fed. Reg. 5862 (Feb. 2, 2011).

Section 455.23(c), "Duration of suspension"

(1) All suspension of payment actions under this section will be temporary and will not continue after either of the following:

(i) The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(ii) Legal proceedings related to the provider's alleged fraud are completed.

Section 455.23(d), "Referrals to the Medicaid fraud control unit"

(1) Whenever a State Medicaid agency investigation leads to the initiation of a payment suspension in whole or part, the State Medicaid agency must make a fraud referral to either of the following:

(i) To a Medicaid fraud control unit established and certified under part 1007 of the title;[11] or

(ii) In States with no certified MFCU, to an appropriate law enforcement agency.

Section 455.23(e), "Good cause not to suspend payments"

A State may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment 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, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

(4) Recipient access to items or services would be jeopardized by a payment suspension because of either of the following:

[11] Title 42 of the Code of Federal Regulations.

(i) An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

(ii) The individual or entity serves a large number of recipients within a HRSA [Health Resources and Services Administration]-designated medically underserved area.

(5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of paragraph (d)(3) of this section.

(6) The State determines that payment suspension is not in the best interests of the Medicaid program.

Informational Bulletin CPI-B 11-04

On March 25, 2011, the CMS Center for Program Integrity and the CMS Center for Medicaid, CHIP,[12] and Survey & Certification jointly issued an Informational Bulletin to provide additional guidance to States concerning the States' obligation to suspend payments when there is a credible allegation of fraud. Among its responses to Frequently Answered Questions, CMS clarified the definition for credible allegation of fraud as follows:

> Generally, a "credible allegation of fraud" may be an allegation that has been verified by a State and that has indicia of reliability that comes from any source. Further, CMS recognizes that different States may have different considerations in determining what may be a "credible allegation of fraud." Accordingly, CMS believes States should have the flexibility to determine what constitutes a "credible allegation of fraud" consistent with individual State law.

The Informational Bulletin also states that once a State verifies an allegation of fraud, the State is required to refer the suspected fraud to its MFCU or other law enforcement agency for further investigation.

STATE REQUIREMENTS

Memorandum of Understanding

The State agency and the MFCU executed an MOU on March 5, 2013.

Section V (A)(1) states:

> The [State a]gency shall promptly refer suspected cases of civil or criminal fraud or a violation and provide all relevant information for civil or criminal prosecution.

[12] Children's Health Insurance Program.

Section V (A)(4) states:

> The [State a]gency shall act to suspend Medicaid payments to the provider upon referral of credible allegations of fraud to the Medicaid Fraud Control Unit unless there is good cause not to suspend payment or to suspend payment only in part. The payment suspension should remain in effect for the duration of any resulting investigation and until completion of any legal proceedings arising there from, but need not exceed 18 months. If MFCU determines that a payment suspension would compromise or jeopardize their investigation, a written request (including electronic mail) must be submitted to the Chief, Bureau of Medicaid Program Integrity or their designee requesting that the payment suspension not be imposed.

Section V (A)(5) states:

> When the State agency refers a case involving a credible allegation of fraud to the MFCU, the [State a]gency will allow the MFCU 45 days from the date of referral to exercise the good-cause exemption in 42 CFR § 455.23(e) and (f).

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
INTERIM SECRETARY

November 14, 2016

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Dear Ms. Pilcher:

Thank you for your letter of October 13, 2016, requesting us to provide comments on the draft report number A-04-14-07046 entitled *Florida Did Not Suspend Medicaid Payments to Some Providers That Had Credible Fraud Allegation Cases in Accordance With the Affordable Care Act.* In accordance with your request, we have mailed a paper copy and sent you an electronic copy of our comments.

If you have any questions regarding our response, please contact Mary Beth Sheffield, Audit Director, at 850-412-3978.

Sincerely,

Justin M. Senior
Interim Secretary

JMS/szg
Enclosure: Response to Draft Report #A-04-14-07046
Attachment A

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Agency for Health Care Administration
Florida Did Not Suspend Medicaid Payments to Some Providers That Had Credible Fraud Allegation Cases in Accordance With the Affordable Care Act
Response to HHS/OIG Draft Report A-04-14-07046 dated October 2016

Findings

- For four cases, credible fraud investigations were ongoing as of May 2015, but the State agency did not suspend Medicaid payments totaling $13,827,876. As a result, the Federal share ($8,056,973) of these payments was not eligible for Federal reimbursement.

- For one case with a completed investigation that resulted in a civil settlement, the State agency did not provide documentation to support that it returned the Federal share of $236,544 to the Federal Government.

- For 49 cases for which the Medicaid Fraud Control Unit (MFCU) had completed its investigation and payment suspension was no longer proper, the State agency had not suspended Medicaid payments totaling $70,257,156 ($40,004,753 Federal share) when a fraud investigation was pending. As a result, the State agency put these Medicaid funds at risk.

Recommendation #1

Refund $8,056,973 to the Federal Government.

Agency Response and Corrective Action Plan

The four cases referenced [redacted] *were referrals to MFCU based on state law provisions which require the referral upon suspected criminal violation. As we have previously discussed, this statutory requirement is a lower threshold than credible allegations of fraud. Section 409.913(4), Florida Statutes (F.S.), provides: "Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General for investigation." Therefore, many referrals to MFCU are not ripe for federal (or other state) payment restriction.*

In each of the four referrals, there was no mention of fraud or credible allegation of fraud, and there is no reference to Federal or State Statute regarding the provider notice to MFCU. The referenced providers were referred in accordance with s. 409.913(4), F.S., and 42 CFR 455.21, in which the Agency sent notice to MFCU of the agency's review of the provider's activities as being suspicious. The requirement for the suspension of payments is not required until there is a determination of a credible allegation of fraud in accordance with 42 CFR 455.23.

While we have greatly improved Agency processes since these audits were initiated (and are more clear in our referral letters to MFCU as to whether we are relaying suspected fraud versus a credible allegation of fraud), we believe all of the cases referenced in the audit's findings fall outside the scope of the cited controls related to suspensions of Medicaid payments predicated upon credible allegations of fraud. Without the specific reference to the higher indicia of reliability required for a referral based upon 42 CFR 455.23, we assert the referrals associated with the audit's findings were made in accordance with s. 409.913(4), F.S., or were exempt from payment suspension requirements due to the provisions of 42 CFR 455.23(e).

We do not concur with the findings and therefore are not proposing corrective action. Our supporting information is contained within Attachment A of this response.

Recommendation #2

Refund $236,544 to the Federal Government related to one case for which the State agency did not provide documentation to support that it returned the Federal share to the Federal Government.

Agency Response and Corrective Action Plan

The Agency's Bureau of Financial Services indicates that it concurs that the Federal share related to the one case had not been returned via the CMS-64 Report. In receiving the documentation to establish the receivable from MFCU, information was coded incorrectly to "all state." However, Financial Services does not concur with the calculation of the Federal Share.

Financial Services calculated the overpayment to be returned based on the audit period ending September 30, 2012, when the FFP rate was 56.04%. A credit of $228,235.70 will be credited on the Q1 2017 Federal Report on or by January 30, 2017.

Recommendation #3

Update its policies and procedures to ensure that it adheres to the memorandum of understanding (MOU) and complies with the ACA requirements to suspend Medicaid payments to providers with credible fraud allegations, which could have prevented $70,257,156 ($40,004,753 Federal share) from being at risk.

Agency Response and Corrective Action Plan

AHCA does not concur that the 49 cases rose to the level of credible allegations of fraud. That notwithstanding, in all 49 cases MFCU completed their investigation with no findings of fraud. Had the monies been withheld, the Agency would have been responsible for ultimately releasing payment to the provider and would have been at risk for the payment of interest for the withheld funds pursuant to s. 409.913 (25)(a), F.S. The Agency does not concur that a payment restriction would have reduced the ultimate payment totaling $70,257,156 ($40,004,753 Federal share) to the providers.

The Provider Notices reviewed for the audited time period of March 1, 2011, through December 31, 2012, (as referenced in the engagement letter dated February 5, 2014), and later extended to calendar year 2013 identified providers referred to MFCU on a lower threshold than one of a credible allegation of fraud. As referrals were further reviewed and analyzed and a credible allegation of fraud was determined, the Agency took appropriate action in regard to the suspension/withhold of Medicaid payments. This appropriate action may have included the actual suspension/withhold of payments or the continued monitoring of the situation based on the MFCU's request of law enforcement's good cause exception as referenced in 42 CFR 455.23 (e)(1).

Notwithstanding our non-concurrence with the audit findings, the agency has improved its processes since the initiation of this audit. In late 2014, MPI conducted a functional assessment, which served as guidance for several organizational adjustments. Among the organizational changes that have occurred following the functional assessment has been the assignment of specific staff dedicated to conducting preliminary investigations and preparing referrals to MFCU. Similarly, MPI now has specific staff dedicated to issuing payment restrictions and conducting quality control reviews and reconciliation of all MFCU referrals and payment restrictions. MPI continues to assess and refine processes so that it may efficiently make referrals to MFCU. As a result, MPI has established practices for referrals to MFCU that clearly identifies and distinguishes informational only referrals as well as referrals under state law related to suspicions of criminal activity and referrals under federal law that involve credible allegations of fraud. Additionally, MPI and MFCU have established practices for MFCU to make referrals of credible allegations of fraud to MPI for consideration of payment restrictions.

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[redacted]
Provider status: Active

The following excerpt is from the Provider Notice which was sent from the Office of the Deputy Secretary for Medicaid, Fraud Prevention and Compliance Unit to MFCU on July 9, 2012;

> "The Office of the Deputy Secretary for Medicaid, Fraud Prevention and Compliance (FPCU) is forwarding information to you on the above-referenced provider; please consider this a Provider Notice. Preliminary review of this matter indicates that [redacted] has refused to furnish the necessary documents required for a satisfactory audit by Medicaid Audit Services."

The provider was not placed on Payment Withhold – MFCU requested good cause exception based on law enforcement request pursuant to 42 CFR 455.23 (e)(1) – September 30, 2014, and February 10, 2015.

Confirmation was received from MFCU on November 3, 2016, indicating their investigation is still active along with the request for law enforcement's good cause exception.

[redacted]
Provider status: Active

The following excerpt is from the Provider Notice which was staffed with MFCU on October 2, 2013;

> "The Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI), is forwarding information to you on the above-referenced provider for investigation by your office. Preliminary review of this matter indicates the provider continues to bill for the highest levels of Inpatient Hospital Care which may not be medically necessary."

This provider was not placed on Payment Withhold – MFCU requested good cause exception based on law enforcement request pursuant to 42 CFR 455.23 (e)(1), for the time period of January 15, 2014, and September 30, 2014.

This provider continued to not be on Payment Withhold prior to June 29, 2015, at the continued request of MFCU. At the May 5, 2015 Exit Conference meeting with HHS, this provider was discussed in detail regarding the law enforcement good cause exception request. [redacted] called and spoke with [redacted] regarding their request on May 27, 2015.

The provider was placed on Payment Withhold on July 30, 2015, [redacted]) and the Payment withhold is still in place. Journal notes in FACTS dated September 15, 2016, and October 18, 2016, Payment restriction remains appropriate.

Confirmation was received from MFCU on November 3, 2016, indicating their investigation is still active along with the request for law enforcement's good cause exception.

[redacted]

Provider status: Suspended Medicaid Authority on April 24, 2014
Terminated Medicaid Authority on March 16, 2016

The following excerpt is from the Provider Notice which was staffed with MFCU on March 22, 2011;

> "The Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI), is forwarding information to you on the above-referenced provider for investigation by your office. This case has been discussed with Investigator [redacted]. Investigator [redacted] is waiting on this referral. Preliminary review of this matter indicates that the above listed provider is connected with another Medicaid provider [redacted] and they are seeing the same recipient."

This provider was placed on Payment Withhold on April 5, 2013 ([redacted]) with the Payment Withhold being closed on June 18, 2015.

MFCU closing report dated October 28, 2013. Case Name: [redacted] consolidated under [redacted]. Defendant pled Nolo Contendre on May 6, 2015, restitution set at $66,539.32, with Federal amount of $27,893.28 transaction date of December 31, 2015, [redacted].

[redacted]

Provider status: Active

The following excerpt is from the Provider Notice which was staffed with MFCU on July 3, 2013;

> "The Office of Inspector General, Bureau of Medicaid Program Integrity (OIG/MPI), is forwarding information to you on the above-referenced provider for investigation by your office. Preliminary review of this matter indicates provider may be billing inappropriately due to escalated utilization of services throughout the past year."

The provider was not placed on Payment Withhold – MFCU requested good cause exception based on law enforcement request pursuant to 42 CFR 455.23 (e)(1), for the time period of January 15, 2014, and September 30, 2014.

This provider continued to not be on Payment Withhold prior to January 1, 2015, at the continued request of MFCU. At the May 5, 2015 Exit Conference meeting with HHS, this provider was discussed in detail regarding the law enforcement good cause exception request. [redacted] (Florida Assistant Attorney General, Medicaid Fraud Control Unit) called and spoke with [redacted] regarding their request on May 27, 2015.

The provider was placed on Payment Withhold on January 1, 2015 ([redacted]), with the Payment Withhold being closed on April 19, 2016.

Confirmation was received from MFCU on November 3, 2016, indicating their investigation is still active along with the request for law enforcement's good cause exception.

Code of Federal Regulation - CFR

§455.2 Definitions.
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 complaints.
(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.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

§455.21 Cooperation with State Medicaid fraud control units.
In a State with a Medicaid fraud control unit established and certified under subpart C of this part,
(a) The agency must—
(1) Refer all cases of suspected provider fraud to the unit;

§455.23 Suspension of payments in cases of fraud.
(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.

§455.23 (e) Good cause not to suspend payments.
(1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

Florida Statute (F.S.)

409.913 (1)(c), F.S. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception results in unauthorized benefit to herself or himself or another person. The term includes any act that constitutes fraud under applicable federal or state law.

409.913 (4), F.S. Any suspected criminal violation identified by the agency must be referred to the Medicaid Fraud Control Unit of the Office of the Attorney General for investigation. The agency and the

Attorney General shall enter into a memorandum of understanding, which must include, but need not be limited to, a protocol for regularly sharing information and coordinating casework. The protocol must establish a procedure for the referral by the agency of cases involving suspected Medicaid fraud to the Medicaid Fraud Control Unit for investigation, and the return to the agency of those cases where investigation determines that administrative action by the agency is appropriate. Offices of the Medicaid program integrity program and the Medicaid Fraud Control Unit of the Department of Legal Affairs, shall, to the extent possible, be collocated. The agency and the Department of Legal Affairs shall periodically conduct joint training and other joint activities designed to increase communication and coordination in recovering overpayments.

409.913 (25)(a), F.S. The agency shall withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud, willful misrepresentation, or abuse under the Medicaid program, or a crime committed while rendering goods or services to Medicaid recipients. If it is determined that fraud, willful misrepresentation, abuse, or a crime did not occur, the payments withheld must be paid to the provider within 14 days after such determination. Amounts not paid within 14 days accrue interest at the rate of 10 percent per year, beginning after the 14th day.

Centers for Medicare & Medicaid Services, Center for Program Integrity
Medicaid Payment Suspension Toolkit

Section 6402(h)(2) of the Affordable Care Act (ACA) amended section 1903(i)(2) of the Social Security Act to provide that Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services furnished by an individual or entity to whom a 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, unless the State determines that good cause exists not to suspend such payments. On February 2, 2011, CMS published a final rule implementing these new requirements with an effective date of March 25, 2011.

Frequently Asked Questions:
Q2. When communicating with its MFCU, how can a State mitigate potential confusion between making a formal referral that necessitates a payment suspension versus merely sharing intelligence about concerns regarding a provider(s)?

A2. States may wish to use the term "provider notice" to convey information of a strictly "FYI" nature to distinguish these discussions from formal referrals to a MFCU for purposes of payment suspension.