Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CHALLENGES APPEAR TO LIMIT STATES' USE OF MEDICAID PAYMENT SUSPENSIONS

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Inspector General

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Challenges Appear to Limit States' Use of Medicaid Payment Suspensions

Why OIG Did This Review

State Medicaid agencies (Medicaid agencies) are required to suspend payments for health care items and services when there is a credible allegation of fraud against the provider, unless "good cause" exists not to suspend payment. Using payment suspensions, when appropriate, is important to protect Medicaid funds: payment suspensions based on credible allegations of fraud can swiftly stop the flow of Medicaid dollars to providers defrauding Medicaid. A payment suspension can remain in place throughout a law enforcement investigation and potential prosecution of a health care fraud case.

How OIG Did This Review

We collected self-reported individual case data for credible allegations of fraud, payment suspensions, and good cause exceptions during Federal fiscal year (FY) 2014 from Medicaid agencies. We also surveyed both Medicaid agencies and Medicaid Fraud Control Units regarding challenges and benefits of payment suspensions that are based on a credible allegation of fraud.

What OIG Found

Most Medicaid agencies (41 of 56) reported imposing 10 or fewer payment suspensions during FY 2014. Medicaid agencies reported significant challenges associated with imposing payment suspensions. These include:

- demonstrating sufficient evidence to support payment suspensions when providers appealed,
- not jeopardizing law enforcement investigations when providers appealed, and
- sustaining payment suspensions through lengthy fraud investigations, without unintentionally driving innocent providers out of business.

Key Takeaway

Significant challenges experienced by Medicaid agencies appear to have prevented the Federal payment suspension provisions from achieving their full potential to protect Medicaid funds.

Medicaid agencies often applied "good cause exceptions," during which payments are not suspended, while law enforcement investigated a credible allegation of fraud against a provider. Additionally, Medicaid agencies reported taking actions that improved their processes for payment suspensions, including how they handle fraud allegations and collaborate with law enforcement.

What OIG Recommends and Agency Response

We recommend that the Centers for Medicare & Medicaid Services provide additional technical assistance to help Medicaid agencies fully utilize Medicaid payment suspensions as a program integrity tool. CMS concurred with our recommendation.

Full report can be found at http://oig.hhs.gov/oei/reports/oei-09-14-00020.asp

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OBJECTIVE

To examine State Medicaid agencies' (Medicaid agencies') and Medicaid Fraud Control Units' (MFCUs') experiences with payment suspensions when there is a credible allegation of fraud against a health care provider.

BACKGROUND

A payment suspension is a program integrity tool for States to stop, as early as possible, Medicaid payments when there is a credible allegation of fraud against a provider.[1] When a Medicaid agency determines that a credible allegation of fraud exists, the agency must suspend all or part of the Medicaid payments to the provider while law enforcement investigates and potentially prosecutes the provider, unless "good cause" exists not to suspend payment.

Credible Allegation of Fraud

The Centers for Medicare & Medicaid Services (CMS) generally describes allegations as 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."[2] To accommodate variations among States, the regulations allow Medicaid agencies "flexibility to determine what constitutes a 'credible allegation of fraud' consistent with individual State law."[3] Before determining that an allegation of fraud is credible, a Medicaid agency must conduct a preliminary investigation and may informally consult with MFCUs or other State agencies or law enforcement.[4, 5] Allegations of fraud may come from a variety of sources, such as through a Medicaid agency's analysis of provider billing data, fraud hotline tips, and law enforcement agencies.[6]

When a Medicaid agency determines that a credible allegation of fraud exists, Federal regulations require the agency to either impose a payment

[1] In this report, we use the term "States" to refer collectively to the 50 States, the District of Columbia, and the U.S. Territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

[2] 42 CFR § 455.2.

[3] 76 Fed. Reg. 5935 (February 2, 2011).

[4] 42 CFR § 455.14.

[5] CMS, *Medicaid Payment Suspension Toolkit*. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf on May 11, 2017.

[6] 42 CFR § 455.2.

suspension or apply an exception indicating that "good cause" exists not to suspend payments.[7, 8] Additionally, by no later than the next business day, the Medicaid agency must refer the case for investigation to the State's MFCU (or other appropriate law enforcement agency if the State does not have a MFCU).[9, 10] The MFCU can then accept the referral and begin an investigation, or decline to investigate the provider. If the MFCU declines, then the Medicaid agency must either discontinue the payment suspension or find another law enforcement agency to investigate.[11] See Exhibit 1 on the next page for a general overview of the process.

Medicaid Payment Suspension

When Medicaid agencies impose a payment suspension, Federal regulations specify that they must notify providers of the payment suspension, the temporary nature of the payment suspension, and an appeals process.

Notice of payment suspension to provider. Generally, within 5 days of imposing the payment suspension, regulations require Medicaid agencies to send a notice of the payment suspension to the provider. The notice can be delayed up to 90 days if the MFCU provides a written request to delay notification. The notice must include (1) the legal basis for the payment suspension, (2) the general nature of the fraud allegation (but not specific information concerning an ongoing investigation), and (3) the applicable State administrative appeals process and corresponding citations to State law, among others.[12]

Length of payment suspensions. Federal implementing regulations describe payment suspensions as temporary.[13] According to these regulations, the payment suspensions will not continue after authorities determine that there is insufficient evidence of provider fraud or legal proceedings related to alleged fraud are complete.[14] Federal regulations do not further define the length of payment suspensions, other than that they are "temporary."

[7] P.L. No. 111-148, § 6402(h) codified at Social Security Act (SSA) § 1903(i)(2)(C). Federal regulations were amended effective March 25, 2011. 42 CFR § 455.23.

[8] A Medicaid agency can apply a good cause exception and then later impose a payment suspension (or vice versa) for the same credible allegation of fraud.

[9] 42 CFR § 455.23(d).

[10] MFCUs operate in 49 States and the District of Columbia, except North Dakota and all of the U.S. territories.

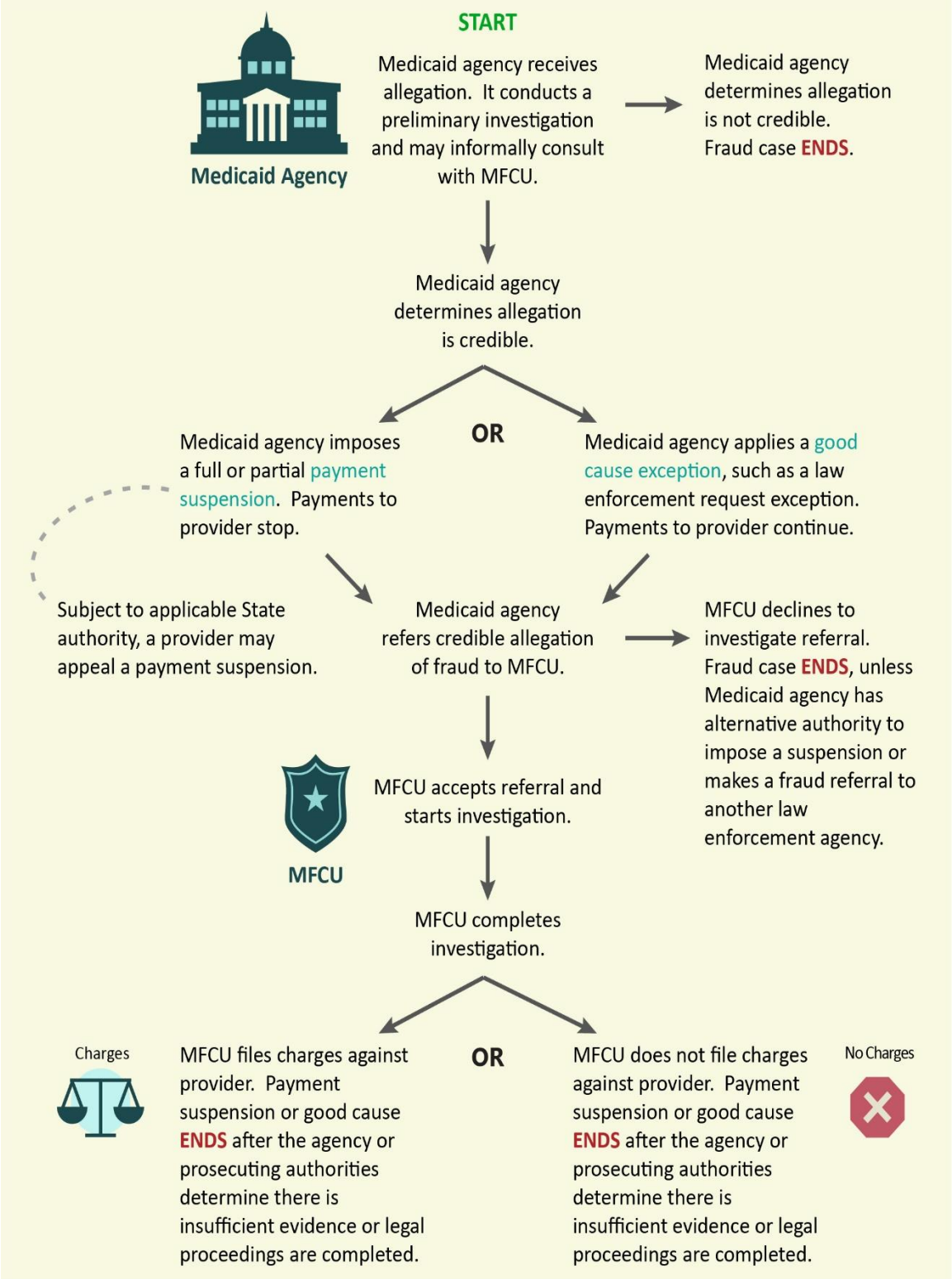
[11] 42 CFR § 455.23(d). Some States may have also State-specific authority to impose a payment suspension outside of the Federal authority that is the subject of this report.

[12] 42 CFR § 455.23(b).

[13] SSA § 1903(i)(2)(C); 42 CFR § 455.23(c). 76 Fed. Reg. 5933 (February 2, 2011).

[14] 42 CFR § 455.23(c).

Exhibit 1. General Overview of States' Processes For Credible Allegations of Fraud
This exhibit illustrates a general overview of the payment suspension process; it does not represent all potential outcomes or State-specific processes.



Provider appeals of payment suspensions. If an individual State's law provides for an administrative appeals process, the provider may request, and must be granted, a review of the payment suspension consistent with the State's appeals process.[15] In general, when a provider appeals a payment suspension, a State administrative court holds a hearing and may either uphold or overturn the payment suspension.[16]

Good Cause Exception

On a case-by-case basis, a Medicaid agency may determine that there is good cause not to suspend payments when there is a credible allegation of fraud against a provider, and instead apply a "good cause exception."[17] For example, law enforcement officials may request that the Medicaid agency not impose a payment suspension to avoid alerting the provider, which could jeopardize a law enforcement investigation.[18] When a Medicaid agency applies a good cause exception, providers continue to be paid (i.e., payments are not suspended) and providers are not notified that they are under investigation.

Law Enforcement Investigations

Law enforcement investigations of credible allegations of fraud continue whether a Medicaid agency imposes a payment suspension or applies a good cause exception. On a quarterly basis, the Medicaid agency must request certification from the MFCU or other applicable law enforcement agency of the continuing investigation.[19]

The MFCU or other applicable law enforcement agency may resolve the investigation in several ways. The investigation continues until (1) appropriate legal action is initiated, (2) the case is closed or dropped because of insufficient evidence to support the allegation of fraud, or (3) the matter is resolved between the Medicaid agency and the provider.[20] Federal regulations do not impose a time limit on law enforcement investigations.

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[15] 42 CFR § 455.23.

[16] For the purposes of this report, we use the term "State administrative court" to refer to the administrative law judges, administrative hearing officers, hearing commissions, and other State court authorities that may judge the legality of payment suspensions in a given State.

[17] SSA § 1903(i)(2)(C); 42 CFR § 455.23(e)-(f).

[18] 42 CFR § 455.23(e)-(f).

[19] 42 CFR § 455.23(d)(3)(ii); CMS, *Medicaid Payment Suspension Toolkit*. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf on May 11, 2017.

[20] 42 CFR § 455.16(a)-(c).

CMS Oversight of Medicaid Payment Suspensions

CMS conducts oversight of Medicaid agencies' use of payment suspensions in several ways. CMS collects selected data related to payment suspensions, provides technical assistance, and issues guidance. Annually, CMS collects data such as the number of payment suspensions, good cause exceptions, and referrals to law enforcement from each Medicaid agency.[21] CMS also provides technical assistance to Medicaid agencies upon request. Further, in March 2011 and October 2014, CMS issued guidance to States about the Federal payment suspension regulations. In 2011, CMS published an informational bulletin addressing questions about implementation of the Federal payment suspension regulations, such as potential sources of credible allegations of fraud.[22] In 2014, CMS published a toolkit that includes additional information on the payment suspension process, such as whether a State may rely on the MFCU to determine if an allegation of fraud is credible. It also outlines factors and steps that Medicaid agencies may consider if a payment suspension creates access to care issues for beneficiaries.[23]

Office of Inspector General Related Work

The Office of Inspector General (OIG) initiated a series of reviews to determine whether Medicaid agencies imposed Medicaid payment suspensions when there is a credible allegation of fraud against a provider in accordance with the Federal regulations. OIG found that the Medicaid agencies in Arkansas, Pennsylvania, Minnesota, and Louisiana complied with the Federal regulations and properly suspended payments when there was a credible allegation of fraud against a provider.[24] However, OIG found that the Medicaid agencies in Washington, Ohio, New Jersey, and Florida did not fully comply with the Federal payment suspension regulations and OIG recommended these States address the identified areas of noncompliance.[25]

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[21] 42 CFR § 455.23(g)(3), 76 Fed. Reg. 5939 (February 2, 2011).

[22] CMS, CPI-B 11-04, *CPI-CMCS Informational Bulletin*. Accessed at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/payment-suspensions-info-bulletin-3-25-2011.pdf on May 11, 2017.

[23] CMS, *Medicaid Payment Suspension Toolkit*. Accessed at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf on May 11, 2017.

[24] OIG, multiple State-specific reports during 2014–2016. Accessed at www.oig.hhs.gov. Reference numbers: A-06-15-00026 (Arkansas), A-03-14-00202 (Pennsylvania), A-05-14-00009 (Minnesota), (A-06-16-00010) (Louisiana).

[25] OIG, multiple State-specific reports during 2014–2016. Accessed at www.oig.hhs.gov. Reference numbers: A-09-14-02018 (Washington), A-05-14-00008 (Ohio), A-02-13-01046 (New Jersey), and A-04-14-07046 (Florida).

METHODOLOGY

We collected and examined case data for allegations of fraud that Medicaid agencies determined to be credible during Federal fiscal year (FY) 2014 (October 1, 2013–September 30, 2014). We surveyed both Medicaid agencies and MFCUs (collectively referred to as respondents). We collected and examined challenges and benefits that the respondents described as relating to the various steps in the payment suspension process, such as determining whether allegations of fraud were credible, imposing payment suspensions, and applying good cause exceptions.

Data Collection and Analysis

Credible allegation of fraud case data. We requested that Medicaid agencies report certain data elements to OIG associated with credible allegations of fraud during FY 2014. We sent our contacts an Excel spreadsheet to record the data elements for each credible allegation of fraud case, such as whether the Medicaid agency imposed a payment suspension, applied a good cause exception, and made a referral to law enforcement. We compiled and calculated aggregate numbers for the data elements across all Medicaid agencies, including the number of credible allegations of fraud, payment suspensions, and good cause exceptions. We received responses from all 56 Medicaid agencies.

Survey data. We surveyed all 56 Medicaid agencies and all 50 MFCUs to learn about their experiences related to the payment suspension process from March 2011 until the completion of OIG's data collection in October 2015. We sent the Medicaid agency survey to the individual that each Medicaid agency identified as its primary contact for this review. We sent the MFCU survey to the MFCU directors. We received responses from all 106 respondents during August–October 2015. We synthesized the survey data and conducted qualitative analysis to identify the most significant challenges and benefits identified by respondents, based on their experiences in using the payment suspension process in their States.

Limitations

The survey data that Medicaid agency and MFCU respondents submitted and the case data Medicaid agencies submitted was self-reported. We generally did not verify the accuracy or completeness of the self-reported data submitted by respondents.

Standards

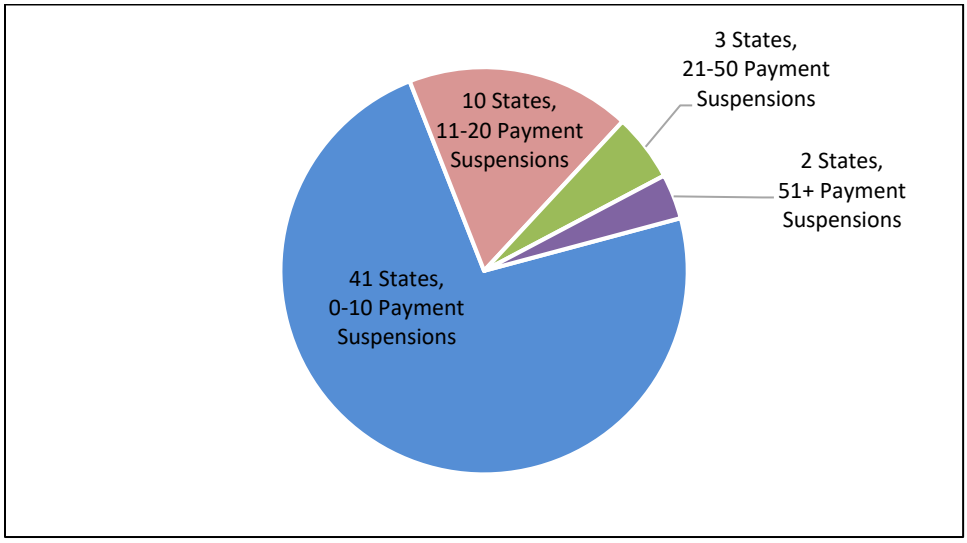
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Most Medicaid agencies imposed few payment suspensions based on credible allegations of fraud, reporting 10 or fewer suspensions in FY 2014

Despite the potential of payment suspensions to help prevent taxpayer-funded Medicaid dollars from being paid when there is a credible allegation of fraud against a provider, each of 41 Medicaid agencies reported imposing 10 or fewer payment suspensions in FY 2014. Furthermore, only 2 Medicaid agencies reported imposing over 50 payment suspensions each. Exhibit 2 displays the distribution of payment suspensions across States for FY 2014. See Appendix A for State-level Medicaid data on payment suspensions, credible allegations of fraud, and good cause exceptions in FY 2014.

Exhibit 2. States' Medicaid Payment Suspensions in FY 2014



Source: OIG analysis of payment suspension data from 56 Medicaid agencies, 2017.

Thirty-one Medicaid agencies reported 10 or fewer credible allegations of fraud in FY 2014 (see Appendix A). Because determining an allegation to be credible is a prerequisite for imposing a payment suspension, Medicaid agencies in these States consequently imposed few payment suspensions. Further, credible allegations of fraud identified by Medicaid agencies are an important source of fraud referrals for MFCUs, OIG, and other law enforcement agencies responsible for investigating and prosecuting providers who defraud Medicaid.

For allegations of fraud that Medicaid agencies determined to be credible, many agencies reported using more good cause exceptions than payment suspensions. Of the combined 1,308 credible allegations of fraud in FY 2014 across all States, Medicaid agencies reported:

- 631 good cause exceptions (48 percent) and
- 360 payment suspensions (28 percent).

For 124 (9 percent) credible allegations of fraud, Medicaid agencies reported using both payment suspensions and good cause exceptions. For the remaining 193 (15 percent) credible allegations of fraud, Medicaid agencies reported that they did not use any good cause exceptions or payment suspensions.[26]

Medicaid agencies experienced significant challenges with imposing payment suspensions

Both Medicaid agency and MFCU respondents described a variety of challenges associated with imposing payment suspensions based on a credible allegation of fraud.

Challenge: Demonstrating a sufficient level of evidence to support payment suspensions when providers appealed

Respondents indicated that State administrative courts (courts) sometimes expected the Medicaid agency to present a higher level of evidence of provider fraud, rather than basing its determination on whether the allegation of fraud was simply "credible," as defined in Federal regulations. When Medicaid agencies used the credible allegation of fraud threshold and providers appealed the payment suspensions, courts sometimes ruled in favor of the providers by overturning the payment suspension, citing a lack of evidence to support the payment suspension.

Challenge: Not jeopardizing ongoing law enforcement investigations when providers appealed

Medicaid agencies explained that when a provider appeals, it is sometimes necessary to present a level of evidence that can risk compromising the fraud case. Imposing a payment suspension alerts a provider to the investigation, but if a provider appeals, Medicaid agencies could face additional concerns. Through the appeals' discovery process, providers can receive copies of investigative reports and other evidence gathered by

[26] Medicaid agencies may not have imposed a payment suspension or applied a good cause exception because they continued to investigate an open credible allegation of fraud case, they determined that there was insufficient evidence of fraud (and therefore, did not further pursue the allegation), or the MFCU or other law enforcement entity did not accept the referral to investigate the allegation.

MFCUs. Access to details of the investigation can give fraudulent providers an opportunity to alter or remove incriminatory evidence before the MFCU can secure it.

Challenge: Sustaining payment suspensions through lengthy fraud investigations without driving innocent providers out of business

Medicaid agencies pointed to a contradiction between the description of payment suspensions as "temporary" and the reality that health care law enforcement investigations are often lengthy. Federal regulations specify that payment suspensions are temporary enforcement actions that Medicaid agencies are to impose while MFCUs or other law enforcement entities investigate the fraud allegations. However, respondents pointed out that law enforcement investigations often take many months, and sometimes years. Investigations can involve multiple steps, such as interviewing witnesses, implementing search warrants, filing subpoenas, and coordinating with other law enforcement agencies. In light of this, respondents reported that courts sometimes overturned payment suspensions, ruling that the suspensions were in place too long to reasonably be considered "temporary."

Respondents also described that lengthy payment suspensions can result in providers going out of business because of a loss of revenue. This outcome would be appropriate or desirable in a case when the evidence demonstrates that the provider was actually defrauding the program. However, this outcome is particularly harmful to providers when their payments are suspended but law enforcement ultimately decides not to prosecute.

Medicaid agencies often applied good cause exceptions

Medicaid agencies more frequently applied good cause exceptions than imposed payment suspensions in FY 2014. Given the challenges associated with payment suspensions based on credible allegations of fraud, respondents explained that good cause exceptions enable MFCUs to build a sufficient level of evidence to support payment suspensions, prevent jeopardizing law enforcement investigations, and do not limit patient access to services provided by health care providers.

Medicaid agencies often applied a good cause exception at the request of law enforcement (61 percent of exceptions in FY 2014) to avoid alerting providers that investigations are underway. Imposing a payment suspension and sending the required notice to providers, in contrast, would alert providers to the investigation. "Law enforcement request"

exceptions allow time for investigators to gather more evidence to support subsequent payment suspensions or to bring criminal charges against providers. Once fraudulent providers are aware of investigations, respondents explained that those providers may alter or destroy records, expatriate or hide funds, or close their practices before law enforcement can execute search warrants and seize evidence.

Medicaid agencies also explained that they applied good cause exceptions when a payment suspension would limit beneficiaries' access to health care services. Imposing a payment suspension can risk beneficiaries' access to services because providers may stop offering services if their business is severely hurt by the revenue loss from the payment suspension. For example, Medicaid agencies might apply a good cause exception on a provider practicing in a rural area where the provider is the sole source of essential specialized services in that area. Medicaid agencies can use two types of good cause exceptions in situations like these, either the "not in the best interest of the State" exception (20 percent of exceptions in FY 2014) or the "access to care" exception (1 percent of exceptions in FY 2014).[27]

Medicaid agencies improved their processes for implementing payment suspensions, including how they handle credible allegations of fraud and collaborate with law enforcement

Despite the challenges associated with payment suspensions, Medicaid agencies indicated that during our review period they took steps to improve their internal processes for addressing credible allegations of fraud. Respondents explained that their agencies developed more formal structures for responding to credible allegations of fraud and suspending payments or applying good cause exceptions. Specifically, some Medicaid agencies improved particular aspects of State processes, such as the timing of various steps in the process, how credible allegations are to be referred to the MFCU, and under what circumstances to delay payment suspensions or end good cause exceptions if the investigations did not reveal actual fraud. Medicaid agencies indicated that they more clearly understand how and when to suspend payments, and the specific roles of the Medicaid agency and MFCU in the payment suspensions process.

[27] The other good cause exceptions used in FY 2014 include other remedies (9 percent); law enforcement declines to certify (5 percent); provider supplied evidence (2 percent); and multiple exceptions (3 percent). Percentages of good cause exception types do not sum to 100 percent because of rounding.

Medicaid agencies and MFCUs engaged in greater collaboration with each other. Respondents described more frequent and substantial communication, such as informal and regularly scheduled meetings to discuss providers suspected of fraud. Medicaid agencies and MFCUs worked together to determine whether allegations were credible, decide whether (and when) to suspend a payment, and prepare for provider appeal hearings. For example, one Medicaid agency described its coordination with the MFCU to impose a payment suspension on the same day as the MFCU executed a search warrant at the provider's facility. This level of collaboration ensured that the provider was not alerted in advance of the search warrant.

CONCLUSION AND RECOMMENDATION

Federal payment suspension regulations afford State Medicaid agencies and their law enforcement partners flexibility in determining how to deal with credible allegations of fraud. Required by Federal regulations to either impose a payment suspension or apply a good cause exception, Medicaid agencies more frequently opted for good cause exceptions. While this choice may allow States to avoid the challenges they experience with imposing payment suspensions, good cause exceptions permit payments to continue to providers under investigation for fraud. Ideally, Medicaid agencies would find ways to overcome the stated challenges that still allow them to fully utilize payment suspensions to stop swiftly the flow of Medicaid dollars to providers defrauding Medicaid.

CMS has issued regulations and guidance for implementing payment suspensions, including the 2014 toolkit to help Medicaid agencies make judicious, case-by-case decisions about credible allegations of fraud. To maximize protection of the Medicaid program, we recommend that CMS:

Provide additional technical assistance to help Medicaid agencies fully utilize Medicaid payment suspensions as a program integrity tool

Because of the various experiences and challenges that States encountered imposing Medicaid payment suspensions, CMS should provide additional technical assistance to Medicaid agencies. To accomplish this, CMS should examine the annual data submitted by Medicaid agencies and identify those agencies that have a low number of payment suspensions based on credible allegations of fraud. CMS should provide additional technical assistance to these Medicaid agencies to help them fully utilize payment suspensions as a program integrity tool. For example, CMS may advise Medicaid agencies to work with their law enforcement partners to identify the earliest time at which a payment suspension would no longer jeopardize the fraud investigation, thereby preventing further waste of Medicaid funds.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with OIG's recommendation. CMS stated that it will continue to provide technical assistance to Medicaid agencies on the use of the payment suspension tool and will follow up when appropriate to determine if additional technical assistance is needed. In providing additional technical assistance in response to the findings of this report, CMS should prioritize the delivery of technical assistance to those State agencies that have a low number of payment suspensions based on credible allegations of fraud.

For the full text of CMS's comments, see Appendix B.

APPENDIX A: STATE MEDICAID AGENCY FY 2014 DATA*

Medicaid Agency**	Credible Allegations of Fraud	Payment Suspensions	Good Cause Exceptions
Alabama	7	6	2
Alaska	20	20	0
Arizona	5	5	0
Arkansas	40	9	37
American Samoa	0	0	0
California	45	22	21
Colorado	4	1	4
Connecticut	15	6	5
Delaware	0	0	0
D.C.	9	1	0
Florida	5	4	5
Georgia	17	1	17
Guam	0	0	0
Hawaii	7	1	5
Idaho	7	2	4
Illinois	16	5	8
Indiana	2	2	0
Iowa	145	20	101
Kansas	4	3	2
Kentucky	27	3	22
Louisiana	128	5	122
Maine	2	0	2
Maryland	17	12	6
Massachusetts	21	2	17
Michigan	39	12	8
Minnesota	60	17	0

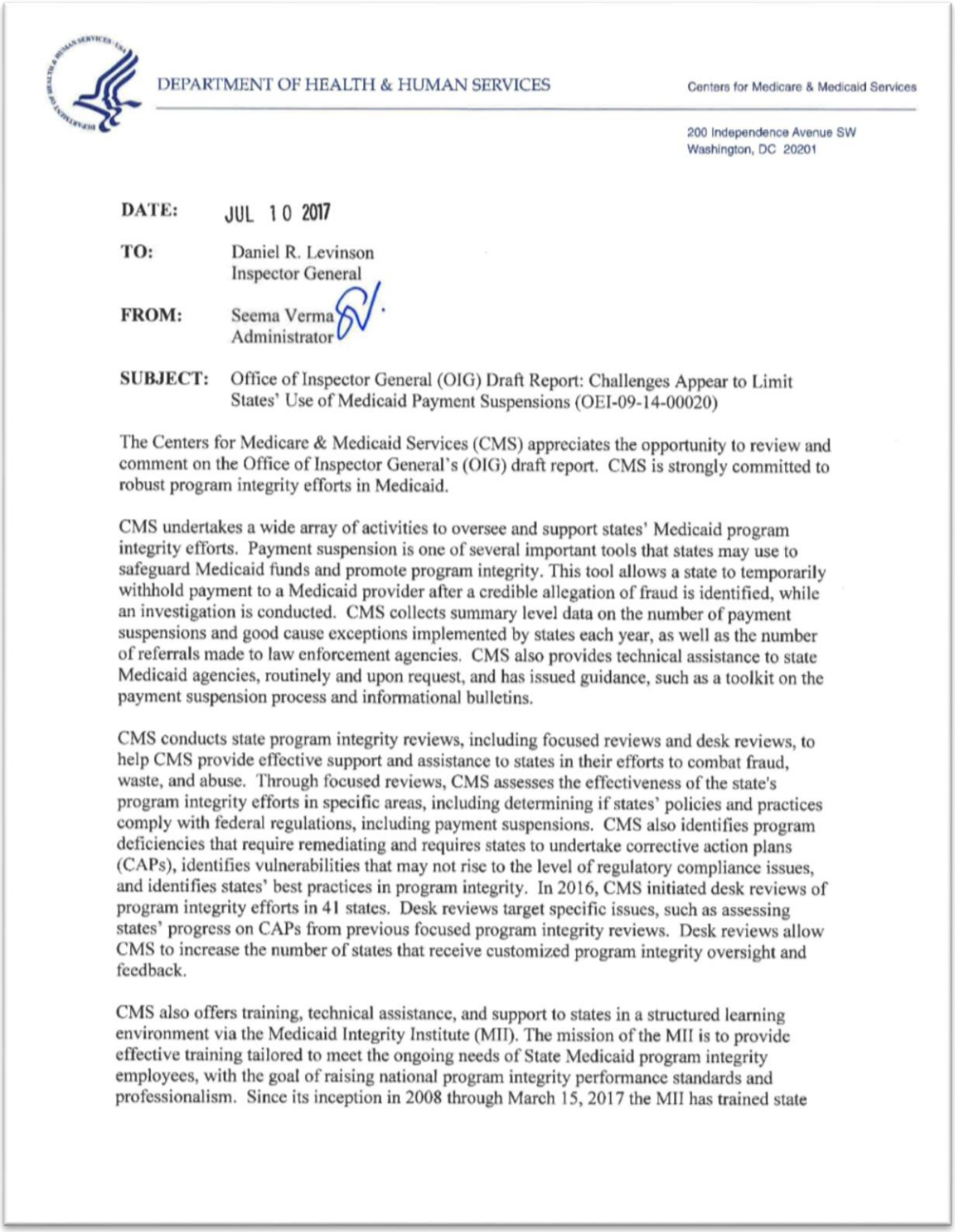
Medicaid Agency**	Credible Allegations of Fraud	Payment Suspensions	Good Cause Exceptions
Mississippi	9	2	8
Missouri	87	28	59
Montana	3	1	1
Nebraska	21	3	21
Nevada	7	0	0
New Hampshire	1	1	0
New Jersey	13	11	2
New Mexico	6	6	3
New York	135	16	129
North Carolina	57	11	42
North Dakota	6	6	0
N. Mariana Islands	0	0	0
Ohio	32	30	32
Oklahoma	2	0	2
Oregon	6	6	0
Pennsylvania	2	2	2
Puerto Rico	19	8	0
Rhode Island	7	4	2
South Carolina	9	5	0
South Dakota	0	0	0
Tennessee	7	7	0
Texas	70	70	30
U.S. Virgin Islands	0	0	0
Utah	12	12	0
Vermont	25	5	19
Virginia	5	5	0
Washington	104	69	13

Medicaid Agency*	Credible Allegations of Fraud	Payment Suspensions	Good Cause Exceptions
West Virginia	2	2	0
Wisconsin	12	12	0
Wyoming	7	3	2
TOTAL	**1308**	**484*** **	**755*** **

* The case data that Medicaid agencies submitted was self-reported. Generally, OIG did not verify the accuracy or completeness of the self-reported case data submitted by Medicaid agencies.
** American Samoa, Delaware, Guam, the Northern Mariana Islands, South Dakota, and the U.S. Virgin Islands did not have any Medicaid payment suspension data to submit.
***The total number of payment suspensions and good cause exceptions include 124 cases with both payment suspensions and good cause exceptions.
Source: OIG analysis of credible allegation of fraud data from 56 Medicaid agencies, 2017.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUL 10 2017

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Challenges Appear to Limit States' Use of Medicaid Payment Suspensions (OEI-09-14-00020)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to robust program integrity efforts in Medicaid.

CMS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. Payment suspension is one of several important tools that states may use to safeguard Medicaid funds and promote program integrity. This tool allows a state to temporarily withhold payment to a Medicaid provider after a credible allegation of fraud is identified, while an investigation is conducted. CMS collects summary level data on the number of payment suspensions and good cause exceptions implemented by states each year, as well as the number of referrals made to law enforcement agencies. CMS also provides technical assistance to state Medicaid agencies, routinely and upon request, and has issued guidance, such as a toolkit on the payment suspension process and informational bulletins.

CMS conducts state program integrity reviews, including focused reviews and desk reviews, to help CMS provide effective support and assistance to states in their efforts to combat fraud, waste, and abuse. Through focused reviews, CMS assesses the effectiveness of the state's program integrity efforts in specific areas, including determining if states' policies and practices comply with federal regulations, including payment suspensions. CMS also identifies program deficiencies that require remediating and requires states to undertake corrective action plans (CAPs), identifies vulnerabilities that may not rise to the level of regulatory compliance issues, and identifies states' best practices in program integrity. In 2016, CMS initiated desk reviews of program integrity efforts in 41 states. Desk reviews target specific issues, such as assessing states' progress on CAPs from previous focused program integrity reviews. Desk reviews allow CMS to increase the number of states that receive customized program integrity oversight and feedback.

CMS also offers training, technical assistance, and support to states in a structured learning environment via the Medicaid Integrity Institute (MII). The mission of the MII is to provide effective training tailored to meet the ongoing needs of State Medicaid program integrity employees, with the goal of raising national program integrity performance standards and professionalism. Since its inception in 2008 through March 15, 2017 the MII has trained state

employees from all 50 States, the District of Columbia, and Puerto Rico through more than 7,400 enrollments in 160 courses and 11 workgroups.

In March 2016, CMS published the Medicaid Provider Enrollment Compendium (MPEC) to help states in implementing various provider enrollment requirements including provider site visit and fingerprint-based criminal background check requirements. The MPEC, which was updated recently in January 2017, serves as a single resource for states about Medicaid requirements related to disclosure of information by providers and fiscal agents, as well as provider screening and enrollment. In addition, CMS conducts state site visits to review and advise on states' provider screening and enrollment implementation challenges. To date, CMS has completed 21 state site visits with additional site visits planned in 2017.

OIG's recommendation and CMS' response is below.

OIG Recommendation

Provide additional technical assistance to help Medicaid agencies take full advantage of payment suspensions.

CMS Response

CMS concurs with OIG's recommendation. CMS will continue to provide technical assistance to state Medicaid agencies on the use of the payment suspension tool and will follow up with Medicaid agencies when appropriate to determine if additional technical assistance is needed.

ACKNOWLEDGMENTS

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This report was prepared under the direction of Blaine Collins, Regional Inspector General for the Office of Evaluation and Inspections in the San Francisco regional office, and Abby Amoroso and Michael Henry, Deputy Regional Inspectors General.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and individuals. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.