Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARKANSAS COMPLIED WITH THE REQUIREMENTS OF THE AFFORDABLE CARE ACT IN ITS REVIEW OF CASES OF CREDIBLE ALLEGATIONS OF MEDICAID FRAUD

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INTRODUCTION

Arkansas complied with the requirements of the Affordable Care Act in its review of cases of credible allegations of Medicaid fraud.

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (Affordable Care Act)[1] requires States to suspend Medicaid payments to providers when they receive a credible allegation that the providers have submitted fraudulent claims. This review of Arkansas' adjudication of such allegations is part of the Office of Inspector General's oversight of the Affordable Care Act.

OBJECTIVE

Our objective was to determine whether Arkansas' Department of Human Services (State agency) complied with the requirements of the Affordable Care Act when it received a credible allegation of fraud by its Medicaid providers.

BACKGROUND

Requirements for Cases With Credible Allegations of Fraud

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Affordable Care Act amended the Act to strengthen payment safeguards over potentially fraudulent claims. Under the Act, States that do not suspend payments to providers when investigation of a credible allegation of fraud is pending are not eligible for Federal matching funds for payments to those providers unless the State shows that it has good cause not to suspend such payment.[2] A State may find that good cause not to suspend payment exists if, for example, law enforcement officials request that a payment suspension not be imposed or if other remedies more efficiently or quickly protect Medicaid funds.[3]

Federal regulations, amended effective March 25, 2011, require the State agency to suspend all Medicaid payments to a provider when it determines that there is a credible allegation of fraud (42 CFR § 455.23). This payment suspension is temporary and will not continue after either of the following: (1) authorities determine that there is insufficient evidence of fraud by the provider or (2) legal proceedings related to alleged fraud are completed. The regulations also require the State Medicaid agency to make fraud referral to either a Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in States without such a unit.

[1] The Affordable Care Act, P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliations Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

[2] Section 1903(i)(2) of the Act, as amended by section 6402(h)(2) of the Affordable Care Act.

[3] A list of "good cause" exceptions is in 42 CFR § 455.23(e).

The MFCU must be a single identifiable entity of State Government, distinct from the State agency, and it must enter into a formal agreement that describes its relationship with the State agency (42 CFR part 1007). This agreement includes the responsibilities for addressing allegations of credible fraud.

Arkansas' Medicaid Payment Safeguards

In Arkansas, the Office of the Medicaid Inspector General (OMIG) and MFCU safeguard Medicaid payments. As of July 1, 2013, OMIG is responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of Medicaid services. OMIG may apply administrative sanctions for abuse or wasteful practices but must refer cases of potential fraud to MFCU. Prior to July 1, 2013, the Program Integrity Unit (PIU) of the State agency had these responsibilities.[4]

Within the Arkansas Office of Attorney General, MFCU investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes them under State law. Since May 2010, an agreement has been in place that requires the State agency to refer cases of potential fraud to MFCU. This agreement was revised in February 2014 to incorporate Affordable Care Act requirements and the transition to OMIG.

HOW WE CONDUCTED THIS REVIEW

Our review covered 22 cases involving credible allegations of fraud reviewed by OMIG or PIU between March 25, 2011, and June 30, 2014.

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 A contains the details of our audit scope and methodology, and Appendix B contains the Federal and State requirements concerning the suspension of payments with a credible allegation of fraud.

RESULTS OF REVIEW

The State agency complied with the requirements of the Affordable Care Act when it received a credible allegation of fraud by its Medicaid providers. Of the 22 cases for which OMIG or PIU found a credible allegation of fraud by Medicaid providers, the State agency suspended payments in 11 of those cases. For the remaining 11 cases, OMIG or PIU provided good cause for not suspending payment. Of these 11 cases, 4 met one of the good cause exemptions in 42 CFR §

[4] With the creation of OMIG in June 2013, PIU was placed under the supervision and direction of the Arkansas Medicaid Inspector General. PIU was formerly a function of the State agency as required by the Centers for Medicare & Medicaid Services (42 CFR § 455).

455.23(e). The remaining 7 were allegations of credible fraud against an employee of the billing provider and the employee did not have a Medicaid provider number to suspend. We concluded that the State agency had good cause not to suspend payments in these cases.

In addition, OMIG implemented its policies and procedures to address the Affordable Care Act requirements concerning allegations of credible fraud. As a result, we have no recommendations.

OTHER MATTERS

The State agency does not have a mechanism for identifying and barring an employee who is fraudulently claiming services through a provider. According to OMIG, the State agency's Medicaid Management Information System (MMIS) identifies a Medicaid provider only by a valid provider identification number. The MMIS does not identify employees of Medicaid providers. Because the MMIS cannot identify employees by a provider number, employees who fraudulently claim services through a provider may escape oversight.

Medicaid provider employees with no provider number accounted for 7 of the 22 cases we reviewed. These cases pertained to allegations against employees of home health agencies and mental health agencies. OMIG has expressed concern that, while MMIS currently identifies the provider who submits the claim, it does not identify the employee who performs the services. Identifying the employee might eliminate payments for improper claims and prevent the employee from working for another provider.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 22 cases involving credible allegations of fraud reviewed by OMIG or PIU between March 25, 2011, and June 30, 2014.

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 limited our review to determining whether Arkansas complied with the requirements of the Affordable Care Act when it received a credible allegation of fraud against its Medicaid providers.

We conducted our audit from February through July 2015 and performed our fieldwork at the State agency, OMIG office, and MFCU office in Little Rock, Arkansas.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes, regulations, and guidance;
- held discussions with OMIG and MFCU officials;
- reviewed OMIG's procedures to gain an understanding of its practices when reviewing credible allegations of fraud;
- reviewed 22 cases involving credible allegations of fraud that were processed by OMIG or PIU between March 25, 2011, and June 30, 2014; and
- discussed our findings with State 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 B: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Section 6402(h)(2) of the Affordable Care Act amended section 1903(i)(2) of the Act to require States to suspend payments if the State determines that there is a credible allegation of fraud concerning a provider's Medicaid claims.

The Centers for Medicare & Medicaid Services (CMS) amended its implementing regulations (42 CFR § 455.23) effective March 25, 2011, to comply with the program integrity provision of the Affordable Care Act.[5] The amended regulations include provisions relating to suspension of payments.

Section 455.23(a), "Basis for suspension," states:

> (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.

Section 455.23(c), "Duration of suspension," states:

> (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," states:

> (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:

[5] "Final Rule," 76 Fed. Reg. 5862, 5932 (Feb. 2, 2011).

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

(ii) In States with no certified Medicaid fraud control unit, to an appropriate law enforcement agency.

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

> 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:
>
> (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.

On March 25, 2011, the CMS Center for Program Integrity and the CMS Center for Medicaid, CHIP[6], and Survey & Certification jointly issued an Informational Bulletin (CPI-B 11-04) to provide additional guidance to States concerning the State's obligation to suspend payments

[6] Children's Health Insurance Program.

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, CPI-B 11-04, also states that once a State verifies an allegation of fraud, it is required to refer the suspected fraud to its MFCU or other law enforcement agency for further investigation.

STATE REQUIREMENTS

The OMIG *Employee Manual*, section 105, "Suspected Criminal Fraud Protocol," addresses the requirements of the Affordable Care Act for determining whether there is a credible allegation of fraud.

Section 105.2(iii)(A), states:

> OMIG will contact MFCU if OMIG determines that a credible allegation of fraud by a Medicaid Provider exists. This complies with 42 CFR § 455.15 and § 455.23.
>
> In the event that a fraud referral from OMIG is formally accepted by MFCU, the OMIG will immediately suspend the Medicaid Provider that is the subject of the referral from the Medicaid Program unless OMIG determines that a good cause exists not to suspend the provider from the Program pursuant to 42 CFR § 455.23 (e) or (f).

Section 105.2(iii)(C)(v) states:

> If during the course [of] an authorized OMIG audit or inquiry any evidence of suspicion of criminal or suspected criminal fraud is uncovered, OMIG personnel must immediately notify the administrative staff. OMIG administration will discuss the suspected criminal activity with OMIG staff and make a determination as to whether the evidence rises to the level of suspected criminal fraud where law enforcement should be contacted.

Section 105.2(iii)(C)(vii) states: "Based on a review, audit or investigation, OMIG may immediately suspend the Medicaid Provider. Pursuant to 42 CFR § 455.15 and § 455.23, OMIG must notify and refer the allegation to MFCU. If MFCU formally accepts the referral the temporary suspension by OMIG will remain in effect until MFCU concludes the referred investigation."

Section 105.2(iii)(C)(viii) states: "OMIG will permanently suspend or exclude a provider from the Medicaid Program upon a felony criminal conviction. OMIG may permanently suspend or exclude a provider from the Medicaid Program if OMIG believes sufficient evidence warrants the exclusion regardless of a decision or outcome from a case referred or submitted to MFCU."