

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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

INTRODUCTION

WHY WE DID THIS REVIEW

The Affordable Care Act¹ requires States to suspend Medicaid payments to providers when they receive a credible allegation that the providers have submitted fraudulent claims. This review of Pennsylvania's 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 Pennsylvania's Department of Public Welfare (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 payments exists if, for example, law enforcement officials request that a payment suspension not be imposed or if other remedies more effectively 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 continues until (1) authorities discern that there is insufficient evidence of fraud upon which to base a legal action or (2) legal proceedings related to alleged fraud are completed. The regulations also require the State agency

¹ The Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 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. States also do not suspend payments for emergency items or services.

³ A description of "good cause" is provided at 42 CFR § 455.23(e).

to refer credible allegations of fraud to either a Medicaid Fraud Control Unit or an appropriate law enforcement agency in States without such a unit.

A Medicaid Fraud Control Unit must be a single identifiable entity of State government, distinct from the State agency, and it must enter into a formal agreement with the State agency that describes the relationship between the Medicaid Fraud Control Unit and the State agency (42 CFR § 1007). This agreement must include the responsibilities for addressing credible allegations of fraud.

Pennsylvania's Medicaid Payment Safeguards

In Pennsylvania, the Bureau of Program Integrity (Program Integrity) and the Medicaid Fraud Control Section (Fraud Control Section) safeguard Medicaid payments. Within the State agency, Program Integrity is primarily composed of medical professionals, particularly registered nurses. Program Integrity is responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of Medicaid services, including managed care organizations. Program Integrity may apply administrative sanctions for abuse or wasteful practices but must refer cases of potential fraud to the Fraud Control Section. In Pennsylvania, the Fraud Control Section is the Medicaid Fraud Control Unit.

Within the Pennsylvania Office of Attorney General, the Fraud Control Section investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes it under State law. Effective November 2001 and continuing throughout our audit period, Program Integrity and the Fraud Control Section had an agreement that required Program Integrity to refer cases of potential fraud to the Fraud Control Section. This agreement was revised in December 2013 to incorporate Affordable Care Act requirements.

Prior Centers for Medicare & Medicaid Services Review

In May 2012, CMS issued the *Pennsylvania Comprehensive Program Integrity Review: Final Report* for State fiscal years 2007–2008 through 2010–2011. Among its findings, CMS identified 24 credible allegations of fraud after March 25, 2011, for which Program Integrity did not suspend payments or identify a good cause exception not to suspend payments. The report stated that, at the time of CMS's review, Program Integrity had drafted policies and procedures to address the Affordable Care Act requirements concerning credible allegations of fraud but had not implemented them.

HOW WE CONDUCTED THIS REVIEW

Our review covered 245 cases involving credible allegations of fraud that Program Integrity reviewed between March 25, 2011, and June 30, 2013. We did not include in our review 153 cases under investigation by the Fraud Control Section because the Fraud Control Section, rather than Program Integrity, initiated the cases.

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. Appendix B contains the Federal and State requirements concerning the suspension of payments with a credible allegation of fraud.

RESULTS OF REVIEW

PENNSYLVANIA COMPLIED WITH FEDERAL AND STATE REQUIREMENTS OF THE AFFORDABLE CARE ACT

The State agency complied with the requirements of the Affordable Care Act in its review of cases for which there were credible allegations of fraud. Of the 245 cases for which it found credible allegations of fraud by Medicaid providers, Program Integrity suspended payment in 2 cases. For the remaining 243 cases, Program Integrity provided good cause to not suspend payment.

Of the 245 cases, 221 were allegations of credible fraud against personal care aides providing services for the home health agencies that submitted the claims. The remaining 24 cases were for non-home health services claims. According to Program Integrity officials, CMS said that they are not required to suspend provider payments when an employee, rather than the provider, is referred, but if there is a repeated pattern of allegations involving the same provider, Program Integrity should consider looking at the provider.⁴ We concluded that the State agency had good cause not to suspend payments in these cases.

All 245 cases were referred to the Fraud Control Section as required. The Fraud Control Section did not recover funds in 151 cases because of insufficient evidence. Seventy cases resulted in an arrest, conviction, fine, or penalty, and 1 case was still under investigation. The case files did not include information about Fraud Control's disposition of 23 cases.

In addition, Program Integrity 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 Program Integrity, the State agency's Medicaid Management Information System (MMIS)⁵ only identifies a home health

⁴ Laurie Rock, Director, Program Integrity, "Sample note in case tracking ...," internal email message, September 19, 2011. The attached email string specified that Program Integrity would use the good cause exception "[o]ther available remedies implemented by the State more effectively or quickly protect Medicaid funds" (42 CFR § 455.23(e)(2)).

⁵ The MMIS is an integrated group of procedures and computer processing operations (subsystems) that, among other things, processes Medicaid claims.

agency by a valid provider identification number. The MMIS does not identify personal care aides employed by home health agencies. Because the MMIS cannot identify personal care aides, personal care aides who fraudulently claim services through a provider may escape oversight.

Personal care aide improprieties accounted for 90 percent of the cases that we reviewed. These 221 cases pertained to allegations against personal care aides employed by home health agencies. In 163 of these cases, officials of the home health agencies themselves reported the allegations to Program Integrity. Program Integrity officials expressed concern that, while MMIS currently identifies the provider who submits the claim, it does not identify the personal care aide who performed the services. Identifying the aide might eliminate payments for improper claims through pre-payment algorithms.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 245 cases involving credible allegations of fraud reviewed by Program Integrity between March 25, 2011, and June 30, 2013. We did not include in this review 153 cases initiated by the Fraud Control Section. For these cases, the Fraud Control Section had notified Program Integrity not to take any action against the providers it was investigating if Program Integrity received a credible allegation of fraud.

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 Pennsylvania 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 December 2013 to March 2014 and performed our fieldwork at Program Integrity's office in Harrisburg, Pennsylvania.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes, regulations, and guidance;
- held discussions with Program Integrity officials and reviewed applicable Program Integrity policies and procedures to gain an understanding of its practices when reviewing credible allegations of fraud;
- reviewed 245 case files containing credible allegations of fraud that were processed by Program Integrity between March 25, 2011, and June 30, 2013; 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 determined that there was a credible allegation of fraud concerning a provider's Medicaid claims.

CMS amended its implementing regulations (42 CFR § 455.23) effective March 25, 2011, to comply with the provision of the Affordable Care Act.⁶ 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:
 - (i) To a Medicaid fraud control unit established and certified under part 1007 of this title; or

⁶ 76 Fed. Reg. 5862, 5928 (Feb. 2, 2011).

(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) Beneficiary 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 beneficiaries within a [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,⁷ 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 when there is a credible allegation of fraud. In that document, CMS clarified the definition for a credible allegation of fraud in the Frequently Answered Questions section, 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.

⁷ Children's Health Insurance Program.

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 in the Frequently Answered Questions section that once a State verifies an allegation of fraud, it is required to refer the suspected fraud to its Medicaid Fraud Control Unit or other law enforcement agency for further investigation.

STATE REQUIREMENTS

In May 2012, the State agency amended its policy and procedures to address the requirements of the Affordable Care Act for determining whether there is a credible allegation of fraud:

- The Program Integrity Case Coordinator will conduct a preliminary investigation including, but not limited to, review of past files, claims history, and supporting documentation to assess if the credibility of the fraud allegation is sufficient to trigger a payment suspension (“Procedure 2”).
- Program Integrity will then discuss its preliminary findings with the Department of Public Welfare’s Office of General Counsel to determine whether a credible allegation of fraud exists against a provider and, as appropriate, will consult with the Office of Attorney General Medicaid Fraud Control Section to determine the credibility of allegations (“Procedure 3”).

After its consultations, Program Integrity considers allegations credible “when they have indicia of reliability and [Program Integrity] has reviewed all allegations, facts and evidence carefully and acts judiciously on a case-by-case basis” (“Definitions”).

In accordance with the Affordable Care Act, the revised policy states that the State agency “must suspend all Medicaid payments to a provider after a determination of a credible allegation of fraud for which an investigation is pending under the [Medicaid] Program against an individual or entity unless [State agency] has good cause to not suspend payments or to suspend payment only in part” (“Policy Statement”).

The policy and procedures also list the good cause exceptions for not suspending payments when there is a credible allegation of fraud. These exceptions mirror those found in the Federal regulations. The first good cause not to suspend payments exists when Fraud Control or other law enforcement officials specifically request that Program Integrity not suspend provider payments because “such a payment suspension may compromise or jeopardize an investigation...” (Procedure 4(a)).