

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OHIO DID NOT ALWAYS COMPLY WITH
THE REQUIREMENTS OF THE
AFFORDABLE CARE ACT IN ITS REVIEW
OF CASES OF CREDIBLE ALLEGATIONS
OF MEDICAID FRAUD**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Sheri L. Fulcher
Regional Inspector General
for Audit Services**

**March 2015
A-05-14-00008**

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

Ohio received Federal reimbursement for claims associated with 24 cases for which it found credible allegations of fraud by Medicaid providers between July 1, 2011, and June 30, 2013.

WHY WE DID THIS REVIEW

The Affordable Care Act requires States to suspend Medicaid payments to providers when they receive a credible allegation that the providers have submitted fraudulent claims. This review of Ohio's adjudication of such allegations is part of the Office of Inspector General's oversight of the Affordable Care Act.

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

BACKGROUND

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 made to those providers unless the State shows that it has good cause not to suspend such payment. 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.

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 a fraud referral to either a Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in States without such a unit.

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 § 1007). This agreement includes the responsibilities for addressing allegations of credible fraud.

In Ohio, two units of government safeguard Medicaid payments. Within the State agency, the Surveillance and Utilization Review Section (SURS) is responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of Medicaid services.

The State agency may apply administrative sanctions for abuse or wasteful practices, but must refer cases of potential fraud to MFCU.

Within the Ohio Attorney General's Office, MFCU investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes it under State law. Effective July 2011 and continuing through our audit period, the State agency and MFCU had an agreement that required the State agency to refer cases of potential fraud to MFCU. This agreement was revised in August 2013 to incorporate Affordable Care Act requirements.

WHAT WE FOUND

The State agency did not always comply with the requirements of the Affordable Care Act in its review of cases for which there were credible allegations of fraud between July 1, 2011, and June 30, 2013. Of the 401 cases for which it found credible allegations of fraud by Medicaid providers, the State agency provided good cause to not suspend payments in 321 cases. For the remaining 80 cases, the State agency suspended payments to the Medicaid providers. However, the State agency continued to pay a limited number of claims for Medicaid providers associated with 24 of the 80 cases and received Federal reimbursement totaling \$96,516. Contrary to Federal requirements, the State agency continued to pay suspended Medicaid providers for claims with dates of service that occurred before the providers' suspension date.

WHAT WE RECOMMEND

We recommend the State agency ensure that it properly suspends all Medicaid payments to a provider when it determines that there is a credible allegation of fraud in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendation and provided details about corrective actions that were implemented.

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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 Ohio'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 the Ohio Department of Medicaid (State agency)² 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 made to those providers unless the State shows that it has good cause not to suspend such payment.³ 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.⁴

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 a fraud referral to either a Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in States without such a unit.

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 Effective July 1, 2013, the Ohio Department of Medicaid replaced the Office of Job and Family Services as the single state agency to supervise the administration of the Medicaid program.

³ Section 1903(i)(2) of the Act, as amended by section 6402(h)(2) of the Affordable Care Act.

⁴ A list of "good cause" exceptions is provided at 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 § 1007). This agreement includes the responsibilities for addressing allegations of credible fraud.

Ohio's Medicaid Payment Safeguards

In Ohio, two units of government safeguard Medicaid payments. Within the State agency, the Surveillance and Utilization Review Section (SURS) is responsible for preventing, detecting, deterring, and correcting fraud, abuse, and wasteful practices by providers of Medicaid services. The State agency may apply administrative sanctions for abuse or wasteful practices, but must refer cases of potential fraud to MFCU.

Within the Ohio Attorney General's Office, MFCU investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes it under State law. Effective July 2011 and continuing through our audit period, the State agency and MFCU had an agreement that required the State agency to refer cases of potential fraud to MFCU. This agreement was revised in August 2013 to incorporate Affordable Care Act requirements.

HOW WE CONDUCTED THIS REVIEW

Our review covered 401 cases involving credible allegations of fraud reviewed by the State agency between July 1, 2011, and June 30, 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 A contains the Federal and State requirements concerning the suspension of payments with a credible allegation of fraud. Appendix B contains the details of our audit scope and methodology.

FINDINGS

The State agency did not always comply with the requirements of the Affordable Care Act in its review of cases for which there were credible allegations of fraud between July 1, 2011, and June 30, 2013. Of the 401 cases for which it found credible allegations of fraud by Medicaid providers, the State agency provided good cause to not suspend payment in 321 cases. For the remaining 80 cases, the State agency suspended payments to the Medicaid providers. However, the State agency continued to pay a limited number of claims for Medicaid providers associated with 24 of the 80 cases and received Federal reimbursement totaling \$96,516. Contrary to Federal requirements, the State agency continued to pay suspended Medicaid providers for claims with dates of service that occurred before the providers' suspension date.

FEDERAL REIMBURSEMENT FOR SUSPENDED MEDICAID PROVIDERS WITH CREDIBLE ALLEGATIONS OF FRAUD

The State agency did not always properly suspend payments involving cases for which it found credible allegation of fraud by Medicaid providers. 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.⁵

During our review, the State agency suspended payments to Medicaid providers associated with 80 cases for which it found credible allegations of fraud. Federal regulations require that all payments be suspended. Contrary to Federal regulations, Ohio allowed the suspension of Medicaid provider payments for claims with a date of service that occurred after the provider's date of suspension.⁶ The State agency continued to pay suspended Medicaid providers for claims with dates of service that occurred before the providers' date of suspension. As a result, the State agency received Federal reimbursement totaling \$96,516 for claims associated with 24 cases for which Medicaid providers were suspended due to a credible allegation of fraud.

Ohio recently proposed to update its provisions to allow the suspension of payments for claims that occurred before and after the provider's date of suspension. The draft proposal was released for public comment on September 26, 2014.

RECOMMENDATION

We recommend the State agency ensure that it properly suspends all Medicaid payments to a provider when it determines that there is a credible allegation of fraud, in accordance with Federal requirements.

STATE AGENCY COMMENTS

In written comments to our draft report, the State agency concurred with our recommendation and provided details about corrective actions that were implemented. The State agency's comments are included in their entirety as Appendix C.

⁵ Section 1903(i)(2) of the Act, as amended by section 6402(h)(2) of the Affordable Care Act.

⁶ Ohio Revise Code 5164.36(D) - Credible allegation of fraud; suspension of provider agreement.

APPENDIX A: 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.

The Centers for Medicare & Medicaid Services (CMS) amended its implementing regulations (42 CFR § 455.23) effective March 25, 2011, to comply with the provision of the Affordable Care Act.⁷ 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

⁷ "Final Rule," 76 Fed. Reg. 5862, 5932 (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,⁸ 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. Among its responses to Frequently Asked Questions, CMS clarified the definition for a 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

⁸ Children’s Health Insurance Program.

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, it is required to refer the suspected fraud to its Medicaid Fraud Control Unit or other law enforcement agency for further investigation.

STATE REQUIREMENTS

Ohio Revised Code, Section 5164.36, “Credible allegation of fraud; suspension of provider agreement” effective 9/29/2011, includes provisions related to the suspension of payments.

Section 5164.36(A)(1), states:

“Credible allegation of fraud” has the same meaning as in 42 C.F.R. 455.2, except that for purposes of this section any reference in that regulation to the “state” or the “state Medicaid agency” means the department of Medicaid.

Section 5164.36(B)(1), states:

Except as provided in division (C) of this section and in rules authorized by this section, on determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against a Medicaid provider, the department of Medicaid shall suspend the provider agreement held by the provider. Subject to division (C) of this section, the department shall also terminate Medicaid payments to the provider for services rendered.

Section 5164.36(D), states:

The termination of Medicaid payment under division (B) of this section applies only to payments for Medicaid services rendered subsequent to the date on which the notice required by division (E) of this section is sent. Claims for payment of Medicaid services rendered by the Medicaid provider prior to the issuance of the notice may be subject to prepayment review procedures whereby the department reviews claims to determine whether they are supported by sufficient documentation, are in compliance with state and federal statutes and rules, and are otherwise complete.

Section 5164.36(E), states:

After suspending a provider agreement under division (B) of this section, the department shall, as specified in 42 C.F.R. 455.23(b), send notice of the suspension to the affected Medicaid provider or owner in accordance with the following timeframes: (1) Not later than five days after the suspension, unless a law enforcement agency makes a written request to temporarily delay the notice; (2) If a law enforcement agency makes a written

request to temporarily delay the notice, not later than thirty days after the suspension occurs subject to the conditions specified in division (F) of this section.

Section 5164.36(F), states:

A written request for a temporary delay described in division (E)(2) of this section may be renewed in writing by a law enforcement agency not more than two times except that under no circumstances shall the notice be issued more than ninety days after the suspension occurs.

Section 5164.36(G), states:

The notice required by division (E) of this section shall do all of the following: (1) State that payments are being suspended in accordance with this section and 42 C.F.R. 455.23; (2) Set forth the general allegations related to the nature of the conduct leading to the suspension, except that it is not necessary to disclose any specific information concerning an ongoing investigation; (3) State that the suspension continues to be in effect until either of the following is the case: (a) The department or a prosecuting authority determines that there is insufficient evidence of fraud by the provider; (b) The proceedings in any related criminal case are completed through dismissal of the indictment or through conviction, entry of a guilty plea, or finding of not guilty and, if the department commences a process to terminate the suspended provider agreement, until the termination process is concluded.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 401 cases involving credible allegations of fraud reviewed by the State agency between July 1, 2011, and June 30, 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 limited our review to determining whether the State agency 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 October 2013 to November 2014 and performed our fieldwork at the State agency's office in Columbus, Ohio.

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 applicable procedures to gain an understanding of its practices when reviewing credible allegations of fraud;
- reviewed 401 cases involving credible allegations of fraud that were reviewed by the State agency between July 1, 2011, and June 30, 2013;
- reviewed claims information associated with Medicaid providers who were suspended due to a credible allegation of fraud; 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 C: STATE AGENCY COMMENTS



John R. Kasich, Governor
John B. McCarthy, Director

February 6, 2015

Ms. Sheri Fulcher
Office of Audit Services, Region VI
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: Report Number A-05-14-00008

Dear Ms. Fulcher,

Please accept this letter as Ohio's response to the draft OIG Audit report listed above.

"Ohio Did Not Always Comply with the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud"

OIG Recommendation: We recommend the State agency ensure that it properly suspends all Medicaid payments when it determines that there is a credible allegation of fraud in accordance with Federal requirements.

The Ohio Department of Medicaid (ODM) concurs with this recommendation.

We implemented the Affordable Care Act requirement to suspend Medicaid payments to providers when there is a credible allegation of fraud with the first suspension under this authority taking place in July, 2011. ODM and the Ohio Attorney General's Medicaid Fraud Control Unit (MFCU) work closely to make the best decisions about suspension of providers when there is a credible allegation of fraud. We meet on a regular basis to discuss cases and determine course of action. Additionally, we continue to improve and refine our protocol and timelines for "good cause exception" designations.

While we strived for full compliance with the federal regulation in our original implementation of suspensions for credible allegations of fraud, we identified some specific enhancements that we could make through discussions with the CMS Medicaid Integrity Group just prior to this audit, and subsequently with the Office of Inspector General auditors during this audit. These enhancements are described below as corrective actions.

Corrective Actions Implemented: In January 2014, ODM revised its provider agreement suspension policy to match the federal definition of suspension of payments for credible allegation of fraud. All suspensions resulting from a credible allegation of fraud from this date suspend all payments to the provider regardless of the date of service.

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During this period, ODM and MFCU worked closely to reduce the time between the following: receipt of a referral and the preliminary determination of “credible”; designation as a “good cause exception” from the MFCU and a quicker release from that designation upon any indication the suspension would not interfere with a complete law enforcement investigation.

ODM also convenes an internal weekly meeting to discuss credible allegation of fraud cases. In some instances, the group determines whether ODM will suspend payments before MFCU has made a final determination on the merits of MFCU’s criminal case.

We appreciate the opportunity to respond and provide specific information as to how Ohio is compliant with the Affordable Care Act requirement to suspend Medicaid payments to providers when we determine there is a credible allegation of fraud.

Sincerely,

John B McCarthy

John B. McCarthy
State Medicaid Director