

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Minnesota 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 Minnesota'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 Minnesota's 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 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 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 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.

Minnesota's Medicaid Payment Safeguards

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

Within the Minnesota Office of Attorney General, MFCU investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes it under State law. Effective April 2007 and continuing through our audit period, SIRS and MFCU had an agreement that required SIRS to refer cases of potential fraud to MFCU. This agreement was revised in September 2013 to incorporate Affordable Care Act requirements.

HOW WE CONDUCTED THIS REVIEW

Our review covered 85 cases involving credible allegations of fraud reviewed by SIRS 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 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

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 85 cases for which it found credible allegations of fraud by Medicaid providers, SIRS referred all 85 cases to MFCU and suspended payment in 20 of those cases. For the remaining 65 cases, SIRS provided good cause to not suspend payment as defined in 42 CFR § 455.23(e).

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 85 cases involving credible allegations of fraud reviewed by SIRS 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 Minnesota 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 March 2014 and performed our fieldwork at the SIRS office in Saint Paul, Minnesota.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal statutes, regulations and guidance;
- held discussions with SIRS officials and reviewed applicable SIRS policies and procedures to gain an understanding of its practices when reviewing credible allegations of fraud;
- reviewed 85 cases involving credible allegations of fraud that were processed by SIRS between July 1, 2011, and June 30, 2013;
- 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.

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.⁴ 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

⁴ "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 HRSA-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,⁵ 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 Answered 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

⁵ 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

In June 2011, 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.

- SIRS conducts 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.
- SIRS investigators discuss their preliminary findings with the SIRS management team 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.

After its consultations, SIRS considers allegations credible “when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.”

In conformance with the Affordable Care Act, the policy states, “except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23 (e) or (f), the commissioner shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if the commissioner determines there is a credible allegation of fraud for which an investigation is pending under the program.”

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 law enforcement officials specifically request that SIRS not suspend provider payments.