

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**WASHINGTON STATE DID NOT  
SUSPEND MEDICAID PAYMENTS TO  
SOME PROVIDERS WITH CREDIBLE  
ALLEGATIONS OF FRAUD IN  
ACCORDANCE WITH THE  
AFFORDABLE CARE ACT**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Washington State did not suspend Medicaid payments to some providers with credible allegations of fraud.*

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) requires a State to suspend Medicaid payments to a provider when the State receives a credible allegation that the provider has submitted fraudulent claims. This review of Washington State's Medicaid payment suspensions is part of the Office of Inspector General's oversight of States' compliance with requirements of the ACA.

Our objective was to determine whether the Washington Health Care Authority (State agency) suspended Medicaid payments to providers with credible allegations of fraud in accordance with the ACA.

### BACKGROUND

The ACA amended the Social Security Act (the Act) to strengthen payment safeguards over potentially fraudulent Medicaid claims. Under the Act, a State that does not suspend payments to a provider when investigation of a credible allegation of fraud is pending is not eligible for Federal reimbursement for payments to that provider unless the State shows that it has good cause not to suspend such payments. A State may use such good-cause exemptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more effectively or quickly protect Medicaid funds.

Effective March 25, 2011, a State agency must suspend all Medicaid payments to a provider when it determines that there is a credible allegation of fraud (42 CFR § 455.23(a)). Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend such payments (76 Fed. Reg. 5862, 5938 (Feb. 2, 2011)). The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)). A State agency must annually report to the Secretary of Health and Human Services summary information on payment suspensions and good-cause exemptions (42 CFR § 455.23(g)(3)).

In Washington, the State agency is responsible for administration of the Medicaid program. Through an agreement with the State agency, the Washington State Department of Social and Health Services (Health Services) was delegated authority to administer, oversee, and manage Medicaid's long-term-care services. The Washington Attorney General's Medicaid Fraud Control Unit (Fraud Control Unit) is responsible for investigation and criminal prosecution of provider fraud in the Medicaid program.

Our review covered 81 providers with credible allegations of fraud, consisting of 11 providers paid by the State agency and 70 providers paid by Health Services. The State agency and Health

Services determined these allegations of fraud to be credible and made formal referrals to the Fraud Control Unit between March 25, 2011, and September 30, 2013.

## **WHAT WE FOUND**

The State agency did not always suspend Medicaid payments to providers with credible allegations of fraud in accordance with the ACA. Of the 81 providers that we reviewed, the State agency suspended Medicaid payments to 33 providers. However, it did not suspend Medicaid payments to 48 providers:

- For one provider, a fraud investigation was ongoing as of October 2014, but the State agency did not suspend \$1,588 (\$794 Federal share) of Medicaid payments to the provider. As a result, these payments were not eligible for Federal reimbursement.
- For 47 providers, the Fraud Control Unit determined that there was insufficient evidence of fraud for 46 providers, and legal proceedings were completed for 1 provider who was found guilty of Medicaid fraud. However, the State agency did not suspend \$989,766 (\$495,631 Federal share) of Medicaid payments to these providers during the investigations or before legal proceedings were completed, putting Medicaid funds at risk.

The State agency repeatedly failed to suspend payments because it did not follow its policies and procedures and Health Services did not have written policies and procedures to suspend Medicaid payments to providers when there were credible allegations of fraud.

In addition, the State agency did not report to the Centers for Medicare & Medicaid Services (CMS) required summary information on good-cause exemptions and Health Services' payment suspensions. The State agency did not follow its policies and procedures to report the summary information on good-cause exemptions, and the State agency's policies and procedures did not specify its responsibility to report Health Services' summary information on payment suspensions.

## **WHAT WE RECOMMEND**

We recommend that the State agency:

- refund \$794 to the Federal Government,
- follow its policies and procedures to ensure that it suspends Medicaid payments to providers when there are credible allegations of fraud,
- ensure that Health Services has adequate policies and procedures to suspend Medicaid payments to providers when there are credible allegations of fraud,
- follow its policies and procedures to ensure that it reports to CMS summary information on good-cause exemptions, and

- strengthen its policies and procedures by including a responsibility to report Health Services' summary information on payment suspensions.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency concurred with our second through fifth recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, the State agency did not fully concur with our first recommendation as originally drafted (i.e., refund \$163,563 to the Federal government). The State agency concurred with the refund amount of \$794 related to one provider and provided information indicating that the Fraud Control Unit had declined the referral for an allegation of fraud against a second provider.

After reviewing supplemental information and documentation provided by the State agency for the second provider, we confirmed that the referral for an allegation of fraud had been declined by the Fraud Control Unit. We included this provider as part of our finding related to the State agency's failure to suspend payments to 47 providers and reduced our recommended refund amount accordingly.

## TABLE OF CONTENTS

INTRODUCTION .....	1
Why We Did This Review .....	1
Objective .....	1
Background .....	1
Federal Requirements Related to Payment Suspensions for Providers With Credible Allegations of Fraud.....	1
Washington’s Medicaid Payment Safeguards .....	2
How We Conducted This Review.....	2
FINDINGS .....	2
The State Agency Did Not Suspend Medicaid Payments to All Providers With Credible Allegations of Fraud.....	3
The State Agency Did Not Report Good-Cause Exemptions and Payment Suspensions.....	4
RECOMMENDATIONS .....	4
STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE .....	5
APPENDIXES	
A: Related Office of Inspector General Reports.....	6
B: Audit Scope and Methodology.....	7
C: State Agency Comments .....	9

## INTRODUCTION

### WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> requires a State to suspend Medicaid payments to a provider when the State receives a credible allegation that the provider has submitted fraudulent claims. This review of Washington State's Medicaid payment suspensions is part of the Office of Inspector General's (OIG) oversight of States' compliance with requirements of the ACA. (Appendix A lists related OIG reports on States' compliance with ACA requirements in reviewing cases of credible allegations of fraud.)

### OBJECTIVE

Our objective was to determine whether the Washington Health Care Authority (State agency) suspended Medicaid payments to providers with credible allegations of fraud in accordance with the ACA.

### BACKGROUND

#### **Federal Requirements Related to Payment Suspensions for Providers 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 ACA amended the Act to strengthen payment safeguards over potentially fraudulent claims. Under the Act, a State that does not suspend payments to a provider when investigation of a credible allegation of fraud is pending is not eligible for Federal reimbursement for payments to that provider unless the State shows that it has good cause not to suspend such payments.<sup>2</sup> A State may use such good-cause exemptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more effectively or quickly protect Medicaid funds.<sup>3</sup>

Effective March 25, 2011, a State agency must suspend all Medicaid payments to a provider when it determines that there is a credible allegation of fraud (42 CFR § 455.23(a)). Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend such payments (76 Fed. Reg. 5862, 5938 (Feb. 2, 2011)). The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)). A State agency must also refer credible allegations of fraud to either a Medicaid Fraud Control Unit or an appropriate law enforcement agency in States without such a unit (42 CFR § 455.23(d)).

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<sup>1</sup> P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

<sup>2</sup> The Act § 1903(i)(2)(C) and 42 CFR § 447.90(b).

<sup>3</sup> A list of good-cause exemptions is provided at 42 CFR § 455.23(e).

## **Washington's Medicaid Payment Safeguards**

In Washington, the State agency is responsible for administration of the Medicaid program, which includes ensuring compliance with all Federal and State requirements related to operation of the program. Through an agreement with the State agency, the Washington State Department of Social and Health Services (Health Services) was delegated authority to administer, oversee, and manage Medicaid's long-term-care services.<sup>4</sup> The State agency and Health Services are responsible for preventing and detecting fraud, waste, abuse, and neglect in programs receiving Medicaid funds.

Within the Washington Office of the Attorney General, the Medicaid Fraud Control Unit (Fraud Control Unit) is responsible for investigation and criminal prosecution of provider fraud, waste, abuse, and neglect in the Medicaid program. Effective February 2012, the State agency, Health Services, and the Fraud Control Unit entered into a memorandum of understanding (MOU), which requires the State agency and Health Services to refer cases of potential fraud to the Fraud Control Unit. The ACA requirements related to suspension of Medicaid payments to providers were incorporated into the MOU.

### **HOW WE CONDUCTED THIS REVIEW**

Our review covered 81 providers with credible allegations of fraud, consisting of 11 providers paid by the State agency and 70 providers paid by Health Services. The State agency and Health Services determined these allegations of fraud to be credible and made formal referrals to the Fraud Control Unit between March 25, 2011, and September 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 B contains the details of our audit scope and methodology.

### **FINDINGS**

The State agency did not always suspend Medicaid payments to providers with credible allegations of fraud in accordance with the ACA. Of the 81 providers that we reviewed, the State agency suspended Medicaid payments to 33 providers. However, it did not suspend Medicaid payments to 48 providers:

- For one provider, a fraud investigation was ongoing as of October 2014, but the State agency did not suspend \$1,588 (\$794 Federal share) of Medicaid payments to the provider. As a result, these payments were not eligible for Federal reimbursement.

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<sup>4</sup> The long-term-care services listed in the agreement include programs such as Residential Habilitation Centers/Public Care Facilities for People with Intellectual Disabilities, section 1915(b) and 1915(c) waivers, and Home and Community Based Services programs.

- For 47 providers, the Fraud Control Unit determined that there was insufficient evidence of fraud for 46 providers, and legal proceedings were completed for 1 provider who was found guilty of Medicaid fraud. However, the State agency did not suspend \$989,766 (\$495,631 Federal share) of Medicaid payments to these providers during the investigations or before legal proceedings were completed, putting Medicaid funds at risk.

The State agency repeatedly failed to suspend payments because it did not follow its policies and procedures and Health Services did not have written policies and procedures to suspend Medicaid payments to providers when there were credible allegations of fraud.

In addition, the State agency did not report to the Centers for Medicare & Medicaid Services (CMS) required summary information on good-cause exemptions and Health Services' payment suspensions. The State agency did not follow its policies and procedures to report the summary information on good-cause exemptions, and the State agency's policies and procedures did not specify its responsibility to report Health Services' summary information on payment suspensions.

### **THE STATE AGENCY DID NOT SUSPEND PAYMENTS TO ALL PROVIDERS WITH CREDIBLE ALLEGATIONS OF FRAUD**

Federal regulations, effective March 25, 2011, require a 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(a)). 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 (42 CFR § 455.23(c)).

The State agency did not suspend Medicaid payments to 48 providers when it had determined that there were credible allegations of provider fraud. The case files for these providers did not contain documentation showing good-cause exemptions to the required payment suspensions, and in one instance the good-cause exemption was inadequately documented.

For 1 of the 48 providers, the Fraud Control Unit had an ongoing investigation of provider fraud as of October 2014.<sup>5</sup> However, the State agency did not suspend \$1,588 (\$794 Federal share) of Medicaid payments to this provider, as required by Federal regulations. As a result, these payments were not eligible for Federal reimbursement.

For the remaining 47 providers, the Fraud Control Unit determined that there was insufficient evidence of fraud for 46 providers, and legal proceedings were completed for 1 provider who was found guilty of Medicaid fraud. However, the State agency did not suspend \$989,766 (\$495,631 Federal share) of Medicaid payments to these 47 providers during the investigations or before the legal proceedings were completed, as required by Federal regulations. As a result, Medicaid funds were put at risk.

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<sup>5</sup> During a meeting with the State agency on March 4, 2015, we asked if the status of the investigation had changed and received no further information.

The table below shows the number of providers with unsuspended Medicaid payments at the State agency and Health Services.

**Table: Number of Providers With Unsuspended Medicaid Payments at the State Agency and Health Services**

	<b>No. of Providers With Ongoing Investigations</b>	<b>No. of Providers With Insufficient Evidence of Fraud</b>	<b>No. of Providers With Completed Legal Proceedings</b>	<b>Total No. of Providers With Unsuspended Payments</b>
State Agency	0	4	0	4
Health Services	1	42	1	44
<b>Total</b>	<b>1</b>	<b>46</b>	<b>1</b>	<b>48</b>

The State agency repeatedly failed to suspend payments because it did not follow its policies and procedures. In addition, Health Services did not have written policies and procedures to suspend Medicaid payments to providers when there were credible allegations of fraud.

**THE STATE AGENCY DID NOT REPORT GOOD-CAUSE EXEMPTIONS AND PAYMENT SUSPENSIONS**

Federal regulations require a State agency to annually report to the Secretary of Health and Human Services summary information on credible allegations of fraud, including payment suspensions and good-cause exemptions (42 CFR § 455.23(g)(3)).

The State agency did not report to CMS summary information on good-cause exemptions and Health Services’ payment suspensions. Specifically, the State agency did not include any good-cause exemptions in its Medicaid payment suspension report for Federal fiscal year (FFY) 2012. In addition, the State agency did not include the required summary information from Health Services on payment suspensions in its reports to CMS for FFYs 2011 and 2012.

The State agency did not report the good-cause exemptions because it did not follow its policies and procedures; its personnel were not familiar with the reporting process. Also, the State agency did not report Health Services’ suspension payment information because it was unaware of this responsibility. The State agency’s policies and procedures did not specify this reporting responsibility.

**RECOMMENDATIONS**

We recommend that the State agency:

- refund \$794 to the Federal Government,
- follow its policies and procedures to ensure that it suspends Medicaid payments to providers when there are credible allegations of fraud,

- ensure that Health Services has adequate policies and procedures to suspend Medicaid payments to providers when there are credible allegations of fraud,
- follow its policies and procedures to ensure that it reports to CMS summary information on good-cause exemptions, and
- strengthen its policies and procedures by including a responsibility to report Health Services' summary information on payment suspensions.

### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, the State agency concurred with our second through fifth recommendations and provided information on actions that it had taken or planned to take to address our recommendations. However, the State agency did not fully concur with our first recommendation as originally drafted (i.e., refund \$163,563 to the Federal government). The State agency concurred with the refund amount of \$794 related to one provider and provided information indicating that the Fraud Control Unit had declined the referral for an allegation of fraud against a second provider.

After reviewing supplemental information and documentation provided by the State agency for the second provider, we confirmed that the referral for an allegation of fraud had been declined by the Fraud Control Unit. We included this provider as part of our finding related to the State agency's failure to suspend payments to 47 providers and reduced our recommended refund amount accordingly.

**APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS**

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Ohio Did Not Always Comply With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<a href="#"><u>A-05-14-00008</u></a>	3/9/2015
<i>Minnesota Complied With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<a href="#"><u>A-05-14-00009</u></a>	11/21/2014
<i>Pennsylvania Complied With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<a href="#"><u>A-03-14-00202</u></a>	6/25/2014

## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered 81 providers with credible allegations of fraud, consisting of 11 providers paid by the State agency and 70 providers paid by Health Services. The State agency and Health Services determined these allegations of fraud to be credible and made formal referrals to the Fraud Control Unit between March 25, 2011, and September 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 conducted our audit from January 2014 to March 2015. We performed our fieldwork at the State agency's office and Health Services' office in Olympia, Washington.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the cooperative agreement between the State agency and Health Services;
- reviewed the MOU between the State agency, Health Services, and the Fraud Control Unit;
- interviewed State agency and Health Services officials and reviewed applicable policies and procedures to gain an understanding of their practices;
- reviewed the annual Medicaid payment suspension reports that the State agency submitted to CMS for FFYs 2011 and 2012;
- reviewed the State agency's and Health Services' case files for 81 providers with allegations of fraud that were determined to be credible (forwarded to the Fraud Control Unit between March 25, 2011, and September 30, 2013);
- compared the number of payment suspensions and good-cause exemptions in the annual Medicaid payment suspension reports for FFYs 2011 and 2012 with the number of providers that had allegations that were determined to be credible and whose case files were forwarded to the Fraud Control Unit;
- analyzed Medicaid payments made to the 81 providers by the State agency and Health Services between March 25, 2011 and February 28, 2014;

- determined the amounts of Medicaid payments made to the providers after the allegations of fraud were determined to be credible and calculated the Federal share of those payments; and
- shared the results of our review with State agency 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



STATE OF WASHINGTON  
**HEALTH CARE AUTHORITY**  
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

June 22, 2015

Lori A. Ahlstrant  
Regional Inspector General  
For Audit Services  
Office of the Inspector General  
90 – 7<sup>th</sup> Street, Suite 3-650  
San Francisco, CA 94103

Dear Ms. Ahlstrant:

**SUBJECT:   OIG Report Number A-09-14-02018 – Washington’s Suspension of Medicaid payments to Providers with Credible Allegations of Fraud**

The Washington State Health Care Authority (HCA) has received and reviewed the Office of Inspector General (OIG) Draft Report Number A-09-14-02018. This audit was conducted by the OIG to determine whether the HCA, the state agency in the state of Washington, suspended Medicaid payments to providers with credible allegations of fraud in accordance with the Affordable Care Act.

HCA is the single state agency in the State of Washington. Through an agreement with HCA, the Washington State Department of Social and Health Services (DSHS or “the Department”) administers, oversees and manages Medicaid’s long term care services. A portion of the responses below refer to DSHS service providers.

### **Summary**

Although HCA concurs with the OIG’s identification and recommendations related to short-term issues pertaining to the State’s early implementation of the payment suspension process, the HCA does not agree that any funds should be refunded to the federal government.

### **OIG Recommendations**

The following are the HCA’s response to each of the five recommendations:

#### **Recommendation 1**

We recommend that the State agency refund \$163,563 to the Federal Government.

*HCA’s response: The State does not concur.*

Lori A. Ahlstrant  
Regional Inspector General  
June 22, 2015  
Page 2

*A single case accounts for more than 99.5 percent of the federal share in question. In this instance, the Washington State Medicaid Fraud Control Unit (MFCU) recommended that the referral in question be declined and closed, which it was. The MFCU recommendation that the case be declined was written October 29, 2014, shortly after the OIG auditors were on site.*

*On June 10, 2015, the HCA forwarded to the OIG the MFCU recommendation that the referral in question be declined and closed. This document was also discussed with OIG auditors on June 15, 2015. The HCA acknowledges its responsibility for the delay in sending this key document to OIG.*

*Given the fact that MFCU declined to open a case, these funds should not be subject to recovery.*

*DSHS' response: The Department concurs with this recommendation with respect to the DSHS share of the refund amount. Of the \$163,563 amount identified, the Department's share, totaling \$794, will be returned through the established process.*

**Recommendation 2**

We recommend that the State agency follow its policies and procedures to ensure that it suspends Medicaid payments to providers when there are credible allegations of fraud.

*HCA's response: The State agency concurs.*

*In addition to the time required to first interpret these new rules, implementation required staffing, development of written procedures, internal business processes, correspondence templates, collaboration with Medicaid Management Information System (MMIS) staff, communication with programs with limited access, and ongoing close coordination with the MFCU.*

*Washington HCA now has policies and procedures in place.*

*In addition, the HCA has recently rewritten and implemented a new set of policies and procedures pertaining to payment suspensions (See OPI Policy and Procedure 5.3.0 and 5.3.1).*

*The State agency is following these policies and procedures.*

**Recommendation 3**

We recommend that the State agency ensure that Health Services has adequate policies and procedures to suspend Medicaid payments to providers when there are credible allegations of fraud.

Lori A. Ahlstrant  
Regional Inspector General  
June 22, 2015  
Page 3

*DSHS's response: The Department concurs with this recommendation and initiated a Payment Suspension Workgroup project in March 2015, with statewide representation from both the Aging and Long Term Support Administration and the Developmental Disabilities Administration. Project deliverables include a statewide payment suspension policy, a revised provider fraud referral form designed to meet Centers for Medicare and Medicaid Services (CMS) Performance Standards, state regulation revision suggestions, and an agency staff training plan. Workgroup project progress is on target for implementation by January 2016. The Department is currently following federal requirements of the CFR with respect to all credible allegations of fraud.*

**Recommendation 4**

We recommend that the State agency follow its policies and procedures to ensure that it reports to CMS summary information on good-cause exemptions.

*HCA's response: The State agency concurs. We are currently reporting to CMS summary information on good-cause exemptions. We will add this information to our current payment suspension policy with a target completion date of July 2015.*

**Recommendation 5**

We recommend that the State agency strengthen its policies and procedures by including a responsibility to report Health Services' summary information on payment suspensions.”

*HCA's response: The State agency concurs. We are currently reporting Health Care Authority and DSHS summary information on payment suspensions to CMS. We will work with DSHS to include policies and procedures in our current payment suspension policy that include this responsibility. Target completion date is July 2015.*

*DSHS's response: The Department concurs with this recommendation. Department staff has collaborated with HCA to determine the required data, and has provided this data for reporting payment suspensions to CMS for the current and last two fiscal year periods.*

Should you have any additional questions, please feel free to contact me by telephone at 360-725-1523 or via email at [dorothy.teeter@hca.wa.gov](mailto:dorothy.teeter@hca.wa.gov).

Sincerely,

Dorothy F. Teeter, MHA  
Director

cc: MaryAnne Lindeblad, Medicaid Director, HCA