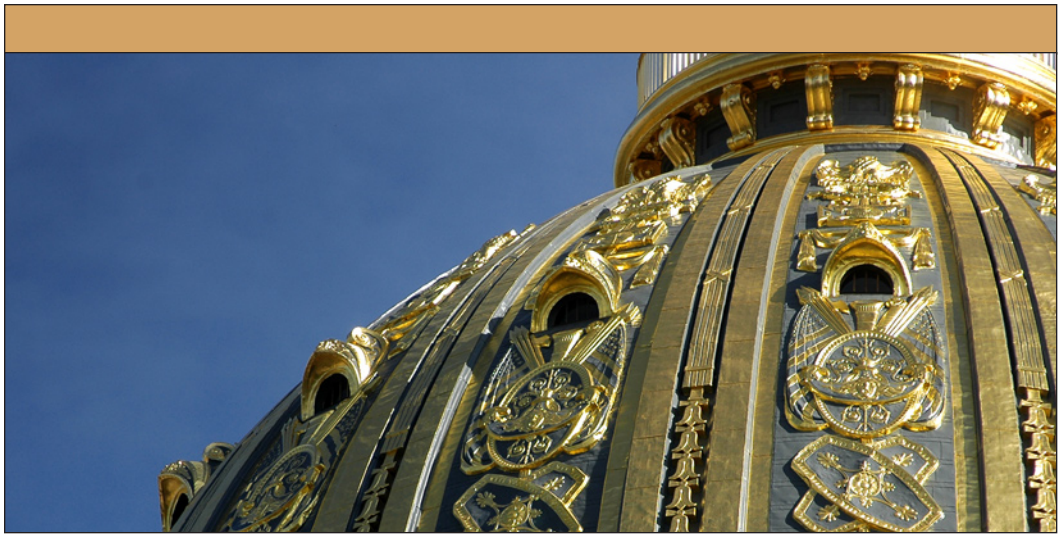

October 2013
PE 13-08-544

AGENCY REVIEW

BUREAU FOR MEDICAL SERVICES
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

AUDIT OVERVIEW

The Bureau for Medical Services Needs to Improve Its Adherence to Federal Regulations in Order to Eliminate the Risk of Losing Federal Financial Participation Matching Funds on Amounts Paid to Providers

WEST VIRGINIA LEGISLATIVE AUDITOR
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CONTENTS

EXECUTIVE SUMMARY

As part of the 2012 Agency Review of the Department of Health and Human Resources (DHHR), pursuant to Chapter 4, Article 10, Section 8 of the *West Virginia Code,* the Legislative Auditor conducted a performance review of the Bureau for Medical Services, Office of Quality and Program Integrity.

Report Highlights

Issue 1: The Bureau for Medical Services Needs to Improve Its Adherence to Federal Regulations In Order to Eliminate the Risk of Losing Federal Financial Participation Matching Funds on Amounts Paid to Providers.

- Federal and state policy require suspension of payment to Medicaid providers with credible allegations of fraud.
- After a review of referrals since March 25, 2011, the Legislative Auditor determined the State does not suspend payments in the cases that have been referred to the Medicaid Fraud Control Unit (MFCU), and the federal Centers for Medicare and Medicaid Services (CMS) also cited in January 2013 that the Office of Quality and Program Integrity (OQPI) was not suspending payments to providers when it referred a case to the MFCU.
- The Affordable Care Act indicates that any state not suspending payments to providers whose investigations are pending is at risk of losing its Federal Financial Participation funding on the amounts paid to the providers that should have been suspended.
- The Legislative Auditor requested a legal opinion regarding the federal language which substantiated the Legislative Auditor's finding that suspension of payments has not been occurring properly.

PERD's Evaluation of the Agency's Written Response

The Office of the Legislative Auditor's Performance Evaluation and Research Division received the Department of Health and Human Resources response on October 16, 2013. The agency response can be found in Appendix E. The DHHR did not concur with the findings and recommendation 1 of this report. However, the agency concurs with recommendation 2. The DHHR does not agree with the legal opinion as to when BMS must suspend payments. The BMS contends that the analysis of the legal opinion is not consistent with the plain language of the regulations as well as subsequent conversations with CMS on this issue. It is the DHHR's position that the BMS has two options in which to refer a file to the MFCU. The DHHR contends that in one option, which falls under *C.F.R. §455.15,* BMS can refer cases to MFCU without a credible allegation of fraud because by definition this referral is when the agency has "*...reason to believe an incident of fraud or abuse has occurred in the Medicaid program....*" DHHR indicates that this definition does not discuss a credible allegation of fraud, nor suspension of payments, therefore provider suspension payment does not have to occur. However, under 42 C.F.R §455.23(d), which discusses payment suspension, it can refer a file to the MFCU when there is a credible allegation of fraud which then warrants a suspension

of payment. The DHHR also reported that the BMS raised this issue with the CMS, and requested a formal opinion from CMS. To date, the CMS has not responded in writing.

The Legislative Auditor does not agree with the agency response. The Legislative Auditor requested a legal opinion for clarification on when must the BMS or the OQPI suspend payments to Medicaid providers. According to the legal opinion, once the OQPI conducts a preliminary review of a complaint, from any source, pursuant to 42 C.F.R. §455.14 and determines there is sufficient basis to warrant a full investigation pursuant to §455.15, then by definition it becomes a credible allegation of fraud. Also, an Informational Bulletin produced by the CMS indicates that a payment suspension is triggered when the State determines that an allegation of fraud is in fact credible and refers the matter to its MFCU. The Legislative Auditor also noted the January 2013 CMS Comprehensive Program Integrity Review of West Virginia's Program Integrity Office found the unit was not complying with Federal regulations regarding suspension of payment in cases involving credible allegations of fraud. The CMS recommended that the BMS develop and implement policies and procedures to suspend payments to providers immediately upon referral to the MFCU when an investigation determines that a credible allegation of fraud exists, or provide written documentation of a good cause exception not to suspend.

Recommendations

1. *The Legislative Auditor recommends that in order to comply with C.F.R. §455.23, once a referral has been made to the MFCU by the OQPI, the BMS should suspend further payments to the provider until the investigation of the file is complete or a good cause exception has been initiated by MFCU or the State.*

2. *The Legislative Auditor recommends that if after five days the OQPI's Office Director has not received a notice to not suspend by the MFCU, the OQPI's Office Director shall submit the suspension notice directly to the provider.*

ISSUE1

The Bureau for Medical Services Needs to Improve Its Adherence to Federal Regulations in Order to Eliminate the Risk of Losing Federal Financial Participation Matching Funds on Amounts Paid to Providers.

The West Virginia Bureau for Medical Services (BMS) is not adhering to the 2011 amendment of the Affordable Care Act (ACA) that requires a suspension of Medicaid payment to a provider once the Medicaid agency determines an allegation of fraud is credible and refers the case to the Medicaid Fraud Control Unit (MFCU).

Issue Summary

The West Virginia Bureau for Medical Services (BMS) is not adhering to the 2011 amendment of the Affordable Care Act (ACA) that requires a suspension of Medicaid payment to a provider once the Medicaid agency determines an allegation of fraud is credible and refers the case to the Medicaid Fraud Control Unit (MFCU). Also, according to the ACA, if the state Medicaid Agency, which is BMS, is not adhering to this regulation it is at risk of losing its Federal Financial Participation on the amounts paid to providers whose investigation is pending. The Federal Financial Participation funding (FFP) is defined as the portion paid by the Federal government to states for their share of expenditures for providing Medicaid services, administering the Medicaid program, and certain other human service programs. The FFP for fiscal year 2013 in West Virginia was 72 percent. The Legislative Auditor recommends that BMS comply with the ACA and federal language regarding the suspension of payments to providers after a referral has been made to the MFCU by the Office of Quality and Program Integrity (OQPI).

Federal and State Policy Requires Suspension of Payment to Providers with Credible Allegations of Fraud

According to the ACA, if the state Medicaid Agency, which is BMS, is not adhering to this regulation it is at risk of losing its Federal Financial Participation on the amounts paid to providers whose investigation is pending.

The ACA passed by the United States Congress and signed into law on March 23, 2010, established new provisions and guidelines for states' program integrity units. One such provision included the suspension of Medicaid payments to providers after the Medicaid agency determines there is a credible allegation of fraud for which an investigation is pending. Under 42 C.F.R. §455.23 state Medicaid Agencies "*...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 payments only in part."* In accordance with the new Federal regulations, the DHHR Provider Manual, Chapter 800(B), Section 10, now has a policy that requires the suspension of payment to a provider after the agency determines there is a credible allegation of fraud. Theoretically, every referral made to the MFCU from the OQPI is made due to a credible allegation of fraud. According to the DHHR's Provider Manual, Chapter 800(B), Section 3.4, "*OQPI investigates each case to determine if there is a credible*

allegation of fraud, waste, or abuse. If it is a credible allegation of fraud, waste, or abuse, the complaint is referred to the West Virginia Office of the Inspector General Medicaid Fraud Control Unit (MFCU)."

According to 42 C.F.R. § 455.23(a) (2), the suspension of Medicaid payment to a provider can actually begin "*...without first notifying the provider of its intention to suspend such payments."* In an effort to clarify this issue, the United States Centers for Medicare and Medicaid Services (CMS) produced an Information Bulletin, dated March 25, 2011, that was intended to provide guidance regarding the implementation of the revised federal mandate. When asked the question of when is a payment suspension triggered under ACA Section 6402 (h)(2), the CMS responded by stating, "*A payment of suspension is triggered when the State determines that an allegation of fraud is in fact credible and refers the matter to its MFCU or other law enforcement agency for investigation in accordance with 42 C.F.R. § 455.15."* Therefore, suspension of payment can be triggered by the state Medicaid Agency or with a referral to the MFCU.

When asked the question of when is a payment suspension triggered under ACA Section 6402 (h)(2), the CMS responded by stating, "A payment of suspension is triggered when the State determines that an allegation of fraud is in fact credible and refers the matter to its MFCU or other law enforcement agency for investigation in accordance with 42 C.F.R. § 455.15."

The term "credible allegation of fraud", according to CMS, may be "*...an allegation that has been verified by a State and that has indicia of reliability that comes from any source."* The allegation can come from any source, such as a fraud hotline, claims data mining, patterns indentified through provider audits or from law enforcement investigations. According to CMS, 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 in accordance with CMS' performance standards for suspected fraud referrals."*

The term "credible allegation of fraud", according to CMS, may be "… an allegation that has been verified by a State and that has indicia of reliability that comes from any source."

Once a file is referred to MFCU, the state Medicaid agency is required to notify the provider of the suspension of payment. According to C.F.R. §455.23 (b) (i) the state Medicaid agency must send notice of suspension of program payments within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold such notice. According to the BMS, "*BMS would be responsible for sending the notifications."* Either the MFCU or the state Medicaid agency has the discretion to issue a good cause exception during the course of the investigation that would discontinue an existing payment suspension in whole or in part, to an provider despite the pending investigation. If not, the suspension may continue until the investigation by the MFCU or any associated enforcement proceedings are complete.

Either the MFCU or the state Medicaid agency has the discretion to issue a good cause exception during the course of the investigation that would discontinue an existing payment suspension in whole or in part, to an provider despite the pending investigation.

The State Does Not Suspend Payments in Cases of Allegations of Fraud

The Legislative Auditor requested from the MFCU all of the cases referred from the OQPI to the MFCU from March 25, 2011, the effective date of the final rule directing states to suspend Medicaid payments based on pending investigations of credible allegations of fraud until May 2013 (see Appendix C). The BMS was asked to include the referral number, the date OQPI referred the case to the MFCU, the referral closure date, the case number, the current status, the date the OQPI was asked not to suspend future payments to the provider and the date when a notice to suspend payments was sent to the provider. Once a referral is made to the MFCU from the OQPI, the MFCU investigator must conduct an initial inquiry to determine whether the referral should be converted to a case and further reviewed or closed, if it is deemed to not be a fraudulent act. The MFCU investigator is also required to inform the OQPI if a good cause exists not to suspend payments. According to the DHHR's Provider Manual 800 (B), Section 10, within five days after the referral to the MFCU, either the MFCU or the BMS' Legal Department must recommend to the OQPI Office Director for a good cause exception to not suspend payment, or to suspend payment only in part. If either recommends a good cause exception, the suspension will not be placed at that time. The Legislative Auditor also met with the Director of the MFCU to review each of the files in question.

After review of 65 referrals made by the OQPI since the effective date of the final rule, March 25, 2011, 24 cases have yet to be initially evaluated by an MFCU investigator. Two of the 24 cases are over two years old.

After review of 65 referrals made by the OQPI since the effective date of the final rule, March 25, 2011, 24 cases have yet to be initially evaluated by an MFCU investigator. Two of the 24 cases are over two years old. **By not initially investigating cases in a timely manner, the MFCU is taking a risk of allowing potentially fraudulent activities to continue.** BMS documented seven cases in which the OQPI had been notified by the MFCU not to initiate the suspension of payments. However, with regards to the remaining 58 cases there was no documentation by BMS that OQPI was notified by the MFCU not to initiate suspension of payment by a good cause exception. Therefore, if proper protocol was followed, and the OQPI was not notified that there was a good cause exception not to suspend payments within five business days, a suspension of payment should have been initiated by BMS. According to C.F.R. §455.23 (b) (ii) the law enforcement, or in this case the MFCU, may request the state Medicaid agency to delay the written notice of suspension of payment for up to 90 days. When asked if the MFCU has requested a delay in sending the written notice of suspension, the Director reported "*…MFCU has never requested QPI to delay notice of suspension."*

BMS documented seven cases in which the OQPI had been notified by the MFCU not to initiate the suspension of payments. However, with regards to the remaining 58 cases there was no documentation by BMS that OQPI was notified by the MFCU not to initiate suspension of payment by a good cause exception.

When initially asked if there were any suspension letters sent in regards to the referrals in Appendix C, BMS reported, "*None of the referenced referrals resulted in a suspension notification being sent to*

the provider." The BMS followed up again with the PERD and reported that there are two separate and distinct referrals from the state Medicaid Agency to MFCU. According to the BMS, in one instance there does not have to be a credible allegation of fraud finding by a state Medicaid Agency to exist prior to a referral to MFCU. BMS utilized 42 C.F.R. § 455.14 for its deduction, and reported "*...if a State Medicaid Agency receives a complaint of Medicaid fraud from any source it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. If the preliminary investigation gives the State Medicaid Agency reason to believe fraud or abuse has occurred then, in WV, a referral must be made to MFCU. 42 C.F.R. § 455.15. These regulations do not discuss a credible allegation of fraud, nor suspension of payments."*

The PERD requested a legal opinion from Legislative Services to clarify the BMS' claims. According to the legal opinion, "It is the contention of BMS that because the section of regulation requiring a referral of suspected fraud to the MFCU does not contain language referring to "credible allegations of fraud" or "suspension of payments" that such suspension are not required simply because a referral to MFCU was made. This is not the case."

The CMS has pointed out that credible allegations of fraud can come from any source and a referral is made to MFCU when the State verifies the allegation of fraud exists. Once the referral is made to MFCU, the suspension of payment is "*...triggered*...." The PERD requested a legal opinion from Legislative Services (see Appendix D) to clarify the BMS' claims. According to the legal opinion, "*It is the contention of BMS that because the section of regulation requiring a referral of suspected fraud to the MFCU does not contain language referring to "credible allegations of fraud" or "suspension of payments" that such suspension are not required simply because a referral to MFCU was made. This is not the case."* In the cases since March 25, 2011, BMS did not suspend payment to a provider immediately upon referral to the MFCU 58 times; therefore, BMS has not adhered to a federal law and the DHHR Provider Manual 58 times. **In order to comply with C.F.R. §455.23, once a referral has been made to the MFCU by the OQPI, the BMS should suspend further payments to the provider immediately, until the investigation of the file is complete or a good cause exception has been initiated by the MFCU or the State.**

In order to comply with C.F.R. §455.23, once a referral has been made to the MFCU by the OQPI, the BMS should suspend further payments to the provider immediately, until the investigation of the file is complete or a good cause exception has been initiated by the MFCU or the State.

Currently, according to C.F.R. §455.23 and the DHHR Provider Manual, Chapter 800(B), Section 10, once the OQPI submits the referral to the MFCU, its only remaining role is to wait on the good cause exception to inform the BMS not initiate suspension of provider payment or to delay the written notice of suspension. It is then the BMS' role to notify the provider of payment suspension. It is the Legislative Auditor's opinion that since the OQPI is the agency that submits the referral and the agency which has immediate knowledge of the referral, it should play a larger role in submitting the suspension letter to providers. **Therefore, it is the Legislative Auditor's opinion that if after five days OQPI's Office Director has not received a notice to not suspend by MFCU, OQPI's Office Director should submit the suspension notice directly to the provider**.

BMS Is at Risk of Losing Its Federal Financial Participation on Amounts Paid to Providers Whose Investigations Are Pending

In section 6402(h)(2) of the Patient Protection and the ACA, Congress amended section 1903(i)(2) of the Social Security Act to provide that FFP in the Medicaid program "*...shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is a pending investigation of a credible allegation of fraud against an individual or entity as determined by the State, unless the State determines in accordance with the federal regulations that good cause exists not to suspend payments."* Therefore, as of March 25, 2011, those states which do not conform to suspending payments to providers after the State determines that an allegation of fraud exists and refers the case to MFCU, are at risk of losing its FFP on amounts paid to those providers who continue to serve Medicaid recipients during the pendency of an investigation for a credible allegation of fraud.

Therefore, as of March 25, 2011, those states which do not conform to suspending payments to providers after the State determines that an allegation of fraud exists and refers the case to MFCU, are at risk of losing its FFP on amounts paid to those providers who continue to serve Medicaid recipients during the pendency of an investigation for a credible allegation of fraud.

CMS has been conducting comprehensive program integrity reviews since 2008. CMS has reported that it will "*…monitor the States' implementation of the Medicaid payment suspension rule through various documentation requirements and State program integrity reviews, to ensure that there are no marked shortcomings with regard to State's processes."* Also, according to C.F.R. §455.23 (g) (2) (i) the state Medicaid agency must maintain for a minimum of five years from the date of issuance each instance when a payment of suspension is not imposed, imposed only in part, or discontinued for good cause. The state Medicaid agency is also required to annually report to the United States Secretary of Health and Human Services each suspension of payment, the basis of the suspension and the outcome as well as the situation in which the State determined good cause existed not to suspend payment.

According to C.F.R. §455.23 (d) (3) (i) if the MFCU or other law enforcement agencies accepts the fraud referral for investigation, the payment suspension may be continued until such time as the investigation is completed. In review of the files referred by the OQPI to the MFCU since March 25, 2011(see Appendix C), there are 36 files that were closed due to the MFCU completing the investigation, but 15 of those took one year or longer to complete the MFCU investigation. Therefore, it is a concern of the Legislative Auditor that BMS is at risk of losing its FFP on the amounts paid to the providers who continue to serve Medicaid recipients during the pendency of their investigation.

In review of the files referred by the OQPI to the MFCU since March 25, 2011(see Appendix C), there are 36 files that were closed due to the MFCU completing the investigation, but 15 of those took one year or longer to complete the MFCU investigation.

Conclusion

The CMS revised its regulations to conform to the amended section of the Patient Protection and Affordable Care Act on February 2, 2011. The regulations included a suspension of payment to a provider after a Medicaid agency determines a credible allegation of fraud exists for which an investigation is pending. The PERD reviewed documentation since the effective date of the rule and found the BMS to not be in compliance. The BMS reported its justification for not suspending payments to providers, but it is the PERD's opinion that this is invalid. In fact, in the January 2013 Comprehensive Program Integrity Review by the CMS, the BMS was cited as not suspending payments in cases of credible allegation of fraud. According to the CMS, "*From March 25, 2011 to the date of the onsite visit, West Virginia referred eight cases to the MFCU without making a timely suspension of payments or providing written justification for non-suspension based on exception criteria in the regulation."* The CMS recommended to the BMS to develop and implement policies and procedures to suspend payments to providers "*... immediately upon referral to the MFCU when an investigation determines a credible allegation of fraud exits, or provide written documentation of a good cause exception not to suspend."* If the BMS does not follow the federal mandate, it runs the risk of losing FFP matching funds for cases that should have had payments suspended.

In fact, in the January 2013 Comprehensive Program Integrity Review by the CMS, the BMS was cited as not suspending payments in cases of credible allegation of fraud. According to the CMS, "From March 25, 2011 to the date of the onsite visit, West Virginia referred eight cases to the MFCU without making a timely suspension of payments or providing written justification for non-suspension based on exception criteria in the regulation."

Recommendations:

1. *The Legislative Auditor recommends that in order to comply with C.F.R. §455.23, once a referral has been made to the MFCU by the OQPI, the BMS should suspend further payments to the provider until the investigation of the file is complete or a good cause exception has been initiated by MFCU or the State.*

2. *The Legislative Auditor recommends that if after five days the OQPI's Office Director has not received a notice to not suspend by the MFCU, the OQPI's Office Director shall submit the suspension notice directly to the provider.*

Appendix A
Transmittal Letter

WEST VIRGINIA LEGISLATURE
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John Sylvia
Director

October 8, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Services
One Davis Square, Suite 100 East
Charleston, WV 25301

Dear Secretary Bowling:

This is to transmit a draft copy of the Performance Review of the Bureau for Medical Services, Office of Quality and Program Integrity. This report is scheduled to be presented during the October 21-23 interim meetings of the Joint Committee on Government Operations, and the Joint Committee on Government Organization. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committees may have.

We need to schedule an exit conference to discuss any concerns you may have with the report. We would like to have the meeting on Friday, October 11, 2013. Please notify us to schedule an exact time. In addition, we need your written response by noon on Wednesday, October 16th in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, October 17th to make arrangements.

We request that your personnel not disclose the report to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

Enclosure

Joint Committee on Government and Finance

Appendix B
Objective, Scope and Methodolgy

The Performance Evaluation and Research Division (PERD) within the Office of the Legislative Auditor conducted this performance review of the Bureau for Medical Services (BMS) as part of the Agency Review of the Department of Health and Human Services, as required and authorized by the West Virginia Performance Review Act, Chapter 4, Article 10, of the *West Virginia Code §9-2-4,* as amended. The purpose of the Bureau for Medical Services is to administer the Medicaid Program while maintaining accountability for the use of resources in a way that assures access to appropriate, medically necessary health care services for all members.

Objective

The objective of this review is to determine if the BMS is adhering to the recent changes to the Affordable Care Act (ACA) in regard to suspension of payments for credible allegations of fraud.

Scope

The scope of this review consisted of referrals made to the Medicaid Fraud Control Unit by the OQPI since March 25, 2011, the effective date of the changes to the ACA, until May 14, 2013, and to what extent the federal regulations have been adhered to by BMS in regard to suspension of payments for credible allegations of fraud.

Methodology

PERD gathered and analyzed several sources of information and conducted audit procedures to assess the sufficiency and appropriateness of the information used as audit evidence. The information gathered and audit procedures are described below.

This report contains information provided to the Legislative Auditor from BMS and the MFCU regarding the case status of referrals made to the MFCU by the OQPI from March 25, 2011 until May 14, 2013. To address audit risk, each referral made to the MFCU from the OQPI was reviewed for authenticity by the Legislative Auditor, who was accompanied by the MFCU Director. The referrals were used to determine if the BMS are adhering to the recent changes to the ACA which became effective beginning March 25, 2011. This report also utilized information from the United States Centers for Medicare and Medicaid Services (CMS) which detailed the most recent evaluation by the CMS of the West Virginia Program Integrity Unit. To address audit risk interpreting federal regulations, the Legislative Auditor requested a legal opinion of the West Virginia Legislative Services Legal Division for clarification of the federal language pertaining to the suspension of payments to a provider with credible allegations of fraud.

This performance review was conducted in accordance with generally accepted government auditing standards. These standards require that the audit is planned and performed to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. The Legislative Auditor believes that the evidence obtained provides a reasonable basis for the report's findings and conclusions based on the audit objectives.

Appendix C
Referrals from OQPI to MFCU March 2011 Through May 2013

Referrals from OQPI to MFCU March 2011 Through May 2013					
Referral Number	Complaint Date	Referral Close Date	Case #	Status	Date of Notice to OQPI Not to Suspend
11-0034R	3/31/2011	5/7/2012			
11-0043R	4/15/2011	5/21/2013			
11-0046R	4/15/2011				
11-0048R	4/15/2011	8/3/2011	11-F-HOM-003	Open	
11-0157R	4/15/2011	6/27/2013			
11-0184R	4/15/2011	6/27/2013			
11-0071R	5/9/2011	6/27/2013			
11-0086R	5/19/2011	5/21/2013			
11-0077R	5/20/2011				
11-0089R	5/23/2011	5/21/2013			
11-0105R	6/27/2011	5/21/2013			
11-0158R	7/18/2011	11/14/2011	11-F-LAB-001	Open	9/5/2012
11-0155R	8/12/2011	4/18/2012	11-F-DOC-004	Open	9/5/2012
11-0235R	9/22/2011	5/21/2013			
11-0247R	10/19/2011				
11-0261R	10/21/2011	6/27/2013			
11-0254R	11/4/2011				9/5/2012
11-0263R	11/7/2011				
11-0245R	11/8/2011	6/27/2013			
11-0255R	11/21/2011	4/17/2012	12-F-HOM-006	Open	
12-0029R	1/10/2012				
12-0008R	1/17/2012	6/27/2013			
12-0140R	1/26/2012	7/16/2013			
12-0030R	1/27/2012	7/8/2013			
12-0031R	2/21/2012	7/8/2013			
12-0067R	3/26/2012	10/18/2012	12-F-HOM-017	Open	
12-0166R	3/26/2012	10/25/2012			
12-0073R	4/11/2012	6/28/2012			
12-0090R	5/2/2012				
12-0112R	5/14/2012				
12-0076R	5/15/2012	5/16/2012			
12-0077R	5/15/2012	2/15/2013			
12-0092R	5/17/2012				
12-0093R	5/17/2012				
12-0091R	5/18/2012				
12-0096R	5/18/2012				
12-0110R	5/30/2012				

Referrals from OQPI to MFCU March 2011 Through May 2013					
Referral Number	Complaint Date	Referral Close Date	Case #	Status	Date of Notice to OQPI Not to Suspend
12-0108R	6/1/2012				
12-0095R	6/7/2012				
12-0133R	6/18/2012	2/22/2013			
12-0145R	7/6/2012				
12-0116R	7/17/2012	2/15/2013			
12-0131R	7/31/2012	2/15/2013			
12-0196R	8/2/2012	4/23/2013			
12-0165R	8/8/2012	10/15/2012	12-F-HOM-016	Open	
12-0158R	8/15/2012				
12-0156R	8/17/2012	12/20/2012	12-F-HOM-020	Open	
12-0154R	8/22/2012	4/10/2013			
12-0161R	8/31/2012	9/6/2012			
12-0181R	9/28/2012				
12-0210R	10/1/2012				
12-0219R	10/1/2012				
12-0221R	10/3/2012	4/10/2013	13-F-HOM-003	Open	
12-0184R	10/3/2012	5/16/2013	13-F-HOM-005	Closed	
13-0001R	1/8/2013				1/11/2013
13-0020R	2/5/2013	3/6/2013			
13-0039R	2/26/2013				3/1/2013
13-0041R	3/8/2013				3/22/2013
13-0053R	4/4/2013				
13-0049R	4/8/2013				
13-0050R	4/9/2013				
13-0051R	4/17/2013				
13-0052R	4/19/2013				
13-0054R	5/7/2013				5/7/2013
13-0057R	5/14/2013	5/14/2013			

Source: West Virginia Bureau for Medical Services and the Medicaid Fraud Control Unit.

Appendix D
Legislative Services Legal Opinion

To: Brian Armentrout, Research Manager, Performance Evaluation and Research Division

From: Brandon Burton, Senior Research Analyst
Maureen Robinson, Attorney, Legislative Services

Subject: BMS and Suspension of Payments

Date: October 1, 2013

You have asked:

1. When must BMS or OQPI suspend payments to Medicaid providers to fulfill the requirements of Title 42 C.F.R. 455?

2. What are the potential ramifications if BMS does not follow the Federal Guidelines of suspension of payment?

1. Suspension of Payments by OQPI

Prior to the passage of the Affordable Care Act (ACA) State Medicaid agencies (BMS in West Virginia) had the permissive authority to suspend payments in cases of alleged fraud. Section 6402(h)(2) of the ACA now mandates that states not receive FFP in cases where they fail to suspend Medicaid payments during any period when there is "pending an investigation of a credible allegation of fraud against an individual or entity as determined by the State" unless the State determines good cause exists not to suspend such payments.

To implement Section 6402(h)(2) of the ACA, 42 C.F.R. §455.23(a)(1) was modified to state that:

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 not to suspend payments or to suspend payments only in part.

According to the Provider Manual published by the West Virginia Department of Health and Human Resources, The Office of Quality and Program Integrity (OQPI) "is charged with meeting the requirements set forth in: Title 42 C.F.R Section 455.1 Program Integrity: Medicaid – Requirements."[1] As such, Federal Regulations state that OQPI "must conduct a preliminary investigation" into every "complaint of Medicaid fraud or abuse from any source."[2] "If the findings of the preliminary investigation" by OQPI "give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must" "refer the case to the [State Medicaid fraud control] unit."[3]

It is the contention of BMS that because the section of regulation requiring a referral of suspected fraud to the MFCU does not contain language referring to "credible allegations of fraud" or "suspension of payments" that such suspension are not required simply because a referral to MFCU was made. This is not the case.

[1] *Department of Health and Human Resources, Provider Manual 800(B): Office of Program Integrity §800.2, page 4 (Dec. 1, 2012)*
[2] *42 C.F.R. §455.14*
[3] *42 C.F.R. §455.15(a)(1)*

"Credible allegation of fraud" is defined by federal regulation as an "allegation, which has been verified by the State, from any source."[4] The source of these allegations may include, but are not limited to:

> *(1) fraud hotline complaints, (2) claims data mining, (3) patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered credible when they have indicia of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.*

42 CFR §455.2.

Once OQPI conducts a preliminary review of a complaint, from any source, pursuant to 42 C.F.R. §455.14 and determines there is sufficient basis to warrant a full investigation pursuant to §455.15, then by definition it becomes a "credible allegation of fraud."

The Center for Medicare & Medicaid Services (CMS) clarified in the Federal Register published along with the update to 42 C.F.R. §455 (2011), that it was their belief "that State agency investigations, though they may be preliminary in the sense that they lead to a referral to a law enforcement agency [or MFCU] for continued investigation, are adequate vehicles by which it may be determined that a credible allegation of fraud exists sufficient to trigger a payment suspension to protect Medicaid funds."[5] Furthermore, an Informational Bulletin produced by CMS states that "a payment suspension is triggered when the State determines that an allegation of fraud is in fact credible and refers the matter to its MFCU . . . for investigation in accordance with 42 C.F.R. §455.15."[6]

In January 2013, CMS conducted a Comprehensive Program Integrity Review of West Virginia's Medicaid program and found eight instances of regulatory non-compliance within BMS which pose a significant risk to West Virginia's Medicaid Program. Ranked top among those issues was "not complying with Federal regulations regarding suspension of payment in cases involving credible allegations of fraud."[7] It was the recommendation of CMS that BMS "develop and implement policies and procedures to suspend payments to providers immediately upon referral to the MFCU when an investigation determines that a credible allegation of fraud exists, or provide written documentation of a good cause exception not to suspend."[8]

Thus, Federal law requires that BMS or OQPI suspend all Medicaid payments to a provider after the agency has referred a matter to the MFCU, in accordance with 42 C.F.R. §455.15, unless the agency documents a good cause not to suspend payments or to suspend payments only in party.

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[4] *42 C.F.R. § 455.2.*

[5] *"Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers," 76 F.R. 20 (February 2, 2011) p. 5932*

[6] *Department of Health and Human Services, CPI – CMCS Informational Bulletin, CPI-B 11-04, Frequently Asked Questions – Affordable Care Act Section 6402(h)(2), p4 (March 25, 2011)*

[7] *West Virginia Comprehensive Program Integrity Final Report, p. 4 (January 2013)*

[8] *Id. at pp.4-5 (emphasis added)*

2. Ramifications for not Suspending Payment

The ACA dictates that where there is a pending investigation of credible allegations of fraud against a provider, a State that fails to suspend payments to the provider will not receive FFP with respect to such payments unless good cause exists not to suspend them.[9]

[9] *"Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers," 76 F.R. 20 (February 2, 2011) p. 5932*

Appendix E
Agency Response

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Medical Services
Commissioner's Office
350 Capitol Street – Room 251
Charleston, West Virginia 25301-3706
Telephone: (304) 558-1700 Fax: (304) 558-1451

Karen L. Bowling
Cabinet Secretary

October 16, 2013

Mr. John Sylvia, Director
West Virginia Performance Evaluation and Research Division
Office of the Legislative Auditor
Building 1, Room W-314, State Capitol Complex
Charleston, West Virginia 25305-0610

RE: Medicaid ACA Compliance with certain ACA Provisions

Dear Mr. Sylvia:

The West Virginia Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) has received and reviewed the draft report regarding program compliance with certain program integrity provisions of the Affordable Care Act (ACA) submitted to our office on October 8, 2013. The BMS offers the following as formal response to the recommendations contained in the draft report:

1. The Legislative Auditor recommends that in order to comply with C.F.R 455.23, once a referral has been made to the MFCU by the OQPI, the BMS should suspend further payments to the provider until the investigation of the file is complete or a good cause exception has been initiated by MFCU or the State.

   The DHHR does not concur with this recommendation. While the Legislative Auditor submitted a Legal Opinion as to when BMS must suspend payments, that analysis is not consistent with the plain language of the regulations as well as subsequent conversations with CMS on this issue.

   As stated in the report, *42 C.F.R. §455.14* mandates that BMS conduct a preliminary investigation when it receives a complaint of Medicaid fraud or abuse from any source or BMS itself identifies questionable practices. The purpose of the preliminary investigation is to determine whether a full investigation is warranted. *42 C.F.R. §455.14.*

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October 16, 2013
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According to the Legislative Auditor's analysis "[o]nce OQPI conducts a preliminary review of a complaint, from any source, pursuant to *42 C.F.R. §455.14* and determines there is a sufficient basis to warrant a full investigation, then by definition it becomes a 'credible allegation of fraud'." This is incorrect.

A referral to MFCU for a "credible allegation of fraud" is not pursuant to *42 C.F.R. §455.15*. Rather, it is pursuant to *42 C.F.R. 455.23(d)*.

Specifically, *42 C.F.R. §455.23(d) Referrals to the Medicaid fraud control unit* states:

(1) Whenever a State Medicaid 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 . . .

42 C.F.R. §455.23(d)

Thus, contrary to the Legislative Auditor's analysis, BMS does not make a referral to MFCU for a "credible allegation of fraud" pursuant to 42 C.F.R. §455.15. Instead the referral, pursuant to Federal Regulations, is mandated by 42 C.F.R. §455.23(d). The Legislative Auditor does not even address 42 C.F.R. §455.23(d) in its report.

The end result of this analysis is BMS can refer cases to MFCU under 42 C.F.R. §455.15, which by definition is "a reason to believe an incident of fraud or abuse has occurred" or under 42 C.F.R. §455.23(d which is the heightened "credible allegation of fraud" and suspension of payment standard.

On September 3, 2013, BMS raised this issue with the Centers for Medicare and Medicaid Services (CMS) and requested a formal opinion (See attached email). While CMS verbally informed BMS that a referral to MFCU under 42 C.F.R. §455.15 is not a credible allegation of fraud, to date, CMS has not responded in writing.

2. The Legislative Auditor recommends that if after five days the OQPI's Office Director has not received a notice not to suspend by the MFCU, the OQPI's Office Director shall submit the suspension notice directly to the provider.

John Sylvia
October 16, 2013
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The Department concurs with the legislative auditor's recommendation when a credible allegation of fraud is determined.

If you have additional questions or concerns, please feel free to contact Alva Page III at 304-558-1700.

Sincerely,

Nancy V. Atkins

Nancy Atkins, RN, MSN, NP-BC
Commissioner

NVA/tb

Attachment

Cc: Karen Bowling, Cabinet Secretary
Brian Cassis, Director, DHHR Office of Internal Control and Policy Development
Dave Bishop, Inspector General

Page, Alva F III

From:	Berman Sandler, Leatrice (CMS/CPI) <Leatrice.BermanSandler@cms.hhs.gov>
Sent:	Tuesday, September 03, 2013 12:49 PM
To:	Page, Alva F III
Cc:	Hypes, Tammy G; Winterfeld, Scott E; Truman, Joel S. (CMS/CPI); Fullen, Tonya (CMS/CPI)
Subject:	RE: Suspension of Payments

Thank you. We will take this request for a response up the chain (per our earlier phone conversation) and get back to you hopefully sooner than later. So please be patient with us. The only correction I want to add to our discussion of CMS policy is that State agencies can and do consult with MFCU's informally before formal referrals are made. State agencies need to be sensitive about the timeliness of such consultations but our FAQs, issued March 2011 (bottom of p.3 of 5) support the process of consultation as distinguished from formal referrals. I believe I shared this with you, but you are raising really another issue below.

Look forward to having you on the phone. This issue per se did not come up in our discussion of the WV's CAP and you have raised a new question related to payment suspension guidance, so we address your question in a more formal response. Please feel to raise questions, however, on the call today if this is something you want to raise and if we have time.

Leatrice Berman Sandler MA, JD / Medicaid Integrity Group (MIG) / Centers for Medicare & Medicaid Services 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 /Tele: 312.886.3597/ fax: 443-380-6556 / email: leatrice.bermansandler@cms.hhs.gov

From: Page, Alva F III [mailto:Alva.F.Page@wv.gov]
Sent: Tuesday, September 03, 2013 11:02 AM
To: Berman Sandler, Leatrice (CMS/CPI)
Cc: Hypes, Tammy G; Winterfeld, Scott E
Subject: Suspension of Payments

Ms. Sandler:

I am General Counsel to WV Medicaid and I had the pleasure of speaking with you around two (2) weeks ago regarding "credible allegations of fraud" and suspension of payments. It is my understanding, based on our conversation and CMS guidance, that *any* referral from a state Medicaid agency is considered a *de facto* "credible allegation of fraud" and, therefore, the state Medicaid agency must suspend payments unless MFCU invokes the law enforcement exception or the state Medicaid agency finds "good cause" not to suspend payments. For reasons set forth below, WV does not necessarily agree with this interpretation.

42 C.F.R. §455.14 mandates that if a state Medicaid agency "receives a complaint of Medicaid fraud or abuse" it *must* "conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation." If the findings of a preliminary investigation give the state Medicaid agency "reason to believe that an incident of fraud or abuse has occurred in the Medicaid program. . . " WV must refer it to WVMFCU. Thereafter, as you know, 42 C.F.R. §455.16 provides resolutions after the full investigation is completed.

With that, 42 C.F.R.§45.23(d) provides: *Referrals to the Medicaid fraud control unit*. (1) Whenever a State Medicaid agency investigation **leads** to the initiation of a payment suspension in whole or part, the State Medicaid must make a fraud referral to either of the following: (1) To a Medicaid fraud control unit established and certified under part 1007 of this title; or . . .

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A reasonable interpretation of the regulations clearly allows for two (2) separate "referrals" to a state MFCU. One for a full investigation and the second when the state Medicaid agency investigation leads to the "initiation of a payment suspension. . ."

Thank you for your attention to this matter. Should you have any questions or comments please do not hesitate to contact me.

Alva Page III Counsel
Bureau for Medical Services
PHONE: 304-356-4909

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