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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CPI – CMCS INFORMATIONAL BULLETIN

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SUBJECT: **Affordable Care Act Program Integrity Provisions - Guidance to States -- Section 6402(h)(2) - Suspension of Medicaid Payments Based Upon Pending Investigations of Credible Allegations of Fraud**

This Informational Bulletin is part of a series of bulletins intended to provide guidance regarding implementation of certain provisions of the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, together called the "Affordable Care Act." Specifically, this bulletin provides guidance on the following program integrity provision in the Affordable Care Act that was included in final regulations CMS-6028-FC, published on February 2, 2011:

- Section 6402(h) regarding suspension of payments pending an investigation of a credible allegation of fraud.

Suspension of Payments

Section 6402(h)(2) of the Affordable Care Act, Suspension of Medicaid Payments Pending Investigation of Credible Allegations of Fraud amends section 1903(i)(2) of the Social Security Act to provide that Federal Financial Participation (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 pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State, unless the State determines that good

cause exists not to suspend such payments. On February 2, 2011, CMS published the final rule implementing this provision, with an effective date of March 25, 2011. *See* http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf.

Good Cause Exceptions

There are several circumstances that, under the final rule, constitute "good cause" for a State to determine not to suspend payments, or to discontinue an existing payment suspension, to an individual or entity despite a pending investigation of a credible allegation of fraud. Good cause exceptions to terminate a whole payment suspension or impose a partial suspension generally include the following:

1. Specific requests by law enforcement that State officials not suspend (or continue to suspend) payment.
2. If a State determines that other available remedies implemented by the State could more effectively or quickly protect Medicaid funds than would implementing (or continuing) a payment suspension.
3. If a provider furnishes written evidence that persuades the State that a payment suspension should be terminated or imposed only in part.
4. A determination by the State agency that certain specific criteria are satisfied by which recipient access to items or services would otherwise be jeopardized.
5. A State may, at its discretion, discontinue an existing suspension to the extent law enforcement declines to cooperate in certifying that a matter continues to be under investigation and therefore warrants continuing the suspension.
6. A determination by the State agency that payment suspension (in whole or in part) is not in the best interests of the Medicaid program.
7. The credible allegation focuses solely on a specific type of claim or arises from only a specific business unit of a provider and the State determines that a suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.

Questions and Answers

Attached to this Informational Bulletin is operational guidance in the form of "Frequently Asked Questions" regarding 6402(h)(2) of the Affordable Care Act.

Thank you for your continued commitment to combating fraud, waste and abuse in the Medicaid and CHIP programs. We look forward to our continuing work together as we implement this important legislation. Questions regarding this information can be directed to Angela Brice-Smith at 410-786-4340 or via email at Angela.Brice-Smith@cms.hhs.gov.

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Frequently Asked Questions
Section 6402(h) of the Patient Protection and Affordable Care Act
March 2011

Section 6402(h)(2) of the Affordable Care Act, Suspension of Medicaid Payments Pending Investigation of Credible Allegations of Fraud amended section 1903(i)(2) of the Social Security Act to provide that Federal financial participation (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 pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State, unless the State determines that good cause exists not to suspend such payments. On February 2, 2011, CMS published its final rule implementing this provision. *See* http://edocket.access.gpo.gov/2011/pdf/2011-1686.pdf.

Q. What constitutes a "credible allegation of fraud"?

A. In the final rule, CMS provides certain bounds around the definition of "credible allegation of fraud" at 42 C.F.R. § 455.2. 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 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. However, a credible allegation of fraud, for example, could be a complaint made by an employee of a physician alleging that the physician is engaged in fraudulent billing practices, *i.e.*, the physician repeatedly bills for services at a higher level than is actually justified by the services rendered to beneficiaries. Upon State review of the physician's billings, the State may determine that the allegation has indicia of reliability and is, in fact, credible.

Q. What could be potential sources of credible allegations of fraud?

A. A credible allegation of fraud may be an allegation from any source, including but 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. We recognize that credible allegations may stem from a variety of sources.

Q. What should a State do when it receives an allegation of fraud?

A. A State must follow the requirements of 42 C.F.R. § 455.14 which describes preliminary investigations. States must also review all allegations, facts, and evidence carefully and act judiciously on a case-by-case basis. CMS recognizes that there may be mistaken or false reports of allegations of fraud. Due to the potential for false allegations, CMS encourages States to not solely rely on a

singular allegation without considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations.

Q. Once a State verifies an allegation of fraud, what should it do next?

A. A State 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 (https://www.cms.gov/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsstateagencytomfcu.pdf). In addition, a State is required to suspend payments for such provider unless the State has "good cause" not to suspend payments and follow the procedures required to analyze and/or document such good cause.

Q. If a MFCU declines to accept a referral from a State due to a lack of resources, but not because the MFCU thinks there is an insufficient credible allegation of fraud, what should a State do?

A. A State may refer the matter to another law enforcement agency that has capacity to accept the referral from the State agency. If the second referral is made, the payment suspension should continue. If not, the suspension should be ended.

Q. If a no law enforcement investigation is conducted due to lack of resources, is there any other way for the payment suspension to continue?

A. If no law enforcement agency accepts the referral, the State must immediately release the payment suspension unless the State has alternative Federal or State authority by which it may impose a suspension. In that case, the requirements of that alternative authority, including any notice and due process or other safeguards, will be applicable.

Q. If a MFCU accepts a fraud referral from the State but does not want the State to suspend payments because it may alert a provider to a pending investigation, what should the State do?

A. If law enforcement officials have specifically requested that a State not impose a payment suspension due to the fact that such suspension may compromise an existing investigation, this qualifies as good cause to not suspend under the final rule. The State should get this request in writing and include the request in its file for purpose of annual reporting to the Secretary.

Q. If a State receives an allegation regarding patient abuse, does the payment suspension rule apply?

A. Generally, patient abuse is outside the scope of the final rule, which requires a State to suspend payments based upon a pending investigation of a credible allegation of fraud. A State, however, is not precluded from taking other action against a provider in order to address the patient abuse allegation.

Q. What action can a State take if a provider argues that a total payment suspension is disproportionate to the scope of the alleged fraud?

A. Under the final rule, a State is permitted to impose just a partial payment suspension if it believes that there is good cause. For example, a provider may submit written evidence that is acceptable to the State that the payment suspension should be imposed only in part. In addition, if a State agrees with the provider and suspends only in part, a State must document the basis of the good cause for the partial suspension for its files and for purposes of reporting to the Secretary.

Q. When will States be expected to start initiating payment suspensions based upon pending investigations of credible allegations of fraud?

A. The effective date of the final rule directing States to suspend Medicaid payments based upon pending investigations of credible allegations of fraud is March 25, 2011. All MFCU referrals meeting the credible allegation requirement made prior to March 25 as well as all on or after that date, must have payments suspended unless there is good cause not to do so. We stated in the final rule: "We will not require States to retroactively apply the law regarding suspension of payments based on pending investigations of credible allegations of fraud. However, upon the effective date of this final rule with comment period, we expect States, to the extent they have not already done so, to suspend payments to providers against whom there exist pending investigations of credible allegations of fraud." (76 Fed. Reg. 5860, 5938).

Q. How can States mitigate any potential confusion between sharing intelligence about concerns regarding providers with their MFCUs and making formal referrals which necessitate a payment suspension?

A. CMS recognizes that States may need to consult and/or exchange information with their respective MFCUs prior to making a formal referral. We do not seek to limit or otherwise define the circumstances pursuant to which States engage in such communications with their MFCUs. In an attempt to limit confusion between informal discussions and formal referrals, States may wish to use the term "provider notice" when providing information of a strictly "FYI" nature about providers to distinguish these discussions from formal referrals to a MFCU for purposes of payment suspension.

Q. If a State agency finds billing errors during a provider audit that are not related to allegations of fraud would this trigger a payment suspension?

A. Unless there is evidence or information to the contrary, CMS generally believes that mere errors found during the course of an audit would not rise to the threshold of "an investigation of a credible allegation of fraud" necessary to trigger a payment suspension. Similarly, billing errors that are attributable to human error, *e.g.*, inadvertent billing and processing errors, would typically not rise to the level of fraud.

Q. Are managed care organizations subject to payment suspensions?

A. Yes, managed care organizations are subject to payment suspensions. States should suspend payments to managed care entities based upon a pending investigation of a credible allegation of fraud.

Q. When is a payment suspension triggered under section 6402(h)(2)?

A. An investigation in accordance with 42 C.F.R. § 455.14 regarding the validity of an allegation of fraud does not itself trigger a payment suspension. 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 or other law enforcement agency for investigation in accordance with 42 C.F.R § 455.15.

Q. Is FFP available to States on interest that accrues on suspended payments to Medicaid providers?

A. No, FFP is not available on interest accrued on suspended payments to providers.

Q. If CMS defers or disallows a State's FFP and the underlying allegations of fraud are later cleared, what is the process by which FFP will be restored?

A. When CMS determines that claims associated with deferred or disallowed FFP are permissible, it will release the deferred or disallowed funds to a State by providing FFP for the subject claims.

Q. Does the final rule regarding suspension of payments apply to individual providers who are employed or contracted by institutional providers?

A. Yes, the payment suspension rule applies to institutional providers as well as providers who are employed or contracted by such institutional providers.

Q. Can State Medicaid agencies share potentially helpful information with their MFCUs without following the requirements in the rule regarding documentation and timing of the referral of a credible allegation of fraud?

A. States certainly may share information or otherwise consult with their MFCUs. CMS does not want to define the circumstances pursuant to which States initially communicate with their respective MFCUs with regard to potential referrals of fraud to the MFCU. Moreover, CMS recognizes that States may need to consult and/or exchange information with their respective MFCUs prior to making a formal referral. Nevertheless, fraud referrals from State agencies to MFCUs must meet the requirements that are set out in the final rule.

Q. Are States required to request a quarterly certification from a MFCU or other law enforcement agency that a matter accepted on the basis of a fraud referral, and which triggered a payment suspension, continues to be under active investigation?

A. Yes. A State's receipt of certification that an active law enforcement investigation remains ongoing will assist a State in determining that there is a basis to warrant continuing an existing payment suspension. Conversely, law enforcement's declination or other refusal to provide such certification in response to a State's request may be a factor in a State's determining that good cause exists not to continue a payment suspension. CMS did not prescribe any precise format that law enforcement certification must take, and recognized that, due to various constraints, law enforcement may not be able to provide any specific details with respect to matters for which it provides a certification of investigatory status.

Q. How should States annually report payment suspensions that were imposed on providers as a result of pending investigations of credible allegations of fraud to the Secretary?

A. CMS is in the process of creating a web-based portal for purposes of State reporting in connection with various provisions of the Affordable Care Act. We anticipate that States will initially report information about payment suspensions that were imposed on providers during the 3rd and 4th quarters of fiscal year 2011 using this web-based portal prior to April 1, 2012.

The information reported by States should include: the nature of the suspected fraud, the basis for the suspension, and the outcome of the suspension, where applicable, and any other information the Secretary may require. In addition, if States exercise good cause to discontinue an existing payment suspension or suspend only in part, then such States should also include in their annual reports the nature of the good cause.