



Medicaid Payment Suspension Toolkit

Section 6402(h)(2) of the Affordable Care Act (ACA) 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 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 a final rule implementing these new requirements with an effective date of March 25, 2011.

This toolkit has been developed to reiterate the steps involved in suspending Medicaid payments based upon pending investigations of credible allegations of fraud to States and other program integrity stakeholders. The following chart outlines the general process States should be following when they receive an allegation of fraud:

Receive an Allegation or Complaint of Fraud & Conduct a Preliminary Investigation

- Sources include but are not limited to fraud hotline complaints, claims data mining, or patterns identified through provider audits, civil false claims, and law enforcement investigations.
- A state must review all allegations, facts, and evidence carefully in accordance with 42 CFR 455.14 and 455.15 to determine the validity of an allegation.

↳ Determine if an Allegation of Fraud is Credible

- The state can conduct whatever due diligence it deems necessary, including informal consultation with other agencies and/or law enforcement to assess the credibility of an allegation of fraud.
- Per 42 CFR 455.2, allegations are considered to be credible when they have indicia of reliability and the state has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

↳ Suspend Payments or Document a Good Cause Exception Not to Suspend

- The state must suspend all Medicaid payments to a provider after it determines there is a credible allegation of fraud unless it has good cause not to suspend, or to suspend only in part.
- The state must follow the procedures outlined in the regulation to analyze and document good cause exceptions, which may also include an access to care determination.

↳ Refer the case to the Medicaid Fraud Control Unit (MFCU) or other appropriate law enforcement agency

- Referral must be in writing and provided to the MFCU no later than the next business day after the suspension / good cause exception is enacted.
 - Referral must comply with the CMS Referral Performance Standards.
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 **Follow Up**

- Payment suspensions are intended to be temporary in nature. They may be continued until the investigation and any associated law enforcement proceedings are completed.
 - On a quarterly basis, the state must request a certification from the MFCU that a referral continues to be under investigation thus warranting the continuation of the payment suspension. Further, the State should conduct ongoing monitoring of a suspension to determine if there is a basis to exercise good cause to lift the suspension.
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Frequently Asked Questions:

Q1. 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?

A1. Although formal referrals from State agencies to MFCUs that involve credible allegations of fraud must meet the requirements set out in the final rule, CMS recognizes that States may need to consult and/or exchange information with their respective MFCUs prior to making a formal referral of fraud.

Q2. When communicating with its MFCU, how can a State mitigate potential confusion between making a formal referral that necessitates a payment suspension versus merely sharing intelligence about concerns regarding a provider(s)?

A2. States may wish to use the term “provider notice” to convey information of a strictly “FYI” nature to distinguish these discussions from formal referrals to a MFCU for purposes of payment suspension.

Q3. May a State rely on its MFCU to determine if an allegation of fraud is credible?

A3. Pursuant to 42 CFR 455.23(a), the State Medicaid agency must determine the credibility of an allegation of fraud, but the regulation does not specify or limit who, or what other agency, the State Medicaid agency may consult, or gather information from, to make its appraisal. We recognize that the process to determine whether an allegation of fraud is credible may vary among States, but we do not want to limit a State’s due diligence process or preliminary investigations with respect to its assessment of credibility, and defer to States to apply the principles of careful review and judicious action to determine whether an allegation or complaint rises to a credible allegation of fraud. Once a State Medicaid agency determines an allegation of fraud is credible, it must submit a formal written referral to its MFCU regardless of whether the MFCU was consulted in assessing the allegation’s credibility.

Q4. When is a payment suspension triggered under section 1903(i)(2)(C)?

A4. A preliminary investigation in accordance with 42 CFR 455.14 to assess 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 credible in accordance with 42 CFR 455.23.

Q5. Once a State verifies an allegation of fraud is credible, what should it do next?

A5. A State is required to suspend payments to a provider unless the State has good cause not to suspend payments and follows the procedures required to document/demonstrate such good cause. A State is required to refer the suspected fraud to its MFCU or other law enforcement agency for further investigation in accordance with CMS’s performance standards for suspected fraud referrals (<https://www.cms.gov/FraudAbuseforProfs/Downloads/fraudreferralperformancestandardsStateagencytomfcu.pdf>).

Q6. When is a partial payment suspension warranted?

A6. Generally, a payment suspension should apply to all of a provider’s claims because it may be difficult to determine which claims are “clean” until the completion of an investigation and one purpose of a payment suspension is to build a type of escrow account from which any overpayments may be deducted when an investigation is concluded. However, the regulations at 42 CFR 455.23(f) provide States the flexibility to find that good cause exists to suspend payments only in part. Although CMS anticipates States will exercise partial payment suspensions sparingly, several regulatory bases

can potentially justify partial payment suspensions: (1) where suspension in whole would so jeopardize beneficiary access to items or services as to present a danger to life or health; (2) where an investigation is solely and definitively centered on only a specific type of claim in which case a State may determine it is appropriate to impose a payment suspension on only that type of claim; (3) where an investigation of a credible allegation of fraud is limited to a particular business unit or component of a provider such that a suspension need not apply to certain business units or components of a provider; or (4) where the State deems it in the best interests of the Medicaid program.

Q7. What should the State do if a MFCU accepts a fraud referral but does not want a provider's payments to be suspended because it may alert a provider to a pending investigation?

A7. A law enforcement request that a State not impose a payment suspension so as not to compromise an existing investigation qualifies as good cause to not suspend under the regulations at 42 CFR 455.23(e)(1). The State should get this request in writing and include the request in its file for purposes of annual reporting to the Secretary.

Q8. Is it acceptable to make a formal referral to the MFCU and delay the imposition of a payment suspension in order to give the MFCU time to evaluate the case to decide if the payment suspension should not be imposed?

A8. No. CMS recommends that the State and the MFCU communicate frequently regarding case development so that upon the State determining that an allegation of fraud is credible and making a formal referral to the MFCU, a payment suspension occurs unless the MFCU has already requested that a payment suspension not be imposed per 42 CFR 455.23(e)(1) or the State exercises one of the other good cause exceptions. Good cause exceptions should be documented in the case file at the time of referral to the MFCU.

Q9. What should a State do if the MFCU will not provide any information to it in writing, including good cause exception notices, for fear that these could be subject to Freedom of Information Act (FOIA) requests and hinder the development or prosecution of fraud cases?

A9. The regulations at 42 CFR 1007.9 require that when the MFCU accepts or declines a case referred by the State, the notification must be made in writing. Further, the regulations at 42 CFR 455.23(g) require that the State maintain all materials documenting the life cycle of a payment suspension as well as each instance where a payment suspension was not imposed, imposed only in part, or discontinued for good cause. CMS recognizes 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. We encourage States to work collaboratively with their MFCU to determine what level of documentation the MFCU can provide. We also note that disclosures regarding pending law enforcement cases generally fall within exceptions to the requirements of the federal, and likely many or all State's, FOIAs. In any event, States should keep detailed notes on all actions taken on a case to comply with the provisions of the regulation and for logical tracking of a case.

Q10. Is it acceptable for a MFCU to request a "blanket" good cause exception for all "credible allegation of fraud" cases referred by the State?

A10. No. Each case must be evaluated on its own merits to determine the appropriate course of action. Once a State has determined that an allegation of fraud is credible, the State must suspend payments unless it determines that good cause exists not to suspend payments, or not to continue a previously imposed suspension, with respect to the specific individual or entity.

Q11. Should the State's memorandum of understanding with the MFCU include a process for payment suspensions?

A11. Yes, the State and the MFCU should have written procedures on each agency's expectations and roles in implementing a payment suspension based on a credible allegation of fraud. The U.S. Department of Health and Human Services Office of Inspector General's MFCU performance standards includes a requirement that the memorandum of understanding between the MFCU and the State Medicaid agency meets current federal legal requirements as contained in law or regulation, including 42 CFR 455.21, "Cooperation with State Medicaid fraud control units," and 42 CFR 455.23, "Suspension of payments in cases of fraud."

Q12. How long should a payment suspension last?

A12. Payment suspensions are intended to be temporary in nature in order to stem the flow of Medicaid dollars to providers against whom there are credible allegations of fraud, during the pendency of the investigation, which includes any related proceedings. On a quarterly basis, the State is required to request a certification from the MFCU or other law enforcement agency that any matter accepted on the basis of a referral continues to be under investigation, thus warranting continuation of the payment suspension. A payment suspension will not continue after either of the following: the State or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider, or legal proceedings related to the provider's alleged fraud are completed. States should conduct ongoing monitoring of payment suspensions to determine if there is a basis to exercise good cause to lift any suspensions.

Q13. What should a State do if it believes a payment suspension would create an access to care issue for beneficiaries, and what factors should States consider when making access to care determinations?

A13. In tandem with a State's responsibility to protect its and the federal fisc by suspending payments to providers upon determining a credible allegation of fraud, CMS also recognizes, and balances, the paramount importance of beneficiary access to care. States likewise should balance these potentially competing interests. The payment suspension regulation at 42 CFR 455.23(e) and 42 CFR 455.23(f) thus contemplate beneficiary access burdens as potential bases for good cause exceptions. For example, 42 CFR 455.23(e)(4) and (f)(1) specify that, credible allegations of fraud notwithstanding, bases to either not suspend payments, or to suspend payments only in part, may exist where beneficiary access to care is jeopardized because is a sole community physician, sole source of essential services, or the provider in question serves a large number of beneficiaries in a federally designated medically underserved area.

In making any decision relating to payment suspensions, the State Medicaid agency has an ongoing responsibility to ensure that beneficiaries have access to appropriate critical services and must balance ease of access to care against potential risks raised by the credible allegations of fraud that triggered the suspension. The State may consider certain factors to determine if there is enough of an access to care issue that it amounts to good cause not to suspend payments, but likewise should consider whether the circumstances raised by the credible allegations of fraud nevertheless continue to justify imposition of a payment suspension. A State should also revisit its decision should circumstances surrounding access change. Factors States may consider include, but are not limited to, the following:

1. Risk Assessment: Determine possible consequences of suspension.
 - a. Risk of Closure. Assess likelihood of closure, number of patients/beneficiaries that would require similar or alternate care, type of care, and urgency of transition to another provider, timeframes for the transition, and estimate future utilization that will need to use alternate providers.
 - b. Risk of Withdrawal from the Medicaid program.
 1. Assess likelihood of immediate Medicaid beneficiary abandonment, number of beneficiaries that would require alternate care, type of care, and urgency of placement.
 2. Assess likelihood of controlled Medicaid beneficiary discharge, number of beneficiaries that would require alternate care, type of care, and urgency of placement.

3. Assess likelihood of withdrawal and estimate future utilization that will need to use alternate providers.
- c. Risk of selective restriction of services: Assess likelihood and impact of any other scenarios, such as a decision by the provider to stop performing a particular procedure or service while continuing to provide other services.

2. Risk Mitigation

- a. Determine availability of alternate providers
 1. Determine the number and capacity of similar providers in the immediate region (city/county/metropolitan area) and estimate available capacity to provide alternate care of the same type in both the immediate timeframe and with adequate warning, e.g., in the case of controlled beneficiary discharge. Determine timeframes for potential referrals and transitions. Use the appropriate metrics for the provider, e.g. bed and census information for hospitals.
 2. Determine the number and capacity of similar providers in the extended catchment area that can provide services on a short term basis with a small amount of additional provider effort, beneficiary inconvenience, or program cost.
 3. Determine the number and capacity of other providers that could provide alternate care that, in the short term, would still meet the clinical needs of beneficiaries.
- b. Determine available resources to assist beneficiaries
 1. Identify State and local resources that can assist physicians and beneficiaries needing referral or placement for urgent or routine care.
 2. Identify additional resources that could, in an emergency, be called upon to assist physicians and beneficiaries.
- c. Determine additional actions to protect beneficiaries and protect program funds: Identify any additional interventions that can or should be coordinated with the payment suspension to, most importantly, protect beneficiaries or, secondarily, protect program funds. For example, it may be desirable to coordinate State oversight agency inspections or law enforcement intervention.

Q14. What other steps should a State consider taking when suspending payments based upon a credible allegation of fraud?

A14. The State should follow the steps outlined in the regulation at 42 CFR 455.23 for imposing a payment suspension and conducting the associated follow up. The State Medicaid agency likewise has an ongoing affirmative obligation to ensure appropriate beneficiary access to services. Accordingly, States should regularly reassess the impact and effects of a payment suspension, and, balancing all interests, make any necessary adjustments to fulfill its obligations. CMS also suggests that States take the following steps when imposing payment suspensions they determine may impact access to care:

1. Create a Communication Plan
 - a. Identify partners for coordinated action and detailed assessment of alternate resources.
 - b. Identify key individuals to contact to alert to be aware of possible disruptions and prepare a general message.
 - c. Identify additional individuals to notify in the event a potential scenario materializes and prepare messages for each potential scenario.
2. Create a Beneficiary Assistance Plan
 - a. Identify individuals to assist providers and prepare a message and plan to distribute if needed because of care disruption. Prepare a distribution list to be used if needed.

- b. Identify individuals or agencies to assist beneficiaries and prepare a message and plan to distribute if needed because of care disruption. Prepare a distribution list to be used if needed.
 - c. Identify an ombudsman or other party for beneficiaries to contact if all other assistance fails.
3. Develop a Monitoring Plan
- a. Develop a plan for monitoring the potential movement of beneficiaries/patients to alternate providers where appropriate
 - b. Collect information regarding the ongoing delivery of necessary services
 - c. Monitor calls regarding access issues to affected area/beneficiary (if possible).

Additional Resources

Section 6402(h)(2) of the Affordable Care Act: http://www.ssa.gov/OP_Home/ssact/title19/1903.htm

CMS-6028-FC: <http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf>

42 CFR 455.23: <http://www.ecfr.gov/cgi-bin/text-idx?SID=b92034b7e375f51ef0a719a918e6da91&node=42:4.0.1.1.13.1.132.11&rgn=div8>

CPI-CMCS Informational Bulletin on Suspension of Medicaid Payments Based upon Credible Allegations of Fraud: <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf>

Fraud Referral Performance Standards:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/downloads/fraudreferralperformancestandardsStateagencytomfuc.pdf>