

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**LOUISIANA COMPLIED WITH THE  
REQUIREMENTS OF THE  
SOCIAL SECURITY ACT IN ITS  
REVIEW OF CASES OF CREDIBLE  
ALLEGATIONS OF MEDICAID FRAUD**

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# *Office of Inspector General*

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

## Report in Brief

Date: June 2017

Report No. A-06-16-00010

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Review

The Social Security Act (the Act) requires a State to suspend Medicaid payments to a provider when the State receives a credible allegation that the provider has submitted fraudulent claims.

Our objective was to determine whether the Louisiana Department of Health and Hospitals (State agency) complied with the requirements of the Act when it received a credible allegation of fraud by its Medicaid providers.

### How OIG Did This Review

Our review covered 225 providers with allegations of fraud that the State agency deemed credible between July 1, 2013, and June 30, 2015.

## Louisiana Complied With the Requirements of the Social Security Act in Its Review of Cases of Credible Allegations of Medicaid Fraud

### What OIG Found

The State agency complied with the requirements of the Act when it received a credible allegation of fraud by its Medicaid providers. Of the 225 cases we reviewed, the State agency had good cause not to suspend payment for 194 cases and properly suspended payments for the remaining 31 cases.

### What OIG Recommends

This report contains no recommendations.

## INTRODUCTION

*Louisiana complied with the requirements of the Social Security Act in its review of cases of credible allegations of Medicaid fraud.*

### WHY WE DID THIS REVIEW

The Social Security Act (the Act)<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. (Appendix A lists related OIG reports on States' compliance with Federal requirements in reviewing cases of credible allegations of fraud.)

### OBJECTIVE

Our objective was to determine whether the Louisiana Department of Health and Hospitals (State agency) complied with the requirements of the Act when it received a credible allegation of fraud by its Medicaid providers.

### 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 Act). The Affordable Care Act amended portions of the Act. Under the amended Act, a State that does not suspend payments to providers when an 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 if other remedies more efficiently or quickly protect Medicaid funds.<sup>2</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

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<sup>1</sup> The Act § 1903(i)(2)(C) and 42 CFR § 447.90(b).

<sup>2</sup> A list of good cause exemptions is provided at the 42 CFR § 455.23(e).

either a Medicaid Fraud Control Unit (MFCU) or an appropriate law enforcement agency in States without such a unit (42 CFR § 455.23(d)).

### **Louisiana's Medicaid Payment Safeguards**

In Louisiana, two units of government safeguard Medicaid payments. The Surveillance Utilization Review (SUR) Department, operated by Molina Medicaid Solutions in partnership with the State agency, reviews provider compliance with the policies and regulations of the Louisiana Medicaid Program. The State agency may apply administrative sanctions for abuse and wasteful practices, but must refer cases of potential fraud to MFCU.

Within the Louisiana Attorney General's office, MFCU investigates fraud and patient abuse and neglect by Medicaid providers and prosecutes them under State law. Since February 2010, an agreement has been in place that requires the State agency to refer cases of potential fraud to MFCU. This agreement was revised in July 2013 to incorporate the requirements of the Act.

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

Our review covered 225 providers with allegations of fraud that the State agency deemed credible between July 1, 2013, and June 30, 2015.

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.

### **RESULTS OF REVIEW**

The State agency complied with the requirements of the Act when it received a credible allegation of fraud by its Medicaid providers. Of the 225 cases we reviewed, the State agency had good cause not to suspend payment for 194 cases and properly suspended payments for the remaining 31 cases.

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

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

<b>Report Title</b>	<b>Report Number</b>	<b>Date Issued</b>
<i>Florida Did Not Suspend Medicaid Payments to Some Providers That Had Credible Fraud Allegation Cases in Accordance With the Social Security Act</i>	<a href="#"><u>A-04-14-07046</u></a>	4/20/2017
<i>New Jersey Did Not Suspend Medicaid Payments to Some Providers With Credible Allegations of Fraud in Accordance With the Affordable Care Act</i>	<a href="#"><u>A-02-13-01046</u></a>	5/25/2016
<i>Arkansas 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-06-15-00026</u></a>	9/21/2015
<i>Washington State Did Not Suspend Medicaid Payments to Some Providers With Credible Allegations of Fraud in Accordance With the Affordable Care Act</i>	<a href="#"><u>A-09-14-02018</u></a>	8/31/2015
<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 Requirement 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 225 providers with allegations of fraud that the State agency deemed credible between July 1, 2013, and June 30, 2015.

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the State agency complied with the requirements of the Act when it received a credible allegation of fraud against its Medicaid providers.

We conducted our audit from November 2015 through January 2017. We performed our fieldwork at the State agency's office and SURS' office in Baton Rouge, Louisiana.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- held discussions with State agency officials and the MFCU;
- obtained and reviewed State agency procedures to understand its practices when reviewing credible allegations of fraud;
- obtained and reviewed the memorandum of understanding between the State agency and the MFCU;
- obtained from the State agency all provider referrals it made to the MFCU during our audit period;
- obtained from MFCU all provider referrals it received from the State agency during our audit period;
- reviewed 225 cases involving allegations of fraud that the State deemed credible and referred to MFCU during our audit period; and
- summarized the results of the review and shared those results with State officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions



based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.