DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Notice of Opportunity for Hearing on Compliance of Alabama State Plan Provisions Concerning Provision of Terminating Coverage and Denying Reenrollment to Otherwise Eligible Individuals Based on a Determination of Fraud or Abuse with Titles XI and XIX (Medicaid) of the Social Security Act

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice of Opportunity for a Hearing; Compliance of Alabama Medicaid State Plan – Provision of Providing Medicaid to all Individuals Who Meet Eligibility Criteria, and Requirements for Handling of Suspected Fraud and Abuse by Providers, Applicants, and Beneficiaries.

CLOSING DATE: Requests to participate in the hearing as a party must be received by the presiding officer by [Insert date 30 days after date of publication in the Federal Register].

FOR FURTHER INFORMATION CONTACT:

Benjamin R. Cohen, Hearing Officer
Centers for Medicare & Medicaid Services
2520 Lord Baltimore Drive, Suite L
Baltimore, MD 21244

SUPPLEMENTARY INFORMATION:

This notice announces the opportunity, pursuant to section 1904 of the Social Security Act (the Act), for an administrative hearing concerning the finding of the Administrator of the Centers for Medicare & Medicaid Services (CMS) that the State of Alabama is significantly out of compliance with the requirements of section 1902 of the Act in administering its state plan because Alabama fails to promptly

enroll and extend coverage to eligible individuals who were subject to an agency determination that they previously engaged in fraud or program abuse, but were never convicted of any act of fraud. This finding will be the basis for withholding federal financial participation (FFP) of one percent of the Alabama Medicaid agency's quarterly claim for administrative expenditures, an amount that was developed based on the proportion of total state Medicaid expenditures that are used for expenditures for eligibility determinations. The withholding percentage will increase by one percentage point for every quarter in which the Alabama Medicaid agency remains out of compliance. The withholding will end when the Alabama Medicaid agency fully and satisfactorily implements a corrective action plan to bring its procedures for processing eligibility determinations under its Medicaid program into compliance with the federal requirements.

The CMS supports state efforts to appropriately address fraud and abuse, and federal law and regulations provide mechanisms to do so. Specifically, federal law and regulations allow states to impose penalties – including suspension, fines and imprisonment – on individuals who are convicted of concealing or failing to disclose information. Federal regulations also require that states investigate instances of beneficiary abuse of program rules and, if confirmed, take appropriate action authorized under the state plan. These federal provisions both provide the state with a mechanism to address fraud and abuse and take precedence over state law and policies.

The CMS has found that Alabama's policies and practices violate sections 1902(a)(8) and 1902(a)(10) of the Act requiring states to provide Medicaid to all individuals who meet the eligibility criteria required under the state plan, consistent with title XIX of the Act and federal regulations. Specifically, re-enrollment in Alabama's Medicaid program is denied to otherwise-eligible individuals who were terminated based on an agency determination that they previously engaged in fraud or abuse for at least one year or until restitution is made, whichever is later. Alabama's practice of recouping funds or

otherwise imposing financial penalties or barring otherwise eligible individuals from Medicaid coverage, absent a criminal conviction, also is not consistent with or authorized by section 1128B(a) of the Act, regulations at 42 CFR 455.15 and 455.16 or Alabama's Medicaid state plan.

Alabama's practices were not identified in Alabama's approved state plan, or otherwise submitted to CMS for review. CMS has raised this issue previously with the state, as we discuss below, but has been unable to resolve the state's non-compliance.

Alabama will have an opportunity for a hearing on these findings. Alabama will have 30 days to request such a hearing. If a request for hearing is timely submitted, the hearing will be convened by the designated hearing officer below, no later than 60 days after the date of this Federal Register notice, or a later date by agreement of the parties and the Hearing Officer, at the CMS Regional Office in Atlanta, Georgia, in accordance with the procedures set forth in federal regulations at 42 CFR Part 430, Subpart D. The Hearing Officer also should be notified if the Alabama Medicaid agency requests a hearing but cannot meet the timeframe expressed in this notice. The Hearing Officer designated for this matter is:

Benjamin R. Cohen, Hearing Officer

Centers for Medicare & Medicaid Services

2520 Lord Baltimore Drive, Suite L

Baltimore, MD 21244

After a final determination that the Alabama Medicaid agency has failed to comply substantially with these requirements in the administration of its state Medicaid plan, made after a hearing or absent a hearing request, consistent with the provisions of section 1904 of the Act, CMS will begin withholding federal funds as specified above. Such withholding will continue until the Alabama Medicaid agency comes into compliance with the requirements described in sections 1902(a)(8) and 1902(a)(10) of the Act, requiring states to provide Medicaid to all individuals who meet eligibility criteria required under the state

plan, and with section 1128B(a) of the Act and regulations at 42 CFR 455.15 and 455.16, requiring that the agency refer cases of suspected fraud to appropriate law enforcement, conduct a full investigation of suspected abuse and limit sanctions to those permitted under the regulations or specified in its approved state plan.

Details about the facts relating to Alabama's practices are set forth in the letter notifying Alabama of the Administrator's finding. The following issues will be considered at any requested hearing:

1. Whether the penalties set forth in Section 22-6-8 of the Alabama Code are consistent with the requirements of sections 1902(a)(8) and 1902(a)(10) of the Act.

2. If so, whether an administrative finding of the type described in section 22-6-8 of the Alabama Code, without a conviction in a court of law, is a sufficient basis to impose such penalties consistent with the requirements of sections 1902(a)(8) and 1902(a)(10) of the Act, and the remedies set forth in sections 1128 and 1128B of the Act, regulations at 42 CFR 455.15 and 455.16 and the Alabama Medicaid state plan.

Beginning in early February 2016, CMS notified Alabama that the state's actions are inconsistent with federal statutory and regulatory requirements. CMS has communicated with the state both in writing and by phone on several occasions since that time, including a July 6, 2016, notice of non-compliance in which CMS advised the Alabama Medicaid agency that if it did not submit a corrective action plan (CAP) to come into compliance with federal policy and the approved state plan within 30 days of the notice, formal compliance proceedings would be initiated. Alabama has consistently defended its policy, including in an August 1, 2016, letter responding to the notice of non-compliance in which the Alabama Medicaid agency requested reconsideration of CMS' determination and a stay of the 30 day deadline for submission of the CAP. CMS reviewed the Alabama Medicaid agency's response and, for the reasons stated above, has determined the Alabama Medicaid agency is not in compliance with the federal statute and regulations or Alabama's Medicaid state plan.

The letter notifying Alabama of the details concerning this compliance issue, the proposed withholding of FFP, opportunity for a hearing, and possibility of postponing and ultimately avoiding withholding by coming into compliance, reads as follows:

Ms. Stephanie Azar

Commissioner

Alabama Medicaid Agency

501 Dexter Avenue

Montgomery, AL 36116

Dear Ms. Azar:

This letter provides notice and an opportunity for a hearing on a finding by the Centers for Medicare & Medicaid Services (CMS) of significant noncompliance with applicable statutory and regulatory requirements in the operation of the Alabama Medicaid program, because the Alabama Medicaid agency inappropriately denies coverage to otherwise eligible individuals who were terminated based on an agency determination that they previously engaged in fraud or abuse.

The CMS supports state efforts to appropriately address fraud and abuse, and federal law and regulations provide mechanisms to do so. As described further in this letter, federal law and regulation allow states to impose penalties – including suspension, fines and imprisonment – for individuals who are convicted of concealing or failing to disclose information. Federal regulations also require that states conduct a full investigation into instances of beneficiary abuse of program rules and, if confirmed, take appropriate action authorized under the state plan. Except in such conditions, states are required by federal statute to promptly enroll and provide medical assistance to all eligible individuals. These federal provisions, discussed in more detail below, take precedence over state law and policies.

The CMS has learned in discussions with state agency staff that Alabama's policies and practices are not consistent with the federal statutory framework governing instances of alleged beneficiary fraud or abuse. Specifically, Alabama denies enrollment in Alabama's Medicaid program to otherwise-eligible individuals who were never convicted of wrong-doing, but were the subject of an agency determination that they previously engaged in fraud or abuse, for at least one year or until restitution is made, whichever is later. This practice is in violation of sections 1902(a)(8) and 1902(a)(10) of the Social Security Act (the Act) requiring states to provide Medicaid to all individuals who meet the eligibility criteria required under the state plan, consistent with title XIX of the Act and federal regulations. Furthermore, Alabama's practice of recouping funds or otherwise imposing financial penalties or barring otherwise eligible individuals from Medicaid coverage, absent a criminal conviction, is not consistent with or authorized by section 1128B(a) of the Act, regulations at 42 CFR 455.15 and 455.16 or Alabama's Medicaid state plan.

Alabama's practices were not identified in Alabama's approved state plan, or otherwise submitted to CMS for review. CMS has raised this issue previously with the state, as we discuss below, but has been unable to resolve the state's non-compliance.

Pursuant to section 1904 of the Act and 42 CFR 430.35, CMS is providing the Alabama Medicaid agency with an opportunity for a hearing on this finding of noncompliance with statutory and regulatory requirements. If the finding is upheld or unchallenged following this opportunity for a hearing, a portion of the federal financial participation (FFP) of the administrative costs associated with the operation of the Alabama Medicaid program, as specified in more detail below, will be withheld until the state ceases this impermissible practice and CMS makes a finding that the state has come into compliance with the statute and regulations.

The factual details of the finding, the proposed withholding, how the Alabama Medicaid agency can request a hearing on the finding, and the steps Alabama can take to avoid sanctions by coming into compliance are described below.

Factual Findings

Section 22-6-8 of the Alabama Code provides that "Upon determination by a utilization review committee or the designated state medicaid agency that a medicaid recipient has abused, defrauded, or misused the benefits of the program said recipient shall immediately become ineligible for Medicaid benefits." Section 22-6-8 of the Code further provides that "Medicaid recipients whose eligibility has been revoked due to abuse, fraud or other deliberate misuse of the program shall not be deemed eligible for future Medicaid services for a period of not less than one year, and until full restitution has been made to the designated State Medicaid Agency."

In implementing section 22-6-8 of the Alabama Code, state agency staff explained that if a beneficiary does not report a change in circumstances which the agency determines would have resulted in termination of eligibility, any payments for services provided to the beneficiary after the change in circumstances may be considered to be an "overpayment." State agency staff further explained that when the Alabama Medicaid agency has made such an overpayment to providers that exceeds $300, the beneficiary's case record is referred to the agency's Payment Review Unit for evaluation. If the Payment Review Unit determines an overpayment has been made, it forwards the case to the agency's Utilization Review Committee (URC) with a recommendation for suspension of eligibility. If the URC votes to suspend, the individual is suspended from Medicaid eligibility for a minimum of one year or until the overpayment to the Medicaid providers during the period of eligibility is paid in full by the beneficiary to the Alabama Medicaid agency, whichever is later.

Applicable Statutory and Regulatory Provisions

In general, the Medicaid statute at section 1902(a)(10) of the Act sets out the groups of Medicaid-eligible individuals, and the conditions under which they are eligible. Some groups are mandatory for states to cover under the state plan, and other groups are covered under the state plan at state option. Section 1902(a)(8) of the Act requires states to provide medical assistance to eligible individuals with "reasonable

promptness." The applicable federal statutory and regulatory provisions do not authorize states to impose additional conditions on eligibility, including exclusion of individuals who meet the conditions of eligibility but are suspected by the state agency of fraud or abuse, and only permit recovery of overpayments from providers, not beneficiaries.

Federal law and regulations do provide for state Medicaid agencies to address instances of beneficiary fraud or abuse. Specifically, 42 CFR 455.15 and 455.16 require that state Medicaid agencies refer cases of suspected fraud to an appropriate law enforcement agency. If an individual is convicted of concealing or failing to disclose information "with an intent fraudulently to secure [Medicaid benefits]," a fine of up to $25,000 or imprisonment up to 5 years or both may be imposed under section 1128B of the Act. Further, per section 1128B(a) of the Act, the agency may limit, restrict or suspend, for up to one year, coverage of an otherwise-eligible individual convicted of fraud. Absent conviction, however, there is no authority either to impose sanctions or deny eligibility under the statute or regulations based on fraud.

Unlike suspected fraud, suspected abuse does not require referral to law enforcement or criminal proceedings. Rather, if the agency believes an individual is abusing the benefits of the Medicaid program, 42 CFR 455.15(c) directs the agency to conduct a full investigation. Per 42 CFR 455.16, the agency's investigation must continue until appropriate legal action has been initiated, the case has been dropped because of insufficient supporting evidence, or the case has been otherwise resolved. Per 42 CFR 455.16(c), if, after a full investigation, the agency finds that an applicant or beneficiary has abused the program, the agency may issue a warning letter or impose "other sanctions provided under the State plan."

Under 42 CFR 455.16(c), resolution of an investigation into allegations of abuse may include suspension of and/or recovery of overpayments from providers. However, these regulations do not authorize recovery of overpayments from beneficiaries. Further, while section 1903(d)(2)(C) of the Act and 42 CFR Part 433 Subpart F provide for recovery of overpayments from providers, there is nothing in the statute or regulations that permits states to recoup payments to providers directly from beneficiaries.

Alabama's Medicaid State plan does not authorize suspension of eligibility from the program merely based on a determination by the Payment Unit or URC that an overpayment has been made or on an agency finding that an applicant or beneficiary otherwise has abused the program; nor does it authorize restitution or recovery of overpayments as a condition of coverage. Instead, Page 36 of Section 4.5 of Alabama's approved Medicaid state plan calls for the agency to establish and maintain methods, criteria and procedures that meet all requirements of 42 CFR 455.13 through 455.23 for prevention and control of program fraud and abuse.

Federal regulations provide for appropriate measures that states must take whenever the agency obtains information indicating a beneficiary is no longer eligible for Medicaid. Specifically, regulations at 42 CFR 435.916(d) provide for a redetermination of eligibility in such circumstances, and regulations in 42 CFR Part 431 Subpart E provide for advance notice and due process protections for beneficiaries determined no longer eligible. While beneficiaries are expected to report changes in their circumstances per 42 CFR 435.916(c), failure to do so does not necessarily constitute fraud or abuse. Some states have instituted periodic data matching with available data sources in order to proactively detect changes in beneficiary circumstances. If a change that may impact eligibility is detected, the Medicaid agency must follow up, in accordance with 42 CFR 435.916(d), to give the beneficiary an opportunity to dispute the change, and provide documentation of ongoing eligibility if necessary. Before terminating, the agency must consider whether there other potential bases for continued eligibility and, for individuals determined ineligible for Medicaid, the agency must determine potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f). We encourage the Alabama Medicaid agency to consider adopting periodic data matching with available sources if it believes that failure on beneficiaries part to report changes in their circumstances poses a program integrity risk.

Although the Alabama Medicaid agency reported that beneficiaries terminated per section 22-6-8 of the Alabama Code are given advance notice prior to being terminated and may appeal their termination, requiring that an individual pay the agency back for the cost of services furnished prior to his or her

termination from coverage effectively represents a retroactive termination of eligibility which renders meaningless the 10-day advance notice of termination required under 42 CFR 431.211 and is not permitted under the regulations.[1] If the agency believes that a beneficiary's failure to report a change in circumstances rises to the level of fraud or abuse of the program, referral to law enforcement for investigation of fraud, or institution of a full investigation into abuse by the agency, are the only appropriate next steps under the statute and federal regulations.

Discussions with the State Medicaid Agency

Beginning in early February 2016, CMS notified Alabama that the state's actions are inconsistent with federal statutory and regulatory requirements. CMS has communicated with the state both in writing and by phone on several occasions since that time, including a July 6, 2016, notice of non-compliance in which CMS advised the Alabama Medicaid agency that if it did not submit a corrective action plan (CAP) to come into compliance with federal policy and the approved state plan within 30 days of the notice, formal compliance proceedings would be initiated. Alabama has consistently defended its policy, including in an August 1, 2016, letter responding to the notice of non-compliance in which the Alabama Medicaid agency requested reconsideration of CMS' determination and a stay of the 30 day deadline for submission of the CAP. CMS reviewed the Alabama Medicaid agency's response and, for the reasons stated above, has determined the Alabama Medicaid agency is not in compliance with the federal statute and regulations or Alabama's Medicaid state plan.

In a phone call on November 3, 2016, the Alabama Medicaid agency suggested that CMS' enforcement of the federal statutory and regulatory provisions at issue would prevent it from taking action against applicants who intentionally misrepresent information or beneficiaries who fail to report changes in circumstances. CMS explained that several tools are available to enable states to effectively address such situations, including robust verification procedures, such as instituting periodic data matching with

[1] The advance notice of termination required is reduced to a minimum 5 days per 42 CFR 431.214 in a case involving probable fraud; such fraud must be verified if possible through secondary sources.

available data sources in order to proactively detect changes in beneficiary circumstances. CMS also explained the steps which the agency can and must follow under regulations at 42 CFR 435.916(d) and 42 CFR part 435 subpart E in the event that the agency later discovers information that suggests someone was not at application, or is no longer, eligible for coverage. Again, if the agency believes that an applicant intentionally provided false information on his or her application, referral to law enforcement for investigation of fraud, or institution of a full investigation by the agency into potential abuse, are the only appropriate next steps under the statute and regulations.

The Alabama Medicaid agency's submission of its quarterly expenditure reports through the CMS-64 includes a certification that the Alabama Medicaid agency is operating under the authority of its approved Medicaid state plan. However, at this time, CMS has not received information from the agency providing evidence of compliance with its approved state plan, sections 1902(a)(8), 1902(a)(10) and 1128B(a) of the Act or regulations at 42 CFR 455.15 and 455.16.

Determination of Non-Compliance and FFP Withholding

The CMS has concluded that the Alabama Medicaid agency is operating its program in substantial noncompliance with federal requirements described in sections 1902(a)(8) and 1902(a)(10) of the Act, requiring states to provide Medicaid to all individuals who meet eligibility criteria required under the state plan, and with section 1128B(a) of the Act and regulations at 42 CFR 455.15 and 455.16, requiring that the agency refer cases of suspected fraud to appropriate law enforcement, conduct a full investigation of suspected abuse, and limit sanctions to those permitted under the regulations or specified in its approved state plan. Subject to the state's opportunity for a hearing, CMS will withhold a portion of federal financial participation (FFP) from the Alabama Medicaid agency's quarterly claim of expenditures for administrative costs until such time as the Alabama Medicaid agency is, and continues to be, in compliance with the federal requirements.

The withholding will initially be one percent of the federal share of the Alabama Medicaid agency's quarterly claim for administrative expenditures, an amount that was developed based on the proportion of total state Medicaid expenditures that are used for expenditures for eligibility determinations, as reported on Form CMS-64.10 Line 50. The withholding percentage will increase by one percentage point for every quarter in which the Alabama Medicaid agency remains out of compliance. The withholding will end when the Alabama Medicaid agency fully and satisfactorily implements a corrective action plan to bring its eligibility policies and procedures under its Medicaid program into compliance with the federal requirements.

Opportunity to Request a Hearing

The state has 30 days from the date of this letter to request a hearing. If a request for hearing is submitted timely, the hearing will be convened by the designated hearing officer below, no later than 60 days after the date of the Federal Register notice, or a later date by agreement of the parties and the Hearing Officer, at the CMS Regional Office in Atlanta, Georgia, in accordance with the procedures set forth in federal regulations at 42 CFR Part 430, Subpart D. The Hearing Officer also should be notified if the Alabama Medicaid agency requests a hearing but cannot meet the timeframe expressed in this notice. The Hearing Officer designated for this matter is:

Benjamin R. Cohen, Hearing Officer

Centers for Medicare & Medicaid Services

2520 Lord Baltimore Drive, Suite L

Baltimore, MD 21244

At issue in any such hearing will be:

1. Whether the penalties set forth in Section 22-6-8 of the Alabama Code are consistent with the requirements of sections 1902(a)(8) and 1902(a)(10) of the Act.

2. If so, whether an administrative finding of the type described in section 22-6-8 of the Alabama Code, without a conviction in a court of law, is a sufficient basis to impose such penalties consistent with the requirements of sections 1902(a)(8) and 1902(a)(10) of the Act, and the remedies set forth in sections 1128 and 1128B of the Act, regulations at 42 CFR 455.15 and 455.16 and the Alabama Medicaid state plan.

If the Alabama Medicaid agency plans to come into compliance with the approved state plan, the Alabama Medicaid agency should submit, within 30 days of the date of this letter, an explanation of how the Alabama Medicaid agency plans to come into compliance with federal requirements and the timeframe for doing so. If that explanation is satisfactory, CMS may consider postponing any requested hearing, which could also delay the imposition of the withholding of funds as described above. Our goal is to have the Alabama Medicaid agency come into compliance, and CMS continues to be available to provide technical assistance to the Alabama Medicaid agency in achieving this outcome. However, if CMS does not find the Alabama Medicaid agency's plan or explanation satisfactory, CMS will not postpone any requested hearing.

Should you not request a hearing within 30 days, a notice of withholding will be sent to you and the withholding of federal funds will begin as described above.

If you have any questions or wish to discuss this determination further, please contact:

Jackie Glaze

Associate Regional Administrator

Division of Medicaid and Children's Health Operations

CMS Atlanta Regional Office, 61 Forsyth Street, Suite 4T20

Atlanta, Georgia 30303

404-562-7417

Sincerely,

Patrick H. Conway

Acting Administrator

(Catalog of Federal Domestic Assistance Program No. 13.714, Medicaid Assistance Program.)

Dated: **February 14, 2017**

_____

Patrick H. Conway
Acting Administrator
Centers for Medicare & Medicaid Services

Billing Code: 4120-01-P

[FR Doc. 2017-03292 Filed: 2/16/2017 8:45 am; Publication Date: 2/17/2017]