Payment Suspensions Snapshot

The Affordable Care Act amended Section 1903(i)(2) of the Social Security Act to remove State Medicaid agency (SMA) discretion to withhold payments to providers and instead require suspension of payments in certain circumstances. Previously, suspension was triggered by receipt of reliable evidence. Now, suspension is required when there is a pending investigation for a credible allegation of fraud.[1]

The Centers for Medicare & Medicaid Services (CMS) adopted regulations specifying that the SMA must suspend all payments when it determines there is a pending investigation for a credible allegation of fraud. The SMA may make an exception if it finds there is good cause not to impose the suspension or to impose a partial suspension. The pending investigation does not need to be conducted by law enforcement. It may be conducted by the SMA, and may still be in the preliminary stages.[2]

The new credible allegation standard is easier to meet than the previous reliable evidence standard.[3] An allegation is considered credible if the SMA finds that the allegation has evidence of reliability after carefully reviewing all allegations, facts, and evidence. In making credibility determinations, the SMA must act judiciously on a case-by-case basis.[4] CMS has commented that the amount of evidence necessary to support a finding of credibility will vary depending on the facts and circumstances surrounding each allegation.[5]

After determining that an allegation is credible, the SMA must immediately suspend payments and make a referral to the Medicaid Fraud Control Unit or another law enforcement agency. The suspension must stay in force until the SMA or prosecuting authorities determine the evidence is insufficient or legal proceedings on the alleged fraud are completed.[6] SMAs can use CMS' "Medicaid Payment Suspension" Toolkit for help in imposing, documenting, and tracking payment suspensions.[7] The toolkit is posted to the Medicaid Program Integrity Education page at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

Payment suspensions have effects that last after the suspension is over. If an enrolling or revalidating provider's Medicaid payments are suspended, the provider will be placed in the high-risk screening category. This means the provider must pass an on-site visit and a fingerprint-based criminal background check.[8] Providers that have had only Medicare payments previously suspended, however, are not subject to this increase in risk level.[9]

The Affordable Care Act requires enrolling and revalidating providers to disclose previous payment suspensions.[10, 11] CMS has not yet published a rule implementing this requirement,[12] but providers should watch for these proposed rules. Additionally, providers should remember the regulations give States considerable flexibility in establishing screening and disclosure requirements for all providers.[13] Providers should check with their SMA to see if there is a State requirement.

For More Information

To see the electronic version of this and other E-Bulletins and for more information on other program integrity topics posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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