



Medicaid and CHIP Managed Care Program Integrity Toolkit

42 CFR 438 Subpart H

*Payment Suspensions Based on
Credible Allegations of Fraud
§438.608(a)(8)*

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Table of Contents

Content Summary	3
Introduction	4
Background	4
A. Applicability to Medicaid	5
B. Applicability to CHIP	5
Payment Suspensions Based on a Credible Allegation of Fraud	6
A. State Activities under §455.23	6
B. Managed Care Payment Suspensions (§438.608(a)(8))	8
Conclusion	9
Endnotes	10
References	10
Disclaimer	11



Content Summary

Through the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Program Integrity Toolkits, CMS features key topics that will help state Medicaid agencies, as well as managed care plans (MCPs) [Endnote 1], improve program integrity through greater oversight, accountability, and transparency.

This Payment Suspensions Based on Credible Allegations of Fraud Toolkit discusses managed care-related payment suspensions and the procedures in place to suspend payment when there is a credible allegation of fraud, consistent with requirements found in 42 CFR 438.608(a)(8). States have an important oversight responsibility when implementing payment suspensions for network providers, and CMS encourages states and MCPs to collaborate throughout this process.

Introduction

Medicaid and CHIP are federal-state partnerships, and those partnerships are central to the programs' success. Given the extensive and expanding use of managed care in Medicaid and CHIP, it is critical that the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies (SMAs) ensure accountability and strengthen program integrity safeguards in states' managed care programs.

This toolkit summarizes and clarifies certain program integrity provisions in 42 CFR 438 Subpart H, as finalized in the “Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability” rule (referred to as the 2016 Managed Care Final Rule). [Reference 1] This toolkit provides information and examples regarding oversight practices SMAs should consider to ensure that effective program integrity measures are in place. [Endnote 2, Reference 2]

Note: This toolkit does not contain an exhaustive list of all federal requirements and is only intended to be a tool to aid SMAs in the development of contracts with, and oversight of, its Medicaid and CHIP MCPs. The contents of this toolkit do not have the force and effect of law and are not meant to bind the public or any parties in any way, unless specifically incorporated into a contract. This toolkit is intended only to provide clarity to existing requirements under the law and may be revised and updated periodically to reflect statutory, regulatory, and other policy changes. The “Last Updated” date is the date this toolkit was most recently updated.

Background

On May 6, 2016, CMS published the 2016 Managed Care Final Rule that included important program integrity safeguards in Part 438, Subpart H [adopted in CHIP via cross-reference at §457.1285) with the exception of §§438.604(a)(2) and 438.608(d)(4)]. Specifically, these regulations outlined requirements to help address fraud and other improper payments caused by MCPs and related network providers. The final rule also tightened standards for MCPs' submission of certified data, information, and documentation that are critical to program integrity oversight by state and federal agencies.

States and MCPs are required to comply, as applicable, with the program integrity requirements in §§438.600 (statutory basis and applicability), 438.602 (state responsibilities), 438.604 (data, information, and documentation that must be submitted), 438.606 (source, content, and timing of certification), 438.608 (program integrity requirements under managed care contracts), and 438.610 (prohibited affiliations). States have been required to comply with §§438.602(a), 438.602(c) - (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d), since no later than the rating period for contracts starting on or after July 1, 2017. States have been required to comply with §§438.602(b) and 438.608(b) since no later than the rating period for contracts beginning on or after July 1, 2018.

A. Applicability to Medicaid

Federal statute and regulations specify the authorities and requirements under which states can offer services via contracts with Medicaid MCPs [see generally, sections 1902 through 1905 and 1932 of the Social Security Act (the Act)]. These statutory provisions provide the basis of the federal regulatory structure found in Part 438 Subpart H. The SMA must have a monitoring process for compliance with requirements of the state's managed care program and the MCP contract with the state. SMAs are responsible for ensuring that MCPs comply with federal regulations. MCPs must provide the safeguards necessary to ensure that eligibility is determined, and that services are provided, in a manner consistent with simplicity of administration and the best interests of the recipients (see section 1902(a)(19) of the Act).

There are basic requirements listed in Part 438 Subpart H for MCPs to receive payment under a Medicaid managed care program. In general, most of the requirements apply to most MCPs, but there is variation with respect to primary care case managers (PCCMs) and primary care case management entities (PCCM entities). For example, §§ 438.600(b) and (c) apply to PCCMs and PCCM entities but §§ 438.608(a) and (d) do not. PCCMs and PCCM entities must comply with the requirements in §§ 438.604, 438.606, 438.608, and 438.610, as applicable.

B. Applicability to CHIP

Most of the program integrity requirements of Part 438 Subpart H apply to CHIP via a cross reference in § 457.1285. Specifically, § 457.1280 governs contracting standards and § 457.1285 applies the Medicaid program integrity safeguards of Part 438 Subpart H to CHIP. [Endnote 3]



Payment Suspensions Based on a Credible Allegation of Fraud (§438.608(a)(8))

Under §455.23, which implements section 1903(i)(2)(C) of the Act, a state must suspend payments to an individual or entity against which there is a pending investigation of a credible allegation of fraud, unless the state determines that there is good cause not to suspend such payments. CMS regulations at §438.608(a)(8) require that when payment suspensions are state-initiated (that is, when a state determines there is a credible allegation of fraud), MCPs must suspend payments at the direction of the state. As a result, MCPs must have procedures in place to suspend payment to network providers when directed by the state due to a credible allegation of fraud.

Under this requirement, the responsibility of MCPs is limited to promptly suspending payments at the direction of the state until notified by the state that the investigation has concluded.

A. State Activities under §455.23

When a state receives an allegation or complaint of fraud and conducts a preliminary investigation, it must review all allegations, facts, and evidence carefully in accordance with §§455.14 and 455.15 to determine the validity of the allegation or complaint.


A state must first determine if an allegation of fraud is credible. States may 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. Under §455.2, allegations are considered to be credible when they have

signs of reliability and the state has reviewed all allegations, facts, and evidence carefully and acts prudently on a case-by-case basis.

States must suspend all Medicaid or CHIP payments to a provider after they determine there is a credible allegation of fraud unless they have good cause not to suspend, or to suspend only in part. States must follow the procedures outlined in the regulation to analyze and document good cause exceptions, which may also include an access to care determination.

Once a state initiates a payment suspension based on a credible allegation of fraud, or determines that good cause exists to not suspend payment despite a credible allegation of fraud, the case should be referred to the Medicaid Fraud Control Unit (MFCU) or other appropriate law enforcement agency if the state does not have a MFCU. The 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. The referral must comply with the CMS Referral Performance Standards.[Reference 3] Payment suspensions are intended to be temporary in nature. However, 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.

For additional information on §455.23 as it applies to Medicaid fee-for-service (FFS) payment suspensions, states can consult the



CMS Center for Program Integrity
(CPI)/Center for Medicaid and
CHIP Services Information Bulletin
CPI-B 11-04 and CPI Medicaid FFS
Payment Suspension
Toolkit.[References 4,5]

B. Managed Care Payment Suspensions (§438.608(a)(8))

Unless a good cause exception applies, the state may require the MCP to implement a payment suspension for the network provider. CMS regulations at §455.23(e) lists the circumstances in which a good cause exception may apply. States and MCPs should also include in their contracts mutual obligations to communicate when either party is about to impose a payment suspension on a provider, and how the MCPs will prevent the release of the payment of claims to providers that are in payment suspension status. For example, how will claims be adjudicated; for those claims that are payable and held in escrow, will statements be sent to the provider notifying the provider of the claim status; and will appeal rights be afforded to claims adjudicated not payable when the claim payment is held in suspension.

Each party should provide adequate information to the other so that the state and law enforcement partners are able to execute their statutory and regulatory responsibilities and obligations. States should include language in their MCP contracts to allow the state to impose contractual remedies on the MCP in the case of a MCP not suspending payments to the provider when otherwise required.

States must include contract language requiring the MCPs to notify the SMA or CHIP agency when there is a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the MCP, pursuant to §438.608(a)(4).

CMS encourages states to include MCP-initiated payment suspensions in this requirement and require MCPs to notify the state by the next business day of any implemented payment suspensions.

Payment suspensions initiated by the MCPs should be required to comply with all requirements of §455.23. In accordance with 455.23, states should also continue to make the determination as to whether there is a credible allegation of fraud. The MCP should report, at a minimum, the following additional information to the state within two business days after suspension:

- Provider name
- Nature of the suspected fraud
- Basis for the suspension
- Date the suspension was imposed
- Date the suspension was discontinued, if applicable
- Reason for discontinuing the suspension, if applicable
- Amount of payment withheld to date, if applicable
- Good cause rationale for imposing a partial payment suspension, if applicable

State contracts with MCPs should also require the MCP to report, at a minimum, the following information on suspended providers to the state on a monthly basis:

- Provider name
- Nature of the suspected fraud
- Basis for the suspension
- Date the suspension was imposed
- Date the suspension was discontinued, if applicable
- Reason for discontinuing the suspension, if applicable
- Outcome of any appeals
- Amount of payments withheld to date, if applicable
- Good cause rationale for not suspending payment or imposing a partial payment suspension, if applicable

However, if the MCP decides to terminate a provider from their network in lieu of suspending the provider's payments or take any additional action against a provider whom it suspects of credible allegations of fraud, the MCP must report this provider(s) to the state, pursuant to §438.608(a)(4). This report will allow the state to be informed and coordinate with other MCPs in which this provider is enrolled. Furthermore, the state may choose to establish requirements to remove the provider's ability to bill other MCPs or the state directly through Medicaid fee-for-service, if a different MCP has terminated a provider for program integrity concerns.



Conclusion

Detecting risks and implementing mitigation activities are shared responsibilities among CMS, states, and MCPs. These shared activities are critical to protecting Medicaid and CHIP from fraud, waste, and abuse. This toolkit will help states and MCPs achieve their program integrity goals and remain in compliance with CMS requirements.

Endnotes

1. Managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), primary care case managers (PCCMs), and primary care case management entities (PCCM entities) are also referred to throughout as managed care plans (MCPs.). Contracts with Health Insuring Organizations (HIOs) that began operating on or after January 1, 1986, and are not explicitly exempt by statute from requirements in section 1903(m) of the Act, are subject to the requirements of Part 438 Subpart H to the same extent that the requirements apply to MCOs.
2. Medicaid managed care provider screening and enrollment requirements under §438.602(b)-(d) are referenced but not fully addressed in this toolkit. These requirements have been addressed separately in the Medicaid Provider Enrollment Compendium (MPEC).
3. Requirements at §§438.604(a)(2) and 438.608(d)(4) are not applicable to separate CHIP MCPs.

References

1. 81 FR 27497 (May 6, 2016), <https://www.govinfo.gov/content/pkg/FR-2016-05-06/pdf/2016-09581.pdf>.
2. The Medicaid Provider Enrollment Compendium (MPEC), <https://www.medicaid.gov/affordable-care-act/program-integrity/index.html>.
3. CMS Referral Performance Standards <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resource-Library/performance-standard-referrals-suspected-fraud-single-state-agency-medicaid-fraud-control-unit>
4. Center for Program Integrity/Center for Medicaid and CHIP Services Information Bulletin CPI-B 11-04: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/payment-suspensions-info-bulletin-3-25-2011.pdf>
5. Center for Program Integrity Medicaid Fee-For-Service Payment Suspension Toolkit: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf>

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