Medicaid and CHIP Managed Care
Program Integrity Toolkit

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

42 CFR 438 Subpart H

Prompt Referrals of Potential Fraud, Waste, or Abuse

§438.608(a)(7)

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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 (SMAs), as well as managed care plans (MCPs) [Endnote 1], improve program integrity through greater oversight, accountability, and transparency.

This Prompt Referrals of Potential Fraud, Waste or Abuse Toolkit discusses the requirements of MCPs to promptly report and establish clear timelines for referrals of potential fraud, waste, or abuse to the state Medicaid Program Integrity (PI) Unit or Medicaid Fraud Control Unit (MFCU), as required in 42 CFR 438.608(a)(7). When referring potential fraud, waste, or abuse, states have the discretion to stipulate the ways MCPs can report potential fraud.

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]
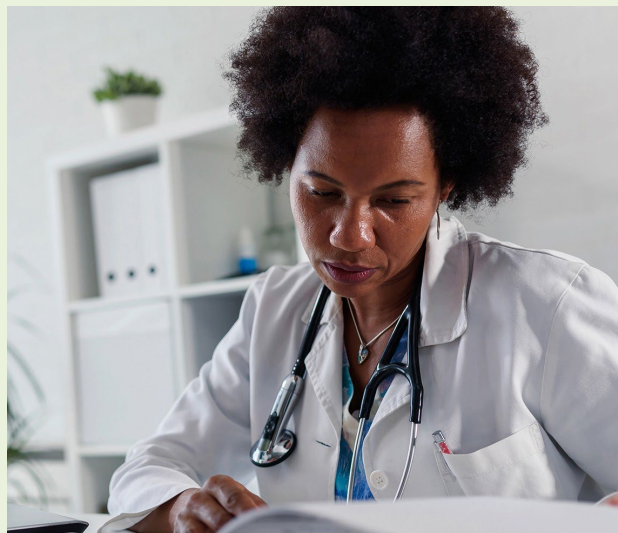
Prompt Referral of Potential Fraud, Waste, or Abuse

States must require in their contracts that MCPs promptly refer any potential fraud, waste, or abuse that the MCP identifies to the state Medicaid Program Integrity (PI) Unit or any potential fraud directly to the Medicaid Fraud Control Unit (MFCU).

A. "Prompt" Reporting of Fraud Referrals (§ 438.608(a)(7))

SMAs have the discretion to determine the timeline for "prompt" reporting by MCPs under § 438.608(a)(7). States should establish clear timelines in the MCP contract for prompt reporting of potential fraud, waste, and abuse. In the context of reporting fraud referrals, based on CMS' fraud investigations and promising practices received from states, CMS encourages "prompt" to be defined as within two business days of the identification of potential fraud, waste, or abuse. To assist MCPs with effectively identifying potential fraud, waste, and abuse and making prompt referrals, SMAs should train MCP program integrity personnel, with assistance from the state's MFCU or Office of Inspector General, on recent program integrity trends and schemes.

B. Referring Potential Fraud (§438.608(a)(7))

Under CMS regulations, states must require in their contracts that MCPs promptly refer any potential fraud, waste, or abuse to the state Medicaid PI Unit or any potential fraud directly to the MFCU. Within this framework, SMAs have some discretion to stipulate to whom MCPs must refer potential fraud, waste, and abuse, depending on the facts of the investigation as well as the format and level of detail required as part of the referral. SMAs may choose from one of the following options:

- To the MFCU

- To both the MFCU and the state's Medicaid PI Unit

- To the state's Medicaid PI Unit (with the expectation that the SMA will in turn refer the case to the MFCU, as appropriate)

Although states may allow MCPs to report potential fraud directly to the MFCU, CMS encourages states to require the MCPs to provide the same information concurrently to the Medicaid PI Unit. This will allow the SMA to assess whether potential fraud is referred promptly under §438.608(a)(7) and better coordinate oversight efforts of providers. CMS encourages states to provide frequent, state-led trainings on program integrity trends and the fraud referral process to managed care plans. State-led trainings have been shown to increase provider fraud referral rates and optimize program integrity. Effective program integrity in managed care requires close collaboration between the Medicaid PI Unit, MFCU, MCP Special Investigations Unit (SIU) (when applicable), and other law enforcement stakeholders. Such relationships are critical to ensuring the exchange of information and collaboration among all involved parties to determine the best course of action for suspected cases of fraud.

C. SMA Actions upon Receiving a Referral of Potential Fraud or Abuse (§§455.14 and 457.925) For any potential Medicaid or CHIP fraud or abuse that is referred to the Medicaid PI Unit, CMS regulations at §§455.14 and 457.925 specify that the Medicaid PI Unit must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. For potential fraud referrals, the Medicaid PI Unit must also cooperate with the MFCU in determining whether there is a credible allegation of fraud, as required under §§455.21 and 23.

States have broad flexibility to establish processing requirements and procedures pertaining to preliminary investigations conducted by the MCP. For example, states may contractually require MCPs to establish committees and Special Investigation Units (SIUs) consisting of persons with different types of investigative expertise to review fraud and abuse allegations in accordance with pre-established procedures and recommended timeframes presented in this toolkit. For those MCPs with their own SIUs to investigate suspected provider fraud, the Medicaid PI Unit should assess the adequacy of the preliminary investigation conducted by the SIUs and seek to avoid the duplication and delay of their own preliminary investigation.

Regardless of the arrangements chosen, states should have policies and procedures in place to evaluate the quality and thoroughness of MCP SIU investigations. SIU reviews can be organized as standalone audits or as part of periodic state reviews of MCPs. Such reviews can be helpful in informing states how to

structure future contractual requirements on managed care fraud investigations and referrals. CMS encourages states to share fraud referrals with all MCPs and work collaboratively to discuss fraud referrals, given that providers typically belong to more than one MCP network as well as the SMA's fee-for-service program. The sharing of such information can be useful in mitigating risk across plans and programs, while also ensuring safeguards are in place to protect and not compromise current investigations.

While the quality of fraud referrals is critical, the number of fraud referrals to the SMA, CHIP agency, or law enforcement coming from MCPs can also be a useful metric in evaluating the program integrity activity of a MCP for annual performance reports.

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 16, 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.

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