DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD #24-005

RE: Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions

December 5, 2024

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is releasing this letter to provide guidance to state Medicaid agencies to protect Medicaid beneficiaries from impermissible sanctions and penalties related to Medicaid beneficiary eligibility-related fraud and abuse. This letter builds upon guidance released on October 17, 2022.[1]

As discussed in more detail below, with narrow exceptions, federal law does not permit state Medicaid agencies to recoup funds from, or lock-out from Medicaid coverage, a beneficiary who the state determined abused or defrauded the Medicaid program.[2] CMS expects state Medicaid agencies to promptly cease the use of any sanctions or penalties for beneficiary fraud and abuse, including administrative recoupment activities and lock-outs, that are inconsistent with this guidance. State Medicaid agencies that continue such prohibited actions may be subject to compliance action, including the withholding of federal financial participation (FFP), per section 1904 of the Social Security Act (the Act) and 42 CFR § 430.35.

Background

Federal regulations at 42 CFR § 455.12 *et seq.* require each state Medicaid agency to operate a fraud and abuse detection and investigation program. Although states' Medicaid program integrity efforts are generally focused on provider fraud and abuse, these programs are also responsible for addressing instances of alleged beneficiary fraud and abuse.

Once a state Medicaid agency determines or redetermines that an individual is eligible for Medicaid, the individual is a Medicaid beneficiary and is entitled to Medicaid benefits until the state Medicaid agency has made a determination of ineligibility and provided at least 10 days

[1] See frequently asked question (FAQ) #31, COVID-19 Public Health Emergency Unwinding Frequently Asked Questions for State Medicaid and CHIP Agencies, October 17, 2022. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/covid-19-unwinding-faqs-oct-2022.pdf.

[2] A "lock-out" refers to a situation where a state Medicaid agency bars an individual from applying for and/or receiving Medicaid coverage for a specified length of time and/or makes receipt of Medicaid services contingent upon repayment of funds.

advance notice and fair hearing rights. These due process protections apply even if the state Medicaid agency subsequently questions the accuracy of the information underlying the original determination or a beneficiary did not timely report a change in their circumstances impacting their eligibility.[3]

Eligibility Determinations and Redeterminations

State Medicaid agencies are expected to make timely and accurate eligibility determinations and redeterminations in accordance with federal regulations and state verification plans, including acting upon information about a change in a beneficiary's circumstances that may affect eligibility.[4] State Medicaid agencies must have procedures in place to ensure that beneficiaries timely and accurately report any change in circumstances that may affect their eligibility and have the option to periodically check electronic data as a way to identify changes in circumstances.[5] State Medicaid agencies must educate applicants and beneficiaries about their responsibility to provide accurate information at initial application and whenever completing a renewal form, as well as their obligation to timely and accurately report to state Medicaid agencies any changes in their circumstances that could affect their eligibility, such as an increase in income or a move out of state.[6] This must be done in a manner that is accessible to individuals with limited English proficiency and individuals living with disabilities.[7]

Inaccurate determinations, which may be due to error on the part of the beneficiary or the state Medicaid agency, may occur even when eligibility determinations and redeterminations have been conducted in accordance with federal regulations and the state's verification plan. A state Medicaid agency that believes an eligibility determination was made erroneously should treat the information that led to this conclusion as a possible change in circumstances and, in accordance with federal regulations, conduct a redetermination of the beneficiary's eligibility.[8] Prior to making a determination of ineligibility, the state must consider the beneficiary's eligibility on all bases.[9] If the beneficiary is determined ineligible for Medicaid on all bases, the state Medicaid agency must provide the beneficiary with advance notice of the Medicaid eligibility termination and fair hearing rights prior to terminating the individual's eligibility.[10] States may not retroactively terminate a beneficiary's coverage back to the date of the inaccurate determination or a previous change in circumstance, as doing so would violate the beneficiary's due process rights. Inaccurate determinations do not fall within the scope of the definitions of fraud or abuse solely because the of their inaccuracy.[11]

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[3] 42 CFR §§ 435.4, 435.930(b), and part 431, subpart E; and Section 1902(a)(3) of the Act.
[4] 42 CFR §§ 435.911-912, 435.916, 435.919, and 435.945-956.
[5] 42 CFR §§ 435.919(a) and 435.940.
[6] 42 CFR §§ 435.905(a), 435.917(b), and 435.919(a)(1).
[7] 42 CFR § 435.905(b). For more information about requirements to effectively communicate with individuals with disabilities under federal law, see also 45 CFR § 92.202, 28 CFR § 35.160, and 45 CFR § 84.77. For more information about requirements to provide meaningful access for individuals with limited English proficiency, see 45 CFR § 92.201.
[8] 42 CFR § 435.919(b).
[9] 42 CFR §§ 435.916(d), 435.919(b)(5)(i), and 435.911.
[10] Section 1902(a)(3) of the Act and 42 CFR part 431 subpart E.
[11] 42 CFR § 455.2.

Fraud and Abuse

Fraud is defined at 42 CFR § 455.2 as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law." Section 1128B of the Act specifies criminal penalties for certain acts involving federal health care programs, including Medicaid, and generally sets out a "knowing and willful" standard for the offending conduct. Abuse is defined at 42 CFR § 455.2 as including "beneficiary practices that result in unnecessary cost to the Medicaid program." State Medicaid agency error does not fall within the scope of these definitions for fraud and abuse, may not be attributed to beneficiaries, and may not be considered beneficiary fraud or abuse.

Federal regulations describe the steps a state Medicaid agency must take to address instances of potential beneficiary fraud or abuse.[12] This guidance does not alter the existing and longstanding requirement to refer suspected incidents of beneficiary fraud to an appropriate law enforcement agency.[13] Given the potential overlap between actions that could constitute beneficiary fraud and actions that could constitute beneficiary abuse, it may be appropriate for the state Medicaid agency to pursue a concurrent investigation of beneficiary abuse in some cases where suspected fraud is referred to law enforcement, provided the potentially fradulent activity also meets the definition for abuse. In such circumstances, a state Medicaid agency should coordinate with the applicable law enforcement agency to ensure that continued state Medicaid agency investigative activity does not jeopardize or interfere with law enforcement activity.

This guidance also does not alter the existing and longstanding requirement that the state Medicaid agency must conduct a full investigation of alleged abuse.[14] Only after conducting a full investigation that finds that beneficiary abuse has occurred may a state Medicaid agency impose administrative sanctions for such conduct. Permissible administrative sanctions for abuse are discussed below. State Medicaid agencies should develop reasonable criteria to determine when a beneficiary's actions rise to the level of abuse in the context of having established, or maintained, eligibility. When assessing a beneficiary's actions, state Medicaid agencies should determine, on a case-by-case basis, whether there was a reasonable explanation for the beneficiary failure to meet the state's standards. Examples of potential reasonable explanations include: an authorized representative failed to report a change in circumstances timely on behalf of a beneficiary; a beneficiary did not know to report any change in circumstances because the state Medicaid agency failed to provide the required communication advising of this requirement, or failed to communicate in a clear and accessible manner;[15] and an individual was

[12] 42 CFR §§ 455.12 through 455.15.
[13] 42 CFR §§ 455.15(b). If the referred beneficiary fraud includes involvement by a provider, the case should also be referred to the state Medicaid Fraud Control Unit (MFCU), consistent with section 455.15(a).
[14] 42 CFR § 455.15(c).
[15] 42 CFR § 435.905(b). For more information about requirements to effectively communicate with individuals with disabilities under federal law, see also 45 CFR § 92.202, 28 CFR § 35.160, and 45 CFR § 84.77. For more

unable to report a change in circumstances by phone because the agency does not provide this required modality.[16] Because not all failures to timely report a change in circumstances will meet the definition of abuse, state Medicaid agencies may not automatically treat every beneficiary failure to report as abuse.

Impermissible Administrative Sanctions

Recoupment of Funds ("Overpayments")

State Medicaid agencies do not have authority to impose an administrative sanction to recoup from beneficiaries funds, or "overpayments," including in instances due to agency error, except in circumstances explicitly provided in federal statute and implementing regulations.[17] These include:

(1) Liens placed on a beneficiary's property prior to the beneficiary's death pursuant to the judgment of a court[18] that Medicaid benefits were incorrectly paid under section 1917(a)(1)(A) of the Act and 42 CFR § 433.36(g)(1),[19]
(2) Estate recovery proceedings for correctly paid Medicaid benefits required under section 1917(b)(1) of the Act, and
(3) Benefits provided pending the outcome of a fair hearing under 42 CFR § 431.230.[20]

Recoupment of funds from beneficiaries for the cost of medical assistance (whether the cost of services provided on a fee-for-service basis or capitation payments to a managed care plan) provided prior to the effective date of a beneficiary's termination would deny the beneficiary their rights to advance notice of termination and a fair hearing. These due process rights are protected not only by federal statute and regulations but also by Supreme Court jurisprudence.[21]

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information about requirements to provide meaningful access for individuals with limited English proficiency, see 45 CFR § 92.201.

[16] The required modalities a state must provide for a beneficiary to report information related to eligibility, including changes in circumstances, are: (1) internet web site; (2) telephone; (3) mail; (4) in person; and (5) other common electronic means (see 42 CFR § 435.907(a)).

[17] The colloquial use of the term "overpayment" in this context is inconsistent with the definition of "overpayment" at 42 CFR §§ 438.2 and 433.304, and in 42 CFR part 455, all of which focus on overpayments to providers. This use of the term "overpayment" is also inconsistent with the definition in section 1128J(d)(4) of the Act, which excludes Medicare and Medicaid beneficiaries from the definition of a person who can receive an overpayment.

[18] A state's fair hearing process, including a fair hearing conducted by an administrative law judge (ALJ), is not considered a court for the purposes of the lien exception at section 1917(a)(1)(A).

[19] For more information on liens, please see Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid (2020), available at: https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf.

[20] States may not recoup the costs of benefits provided pending the outcome of a fair hearing during the COVID-19 public health emergency (PHE). Recoupment of the cost of benefits provided while the continuous enrollment condition was in effect would jeopardize the enhanced match claimed pursuant to section 6008 of the Families First Coronavirus Response Act (FFCRA); see footnote 9 in the March 2022 State Health Official Letter # 22-001 available at: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[21] Advance notice and fair hearing rights are described in federal statute at section 1902(a)(3) of the Act and in federal regulations at 42 CFR part 431, subpart E. These rights include advance notice of termination and the right to a fair hearing before the state. Medicaid beneficiaries are also afforded due process rights under relevant Supreme

State Medicaid agencies also are not permitted to ask that beneficiaries voluntarily remit payment to the state for these costs. Even if voluntary, repayment would effectively function as a retroactive termination of eligibility and would be a violation of the Medicaid beneficiary's due process rights.

Lock-outs

There is no authority under either the federal Medicaid statute or governing regulations for a state Medicaid agency to impose a lock-out as an administrative sanction, except as provided for in limited circumstances under section 1128B(a) of the Act. Section 1128B(a) of the Act provides the state Medicaid agency the discretion to limit, restrict, or suspend, for up to one year, Medicaid coverage of an otherwise-eligible individual who is convicted of fraud in federal court. Such a penalty cannot affect the Medicaid eligibility of any other person, such as children in an affected individual's household, regardless of the relationship between the individual and the penalized beneficiary. Section 1128B of the Act does not authorize lock-outs for state court convictions or for civil judgments.

Except as authorized under section 1128B(a) of the Act, federal law does not permit states to prevent an individual who has been convicted of fraud from applying for or receiving Medicaid. Lock-outs are impermissible because they violate the requirements at sections 1902(a)(8) and 1902(a)(10) of the Act, which require states to allow all individuals to apply for Medicaid, and to furnish benefits to eligible individuals with reasonable promptness and in accordance with their state plans. Lock-outs impermissbly prevent individuals from applying, deny individuals coverage if they are eligible, and violate the requirement that states provide services to eligible individuals with reasonable promptness.

Terminations of Eligibility

State Medicaid agencies cannot terminate the eligibility of any beneficiary, including a beneficiary suspected of committing or determined to have committed fraud or abuse, prior to: (1) conducting a redetermination of eligibility based on a change in circumstances or a renewal that results in a determination that the beneficiary is ineligible for Medicaid on all bases; [22] and (2) providing advance notice of termination and fair hearing rights.[23] In cases of suspected beneficiary fraud, the period of advance notice may be shortened from 10 days to 5 days if the state Medicaid agency has verified facts indicating possible fraud through independent sources.[24] No reductions in the advance notice period are authorized for cases of suspected beneficiary abuse.

Court due process jurisprudence (see Goldberg v. Kelly, 397 U.S. 254 (1970) and its progeny). Additionally, regulations at 42 CFR § 435.930(b) require the state Medicaid agency to continue furnishing Medicaid regularly to all eligible individuals until they are found ineligible.

[22] 42 CFR §§ 435.916, 435.919, and 435.930(b).

[23] Section 1902(a)(3) of the Act and 42 CFR part 431, subpart E.

[24] 42 CFR § 431.214.

Penalties for Beneficiary Fraud

A state Medicaid agency must continue to follow existing regulations regarding fraud, including the obligation to refer cases of potential beneficiary fraud to law enforcement.[25] Individuals convicted of fraud in either state or federal court would be subject to the penalties imposed by the court.[26] Likewise, in a civil fraud proceeding, an individual may be found liable via a court judgment or may settle voluntarily. We note that individuals may be subject to criminal and civil penalities for fraud, or liable for civil damages due to fraud, and such penalties or damages are beyond the scope of this guidance. State Medicaid agencies should consult with their legal counsel on court orders or criminal or civil penalties that they are concerned may be inconsistent with federal Medicaid statute and regulations.

Permissible Sanctions for Beneficiary Abuse

Sanctions for beneficiary abuse may only be applied by a state Medicaid agency to a beneficiary *after* the completion of a full investigation by the state Medicaid agency that results in a determination that the beneficiary committed abuse.[27] Any sanctions for beneficiary abuse other than a warning letter must be approved by CMS and documented in the state plan.[28] Such sanctions cannot conflict with other federal statutory or regulatory requirements.

Warning Letters

The state Medicaid agency may send a warning letter to a beneficary if, after a full investigation, the agency determines that a beneficiary has engaged in abusive behavior. The warning letter may provide notice that continuation of the conduct in question may result in further action.[29] State Medicaid agencies do not need to identify the use of warning letters as a sanction for beneficiary abuse in the Medicaid state plan in order to send such letters.

Fines

The state Medicaid agency may administratively impose fines on beneficiaries who commit eligibility abuse as an "other sanction," subject to the limitations explained below and provided that the state's policy for the circumstances under which fines may be imposed and the amount of such fines are documented in an approved Medicaid state plan amendment.[30]

Fines for abuse imposed administratively by the state Medicaid agency cannot equal or exceed the value of items and/or services provided to, or capitation payments made on behalf of, the

[25] 42 CFR § 455.15(b).
[26] See the definition of "conviction" at 42 CFR § 1001.2. See section 1128B(a) of the Act, which describes the criminal penalties that may be imposed on a beneficiary convicted in federal court of violating this provision.
[27] 42 CFR § 455.15(c).
[28] 42 CFR § 455.16(c)(4).
[29] 42 CFR § 455.16(c)(1).
[30] 42 CFR § 455.16(c)(4).

beneficiary after the instance of abuse, as this would effectively constitute a recoupment of funds which, as discussed above, violates a beneficiary's due process rights.

To ensure that fines do not function as a *de facto* administrative recoupment, fines must be reasonable in amount and not be correlated with the value of items and services provided to the beneficiary after the instance of abuse. Any fine structure tied to the costs of medical assistance incurred by the state Medicaid agency would effectively serve as a retroactive determination of ineligibility, which, as discussed above, is not permitted. State Medicaid agencies considering fines as an administrative sanction for beneficiary abuse should contact their CMS state lead for technical assistance.

If a state Medicaid agency chooses to impose a fine as a sanction for beneficiary abuse and CMS approves a state plan amendment reflecting the agency's fine policy, any fine imposed effectively increases beneficiary liability. Because an increase in beneficiary liability is an adverse action, the state Medicaid agency must provide at least 10 days advance written notice to the beneficiary, including information regarding the beneficiary's fair hearing rights, prior to imposing a fine for abuse.[31] As noted above, no reductions in the advance notice period are authorized for cases of beneficiary abuse.

Other Sanctions

State Medicaid agencies considering sanctions other than those discussed in this section should contact their CMS state lead for technical assistance to determine if such other sanctions are permissible under federal statute and regulations.

Due Process for Beneficiary Fraud and Abuse

State Medicaid agencies must ensure that their processes for investigating instances of suspected Medicaid beneficiary fraud and abuse do not infringe on the legal rights of the individuals involved and afford said individuals due process of law.[32] Individuals must be provided with the opportunity to challenge allegations of fraud or abuse. In cases of suspected fraud, the ability to challenge the allegation is provided through the law enforcement process. In cases of suspected abuse, the state Medicaid agency must provide a process for the beneficiary to challenge the state's allegation of abuse and any sanctions imposed.[33] This could be satisfied through the state's fair hearing process or another process that affords the individual due process of law. As discussed earlier, the state Medicaid agency must provide advance notice and fair hearing rights prior to imposing a fine as a sanction for abuse.

Documentation

[31] 42 CFR §§ 431.201 and 431.211. For more information on the fair hearing content which must be included in the notice, please see 42 CFR §§ 431.206-210.
[32] 42 CFR § 455.13(b).
[33] 42 CFR § 455.13(b)(2).

All states are required to complete Medicaid state plan section 4.5 ("Medicaid Agency Fraud Detection and Investigation Program"), which documents a state's attestation that it maintains a program for the prevention and control of Medicaid fraud and abuse consistent with 42 CFR §§ 455.13 through 455.21 and 455.23. If a state Medicaid agency seeks to impose administrative sanctions for abuse in addition to the warning letter provided for in regulation, the state Medicaid agency must document, and receive CMS approval for, the additional sanctions in its Medicaid state plan, including how each sanction will be implemented, consistent with the guidance in this letter.[34] CMS is available to provide technical assistance on whether such additional sanctions are permissible under federal law and regulations.
As noted earlier, fraud penalties are limited to those provided in criminal and civil statutes, and are outside the scope of this guidance. They should not be included in the Medicaid state plan.

Closing

As noted above, CMS expects state Medicaid agencies to promptly cease the use of any sanctions or penalties for beneficiary fraud and abuse that are inconsistent with this guidance, including administrative recoupment activities and lock-outs, unless expressly permitted in federal statute and/or regulations. State Medicaid agencies that continue such prohibited actions may be subject to compliance action, including the withholding of federal financial participation, per section 1904 of the Act and 42 CFR § 430.35.

CMS is ready to work with and provide technical assistance to states as they implement beneficiary protections that comport with requirements in this letter. If you have any questions regarding the information in this letter, please contact MedicaidPIBeneficiaryProtections@cms.hhs.gov.

Sincerely,

/s/

Daniel Tsai
Deputy Administrator and Director

[34] 42 CFR § 455.16(c)(4).