DHCS Draft Fraud and Abuse Guidance Proposes Major Changes Affecting Providers

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The California Department of Health Care Services (DHCS) has released a draft All Plan Letter (APL) with major implications for Medi-Cal providers. The draft would revise managed care plan duties concerning suspected fraud, waste, and abuse (FWA) and credible allegations of fraud (CAF).

The draft applies directly to Medi-Cal managed care plans (MCPs), but providers may experience its most significant practical effects. MCPs already have substantial fraud-detection, investigation, audit, and referral responsibilities. Federal rules also require them to promptly refer potential FWA to the State. The important change is timing and process. DHCS proposes to require much earlier and more standardized government reporting of suspected misconduct, before a plan has substantiated it. Mandatory investigation and continuing reporting would follow.

The draft would significantly change existing APL 15-026. Under the draft, an MCP would be required to promptly commence and complete a full investigation after making a preliminary report of suspected FWA. This would apply even though the suspected conduct has not yet been validated or substantiated. The draft would also replace APL 15-026's menu of plan responses to a State-verified CAF with a prescribed monitoring protocol.

If the State verifies a CAF, the MCP would be required to place the affected provider under enhanced monitoring and, absent an applicable exception, suspend payments.

The draft comes against a backdrop of increased federal scrutiny of Medicaid managed care plans' fraud-referral practices. In September 2025, the HHS Office of Inspector General (OIG) reported that 10 percent of surveyed Medicaid managed care plans made no provider fraud referrals in 2022. More than half of the plans that did make referrals made two or fewer per 10,000 enrollees. OIG recommended that CMS follow up with States whose plans made no referrals. California providers should expect plans to refer more often and earlier.

Providers should closely watch this proposal and consider commenting before the APL is finalized. Comments are due by close of business on ***December 7, 2026****.*

Plans Would Have to Report Suspected Conduct Before Substantiating It

Preliminary FWA Reporting and CAF Identification: Under the draft, suspected FWA may arise from a complaint, referral, irregularity, anomaly, data outlier, or other suspicious activity. These broad triggers would require an MCP to report alleged misconduct to the government. The MCP would not need to validate or

substantiate the conduct first.

An MCP would have ten Working Days to submit a preliminary report after discovering or receiving notice of suspected FWA. The report would go to DHCS's Program Integrity Unit and the California Attorney General's Division of Medi-Cal Fraud and Elder Abuse.

This preliminary reporting standard differs materially from a CAF determination. Federal regulations require the State to verify a CAF. The State must review the allegations, facts, and evidence. It must also find indicia of reliability.

This critical distinction may warrant emphasis in comments. The final APL should state that a preliminary report alone cannot trigger CAF consequences. Without that safeguard, a billing anomaly could produce a government referral before the provider can respond. The same risk exists for incomplete complaints.

FWA Investigation: After filing the preliminary report, the MCP must promptly commence and complete a full investigation. It must report its findings within ten Working Days after completing the investigation. The report must describe the plan's actions and include supporting documents.

Plans must also submit quarterly reports on preliminary, active, and completed investigations. The draft sets no deadline for completing an investigation. A provider could therefore face extended scrutiny without a defined endpoint.

CAF Monitoring and Payment Suspension Raise Serious Provider Concerns

When DHCS verifies a CAF, the MCP must immediately begin enhanced monitoring. This requirement applies to both in-network and out-of-network providers. The plan must review relevant claims, claim lines, and encounter data within 30 calendar days. Federal rules also require an MCP to suspend payments after the State determines a CAF exists.

The plan must then decide whether an on-site visit is necessary. That decision is due within ten Working Days after the initial review. If a visit is necessary, the plan must seek approval from DHCS and the Attorney General's office.

The draft raises notice concerns, as it prohibits the MCP from disclosing the CAF investigation to the provider. It treats information supplied by DHCS as confidential. A provider could face heightened review or unpaid claims without knowing the reason.

Federal and California law provide protections when the State suspends Medicaid payments based on a CAF. Those protections generally include prompt notice. The notice must identify the general allegations and affected claims. Providers may submit written evidence and pursue an appeal. California law also provides a meet-and-confer process. It gives providers 60 days to appeal the credibility determination in writing. The draft does not explain how these protections apply to an MCP payment hold. It also does not explain how confidentiality affects those rights.

These gaps warrant comment before the draft is finalized. Providers may wish to request clear notice, good-cause, and appeal protections for plan-level payment action. They may also seek a clear process to challenge payment suspension while protecting confidential investigative information.

Provider Comments Should Address Contract Changes and Existing Protections

The draft requires MCPs to communicate the new requirements to network providers and other downstream entities. It also directs plans to review their agreements. Plans may seek new terms concerning reporting, investigations, records, audits, cooperation, and confidentiality.

Providers should not assume the APL authorizes every requested amendment. The APL also does not necessarily give plans unlimited audit or enforcement rights. Existing law and contract terms remain important. California law generally restricts unilateral changes to material provider contract terms. It also requires fair and cost-effective plan-provider dispute procedures.

The APL, as drafted, does not provide clear limits on obligations imposed through plan contracts. An APL directly governs MCP conduct. Provider obligations usually arise from applicable law or the provider agreement. Clear limits would reduce the risk of overbroad contract demands. Plans should not characterize broader rights as DHCS requirements when they exceed governing law or existing agreements.

Providers Have an Opportunity to Raise These Concerns Before the APL Is Final

Providers and provider organizations may wish to submit comments before the APL is finalized. Comments are due to DHCS by close of business on December 7, 2026. Although the draft APL is framed as guidance to MCPs, it could materially affect providers through referrals, confidential monitoring, payment action, investigations, and contract changes. Focused provider comments may help DHCS address concerns before the requirements become final.

Providers should also review their managed care agreements and internal response procedures now. Provisions that may be affected include FWA reporting, audits, investigations, record production, overpayment recovery, confidentiality, payment suspension, termination, dispute resolution, and arbitration.

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