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States Have Missed Some Opportunities to Improve Medicaid Managed Care Organizations' Provider Fraud Referrals

HHS Office of Inspector General

REPORT HIGHLIGHTS

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States Have Missed Some Opportunities to Improve Medicaid Managed Care Organizations' Provider Fraud Referrals

Why OIG Did This Review

- Fraud in Medicaid managed care depletes critical resources and may cause harm to enrollees.
- State Medicaid agencies (States) play a key role in protecting taxpayer dollars by overseeing Medicaid managed care organizations (MCOs) and ensuring that MCOs identify potential fraud—including provider fraud—and refer it to States and Medicaid Fraud Control Units (MFCUs).
- OIG and CMS have cited concerns about a lack of fraud referrals in Medicaid managed care and States' efforts to oversee MCOs' fraud referrals. This evaluation examines how States use contract requirements and other practices to improve the volume and quality of MCOs' provider fraud referrals.

What OIG Found

States' contracts generally required MCOs to refer provider fraud to the State but had key differences:

- Most States reported that their contracts required MCOs to refer "any potential fraud" to the State and/or MFCU, while some other States' contracts used terms such as "credible allegations of fraud."
- States' contracts specified different timeframes for MCOs to make referrals, with timeframes varying from 1 day to 270 days and some States not setting a specific timeframe at all.
- A few States reported that their contracts did not specify the actions the State could take if MCOs did not comply with fraud referral requirements.

Further, some States did not provide fraud referrals training or feedback to MCOs, despite the potential of these practices to improve referrals.

Almost all States identified program-wide actions related to communication, guidance, or processes that CMS could undertake to help them improve the volume or quality of MCOs' provider fraud referrals.

What OIG Recommends

We recommend that CMS help States improve MCOs' provider fraud referrals in these ways:

1. Work with States to ensure that all MCOs are contractually required to refer potential fraud promptly.
2. Urge States to ensure that their contracts with MCOs specify actions the State can take to address MCOs' noncompliance with provider fraud referral requirements.
3. Work with States to expand the feedback provided to MCOs about provider fraud referrals.
4. Assess the feasibility of Federal program-wide actions that States identified as potentially beneficial for improving MCOs' provider fraud referrals and implement those that CMS determines are most promising.

CMS concurred with the first two recommendations. CMS did not explicitly concur or nonconcur with the other two recommendations but indicated that it has undertaken actions to implement them.

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BACKGROUND

OBJECTIVES

To examine how States are using contract requirements, training, and other practices to improve the volume and quality of MCOs' referrals of potential provider fraud.

Fraud in Medicaid managed care depletes critical resources and may cause physical, emotional, and financial harm to enrollees. States play a key role in protecting taxpayer dollars by overseeing MCOs and ensuring that they identify potential fraud—including provider fraud—and refer it to States and MFCUs. Although the amount of provider fraud in Medicaid managed care is unknown, total spending on Medicaid MCOs was more than $450 billion in fiscal year 2024.[1]

Most States contract with MCOs to provide benefits to Medicaid enrollees.[2] According to Federal regulations, these contracts must require MCOs to promptly refer any potential fraud they identify to the State and/or MFCU.[3] However, in 2025, OIG found that some MCOs made few or no referrals of potential provider fraud in 2022.[4] In addition, the Centers for Medicare & Medicaid Services (CMS), through its focused program integrity reviews of States' managed care programs, has identified issues with States' efforts related to fraud referrals. In the resulting reports, CMS has encouraged States to update staffing requirements and other program integrity provisions in their contracts with MCOs, enhance fraud referrals training and/or feedback to MCOs, and make other changes.[5]

Medicaid Managed Care

In December 2024, 44 States (including the District of Columbia and Puerto Rico) contracted with MCOs.[6] The MCOs provide a comprehensive benefits package to their enrollees. States pay MCOs a periodic (usually monthly) fee known as a capitation payment for each enrollee for services covered in the contract, regardless of whether the enrollee uses any services each month.[7] MCOs process, pay, and monitor the claims of providers that render covered services to their enrollees.[8] Further, a single company can operate MCOs in multiple States or have multiple MCO contracts within one State.

Program Integrity in Medicaid Managed Care

CMS, States, MFCUs, and MCOs form a network of entities that share responsibilities to address fraud in the Medicaid program. According to Federal program integrity regulations, States, through their contracts with MCOs, must require MCOs to implement and maintain arrangements or procedures to prevent and detect fraud,

waste, and abuse.[9] Pursuant to these regulations, States must also require MCOs to dedicate staff to ensuring ongoing compliance with program integrity requirements under the contract.[10] States may require MCOs to organize program integrity staff into special investigation units (SIUs).[11] States and/or MCOs sometimes further organize MCOs' staff, such as by dedicating fraud referral staff to making referrals for just that one plan (i.e., rather than for Medicaid and for other health care lines of business, such as Medicare, or for plans in multiple States).[12]

Separate from the State Medicaid agency, each State has a MFCU to investigate and prosecute Medicaid provider fraud and patient abuse and neglect.[13] CMS oversees and supports States' oversight through its program integrity reviews of States' managed care programs, which report findings and recommendations to States, and through Unified Program Integrity Contractor (UPIC) audits of MCOs' program integrity activities, among other program integrity efforts.[14, 15]

Federal program integrity regulations for Medicaid managed care also require States' contracts with MCOs to include a provision for MCOs to promptly refer any potential fraud, waste, or abuse they identify to the State's program integrity unit or any potential fraud directly to the MFCU.[16] Upon receiving a fraud referral from an MCO, States and MFCUs review the referral and may accept it for further investigation.[17, 18] Fraud referrals may not always lead to a finding of fraud by the State or MFCU. Exhibit 1 provides a brief description of selected MCO, State, and MFCU responsibilities related to the referral of fraud in Medicaid managed care.

Exhibit 1: MCO, State, and MFCU responsibilities related to MCOs' fraud referrals

Medicaid MCOs	State Medicaid Agencies	Medicaid Fraud Control Units
MCOs must refer any potential provider fraud they identify to States and/or MFCUs. MCOs must have staff to ensure compliance with Federal program integrity requirements. States may add requirements, such as that program integrity staff be organized into SIUs or be dedicated to that State.	States monitor MCOs' compliance with the program integrity provisions in their contracts, including referral requirements. States refer cases of fraud or abuse to the MFCU or other law enforcement agencies, as needed. The State or MFCU may accept referrals for full investigation.	MFCUs investigate cases of Medicaid provider fraud and patient abuse and neglect and prosecute those cases under State law or refer them to other prosecuting offices. MFCUs must be separate from the State Medicaid agency and are often part of the State's Office of Attorney General.

Sources: Federal regulations at 42 CFR §§ 438.602(a), 438.608(a), 455.14, 455.15(a)(1) and (2), 1007.7, 1007.9(a), and 1007.11(a)(b). CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit Medicaid and CHIP Managed Care Program Integrity Toolkit.

CMS offers guidance and resources to aid States in supporting MCOs' fraud referrals. For example, in November 2023, CMS published a "Prompt Referrals of Potential Fraud, Waste, or Abuse" toolkit that encourages States to establish clear timelines in their contracts for MCOs to promptly report potential fraud, waste, and abuse. Regarding fraud referrals, CMS encourages that "prompt" be defined as "within two business days of the identification of the potential fraud."[19] In June 2025, CMS updated this prompt referrals toolkit to also encourage States to provide "frequent, State-led trainings on program integrity trends and the fraud referral process" to MCOs.[20] In addition, CMS provides its own program integrity education and training for States through the Medicaid Integrity Institute, including courses on referral practices.[21, 22] According to CMS, it expanded the 2026 Medicaid Integrity Institute trainings to include MCO staff.

Related OIG Work

OIG has a substantial body of work examining Medicaid managed care, including work related to Medicaid program integrity and MCOs' fraud referrals.

In September 2025, OIG found that some MCOs made few or no provider fraud referrals in 2022.[23] OIG also found that both (1) MCOs that received training from the State or MFCU and (2) MCOs that had dedicated referral staff made more referrals than MCOs that did not. However, many MCOs reported that they lacked such training or staffing. At that time, some MCOs that reported to OIG that they did not receive feedback from States on the volume or quality of their fraud referrals also reported that such feedback could improve future referrals. OIG recommended that CMS: (1) follow up with States that had MCOs with no referrals and (2) encourage States to increase the number of MCOs that received State-led training on the fraud referral process. CMS implemented the second recommendation by making the June 2025 update to the prompt referrals toolkit mentioned above.[24] As of publication, the first recommendation remains unimplemented.

A prior 2018 OIG report had also found weaknesses in MCOs' efforts to identify cases of potential fraud and refer them to States.[25] In that report, OIG recommended that CMS work with States to improve MCOs' identification and referral of cases of suspected fraud or abuse. CMS implemented this recommendation through the November 2023 publication of program integrity toolkits, including the prompt referrals toolkit.[26]

OIG also administers and oversees the MFCU program, including publishing inspections of individual MFCUs and annual reports summarizing the activities and accomplishments of all MFCUs in that fiscal year. The fiscal year 2025 MFCU Annual Report highlighted MFCUs' activities, including the total number of MCO fraud referrals that MFCUs received during 2021 to 2025.[27]

Methodology

To address our objectives, we collected data from States using a self-administered information request. We sent the information request to 52 States (including the District of Columbia and Puerto Rico) in January 2025 and received responses from 51 States. We analyzed data from 43 States that responded to the request and reported that they contracted with 1 or more MCO(s) in December 2024 (of 44 States that contracted with MCOs as of December 2024).[28] We reviewed and summarized States' responses to closed- and open-ended questions regarding: (1) States' contract requirements related to MCOs' provider fraud referrals; (2) States' practices regarding MCOs' provider fraud referrals, such as the extent of training and feedback to MCOs in 2024; (3) difficulties States faced overseeing MCOs' provider fraud referrals; and (4) CMS and State actions that States believed would improve the volume and/or quality of MCOs' referrals.

One of the forty-three States that contracted with MCOs in December 2024 reported that the State did not receive any fraud referrals from its MCOs in that year.[29] For that reason, only 42 States were eligible to answer questions regarding their feedback to MCOs about referral quality.

Limitations

We did not independently verify the self-reported information that States provided in response to OIG's information request. However, we followed up with States to clarify responses when needed.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

States' contracts generally required MCOs to refer provider fraud to the State, but some specified different standards for the scope and timeliness of MCOs' referrals or for MCO accountability of referrals

Almost all States reported that their contracts required all MCOs to refer provider fraud, as required by Federal regulation.[30] Specifically, 42 of 43 States reported that all of their contracts required MCOs to refer provider fraud to the State's program integrity unit. Nineteen of those forty-two States reported that their contracts also required MCOs to refer provider fraud directly to the MFCU.[31] The remaining State reported that some (but not all) of its contracts required MCOs to refer provider fraud to the State and that its MCOs did not have to refer provider fraud directly to the MFCU.

States' contracts used different terms to describe MCOs' fraud referral requirements

States reported using different contract language to describe MCOs' fraud referral requirements. Thirty-six of forty-three States reported that all of their contracts with MCOs had a provision that required MCOs to specifically refer "any potential fraud" to the State. Seven States reported that some or all of their contracts with MCOs used different language regarding fraud referrals to States. Of the terms used, some States reported requiring MCOs to refer all suspected fraud or any suspected fraud. Some States reported requiring MCOs to refer credible allegations of fraud.

Of the 19 States with contracts that also required MCOs to refer provider fraud directly to the MFCU, most (14 States) had a provision that required all of their MCOs to specifically refer "any potential fraud" to the MFCU. Of those that used other terms, some States reported that their contracts required MCOs to refer all suspected fraud or credible allegations of fraud to the MFCU.

Two States' contracts did not specify a timeframe for MCOs to promptly refer fraud

Two States reported that their contracts did not require MCOs to make provider fraud referrals within a given timeframe after the MCO identified the potential fraud, despite the Federal requirement that States ensure that MCOs refer fraud promptly.[32] Further, although CMS's prompt referrals toolkit encourages States to establish "clear timelines" for fraud referrals in MCOs' contracts, an additional 10 States reported using timeframes that were not a specific number of days (e.g.,

the timeframe was "promptly").[33] See Appendix A for more information regarding States that did not implement referral timeframes and/or other contract provisions and practices related to MCOs' provider fraud referrals.

The remaining 31 States reported that some or all of their contracts specified a set number of days for MCOs to refer potential provider fraud after identifying it. The timeframes set by those 31 States varied, ranging from 1 day to 270 days (the median was 5 days). Five of the thirty-one States required MCOs to make referrals within 2 or fewer days, the timeframe that CMS encourages States to set in its prompt referrals toolkit.[34]

Three States' contracts did not specify the actions the State could take to address MCOs' noncompliance with fraud referral requirements

Three of forty-three States reported that none of their contracts with MCOs specified the actions the State could take if the MCOs did not comply with the provider fraud referral requirements in those contracts. According to CMS, although noncompliance with fraud referral requirements is not a required basis for sanction under the relevant Federal regulations, States have flexibility to impose State-specific sanctions in additional areas of noncompliance.[35, 36] Among the remaining States, most (38 of 40 States) reported that all of their contracts specified the actions the State could take to address MCOs' noncompliance, and 2 States reported that some of their contracts specified such actions.

The 3 most common actions specified were civil monetary penalties (35 States), corrective action plans (34 States), and contract termination (27 States). Other actions, such as options to disenroll members or to suspend payments or contracts, were less common. See Appendix B for more information about the actions States' contracts specified they could take to address MCOs' noncompliance.

Three of the forty States with contract language that specified actions to address noncompliance with fraud referral requirements took action against MCOs in 2024. Specifically, these 3 States took action against 10 total MCOs for not meeting contract requirements to refer provider fraud. These States reported that they required the MCOs to implement corrective action plans, levied civil monetary penalties, and/or recouped a percentage of capitation payments made to the MCOs.

Some States did not train or give feedback to MCOs on fraud referrals, and half did not require MCOs to have dedicated Medicaid program integrity staff, despite the potential of these practices to improve referrals

Three State practices—although not required by CMS—were highlighted both by States (in this review) and in our 2025 evaluation of MCOs as having the potential to improve the volume and/or quality of MCOs' provider fraud referrals: (1) providing fraud referral training to their MCOs, (2) providing feedback to their MCOs about the volume or quality of provider fraud referrals, and (3) requiring their MCOs to have program integrity staff dedicated to Medicaid and/or to that State. However, 26 of 43 States had not adopted 1 or more of these 3 promising practices. Of these 26 States, 3 had not adopted any of them.

In OIG's 2025 report, we found that both (1) MCOs that received training from the State or MFCU on the fraud referral process and (2) MCOs that had fraud referral staff dedicated solely to that MCO made more provider referrals. In addition, some MCOs that reported that they did not receive any State feedback on the volume or quality of their referrals also reported that receiving such feedback could improve their ability to make future referrals.

In this current review, most States that reported increasing training, increasing feedback, or adding staffing requirements after a CMS program integrity review also reported an increase in referral volume and quality after making those (and other) changes. Further, many States—both States that had already implemented some of these practices and States that had not—reported that increasing these efforts would improve referral volume and/or quality.

Eight States indicated that they did not provide fraud referral training to MCOs

Eight of forty-three States indicated that, in 2024, they did not provide training about the fraud referral process to any MCO staff responsible for making provider fraud referrals. Another two States reported that they provided such training to the responsible staff for only some of their MCOs. Thirty-three States provided training to all MCOs.

Of the 35 States that provided training to some or all of their MCOs, most States required the staff responsible for making referrals to take the training. However, eight States did not.

Eleven States—including three of the eight States that did not provide fraud referral training—reported that they did not have enough staff to provide such training to MCOs. States reported that if CMS published training materials (40 of 43 States) or provided training to MCO staff (38 of 43 States) about identifying, investigating,

and/or referring instances of potential fraud, that would help improve the volume and/or quality of provider fraud referrals.[37]

Six States reported that they did not provide feedback to MCOs about the volume or quality of MCOs' provider fraud referrals

Six of forty-three States reported that they did not provide any feedback to MCOs about the volume or quality of their provider fraud referrals in 2024. An additional 14 States did not provide feedback to MCOs about volume (but provided feedback about quality), and 2 States did not provide feedback to MCOs about quality (but provided feedback about volume).

All six states that did not provide feedback to MCOs specific to their referral volume or quality reported that they did otherwise communicate information about provider fraud referrals to MCOs. Specifically, all six States reported meeting with MCOs (e.g., monthly or quarterly). Two States explained that, during those regular meetings, they discussed cases and potential referrals.

Twenty-three States reported that they did not require MCOs to have program integrity staff dedicated solely to Medicaid managed care and/or that State

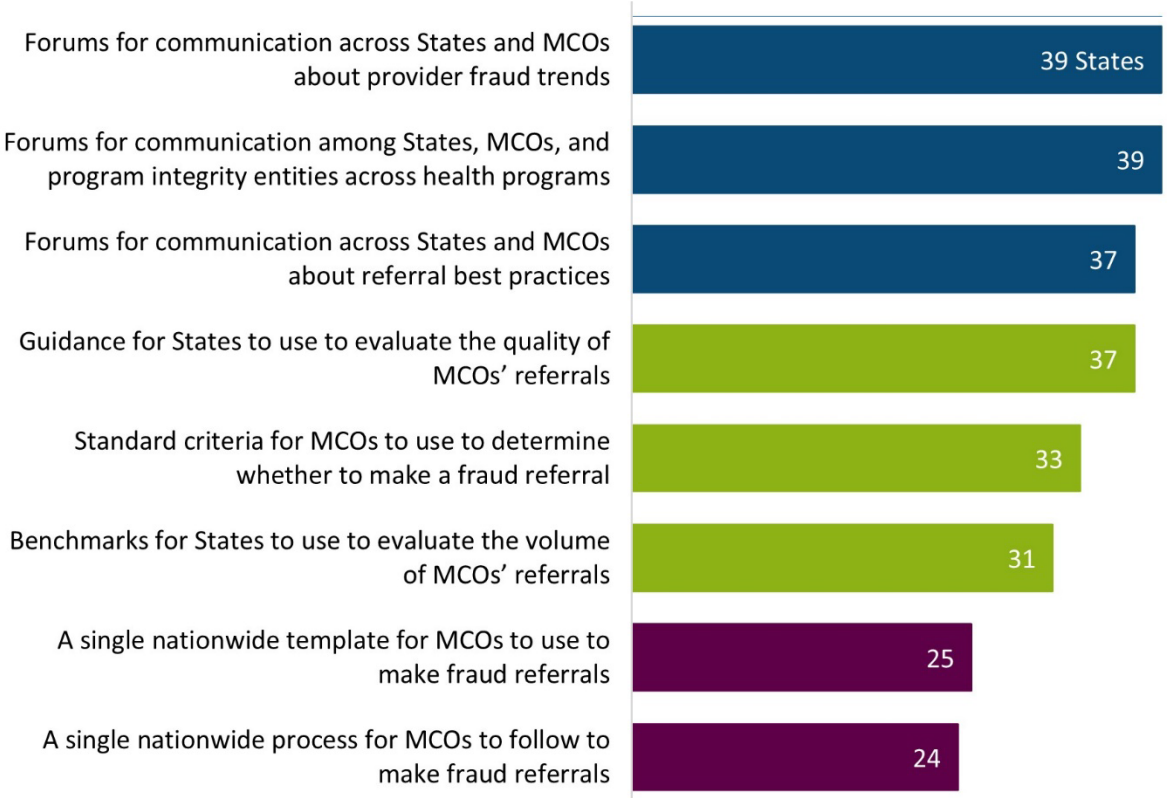
Twenty-three of forty-three States reported that their contracts did not require all MCOs to have program integrity staff dedicated to Medicaid and/or dedicated to the State. None of the 23 States required MCOs to have staff dedicated to conducting program integrity activities for only Medicaid. Nineteen of those States also did not require all MCOs to have program integrity staff dedicated to only that State.

Although MCOs having program integrity staff dedicated to Medicaid and/or dedicated to the State appears to be promising for increasing fraud referral volume and/or quality, some States identified potential drawbacks to this practice. For example, 8 of the 23 States that lacked 1 or both dedicated staffing requirements also reported that they did not believe that adding such requirements would improve the volume and/or quality of their MCOs' fraud referrals. Although not all of these eight States explained their reasons for this, one State offered that adding Medicaid-only staffing requirements could result in difficulty hiring. Another State noted that fraud often occurs across programs (e.g., Medicare and Medicaid), and that having its staff conduct analyses across those programs can sometimes help identify fraud. Notably, a different State, which also lacked dedicated staffing requirements, reported that even though adding the requirements may increase difficulty hiring, the requirements could still improve its MCOs' referrals.

States identified actions that CMS could undertake to help improve the volume or quality of MCOs' provider fraud referrals

Almost all States (42 of 43) identified at least 1 action that CMS could implement to help improve the volume or quality of MCOs' provider fraud referrals. Those actions were related to communication, guidance, and referral processes. For example, 39 of 43 States reported that CMS hosting forums for communication across States and MCOs about provider fraud trends would improve MCOs' referrals. See Exhibit 2 for a list of the CMS actions that States identified.

Exhibit 2: States reported that CMS implementing these actions related to communication, guidance, and referral processes would improve the volume and/or quality of MCOs' provider fraud referrals



Source: OIG analysis of State information request data, 2025.

Some States described the CMS actions that they believed would improve MCOs' provider fraud referrals. For example, one State suggested that CMS facilitate collaboration among States to develop key performance indicators that States could use to monitor MCOs' anti-fraud activities and report on progress and outcomes. Another State reported that, if CMS implements any program-wide actions, that State would want to provide input on templates or processes. Finally, another State noted that templates would need to be flexible to account for variations across States and markets.

Efforts that CMS may undertake regarding the quality of the fraud referrals States receive from MCOs are particularly important given that many States reported that they faced resource constraints in addressing the provider fraud referrals they received from MCOs. Twenty-one of forty-three States reported that they did not have enough staff to investigate the fraud referrals they received from MCOs. Ten States reported that they did not have the technology infrastructure (e.g., software or systems) necessary to analyze and/or evaluate MCOs' fraud referrals.

CONCLUSION AND RECOMMENDATIONS

States play a key role in ensuring that MCOs identify and refer potential provider fraud, as required. However, we found that States missed opportunities to use their contracts with MCOs and other practices to improve the volume and quality of MCOs' provider fraud referrals. In their contracts with MCOs, States' standards for MCOs' referrals varied in how they described fraud referral requirements, set timeframes for referrals, and established actions States can take to address MCOs' noncompliance. Further, some States did not provide fraud referrals training or feedback to MCOs, and half did not require MCOs to have dedicated staff—despite the potential of those practices to improve referral volume and quality.

At the same time, many States reported that staffing and technology limitations hindered their ability to address the provider fraud referrals they received from MCOs. Such constraints underscore the importance of MCOs making quality provider fraud referrals, so that States can prioritize their resources in responding to those referrals. Consequently, it is also important that States establish contract terms that support the outcomes they are seeking, operate as efficiently and effectively as possible, and have opportunities to learn from other States.

We recommend that CMS help States in these ways:

Work with States to ensure that all MCOs are contractually required to refer potential fraud promptly

Although States have discretion in setting timeframes for MCOs to make referrals, they must contractually require MCOs to refer potential fraud promptly.[38, 39] CMS should work with States to ensure that all MCOs' contracts accurately reflect this requirement. Specifically, CMS should follow up with the two States that reported that their contracts did not set a timeframe for MCOs to make provider fraud referrals. CMS could consider following up with the 10 States that reported that their contracts did not specify a number of days to encourage them to establish clear timeframes for MCOs to make referrals, as well as following up with the State whose 270-day timeframe far exceeds the agency's two-business day recommendation.

Urge States to ensure that their contracts with MCOs specify actions the State can take to address MCOs' noncompliance with provider fraud referral requirements

To ensure that MCOs fulfill their responsibilities to identify and refer potential provider fraud, CMS should urge States to have action steps in their contracts to hold MCOs accountable. CMS should encourage States to establish State-specific

sanctions in their contracts with MCOs to address areas of general noncompliance (i.e., noncompliance with any contract requirements) or noncompliance with provider fraud referral requirements specifically.[40] CMS should prioritize outreach to the five States with contracts that did not specify actions the States could take to address MCOs' noncompliance with provider fraud referral requirements. Additionally, CMS should consider whether there are actions that States reported specifying less frequently (e.g., options to suspend payments or contracts) that it would like to promote for additional use.

Work with States to expand the feedback provided to MCOs about provider fraud referrals

CMS should work with States to expand the feedback they provide to MCOs about their provider fraud referrals, as we found that many States were not providing feedback about referral volume and/or quality despite the potential of feedback to improve MCOs' provider fraud referrals. Additionally, CMS should encourage all States to provide feedback to MCOs about both volume and quality of referrals. For example, CMS should update its prompt referrals toolkit to specify that States should provide feedback to MCOs about the volume and the quality of the provider fraud referrals they make to the State. Further, during its State-specific program integrity audits, CMS should follow up with any of the 22 States that reported not providing feedback to MCOs about referral volume and/or quality and from which CMS has not already requested more frequent feedback to MCOs since the period of our review.

Assess the feasibility of Federal program-wide actions that States identified as potentially beneficial for improving MCOs' provider fraud referrals and implement those that CMS determines are most promising

Almost all States identified program-wide actions that they believed CMS could undertake to help improve the volume and/or quality of MCOs' provider fraud referrals. CMS should assess the feasibility of the following actions that States identified as potentially beneficial and implement those that it considers most promising:

- Forums for communication across States, MCOs, and other program integrity entities regarding fraud trends and/or referral best practices
- Guidance for States to use to evaluate the quality of MCOs' referrals
- Standard criteria for MCOs to use to determine whether to make a fraud referral
- Benchmarks for States to use to evaluate the volume of MCOs' referrals

- A single nationwide template for MCOs to use to make fraud referrals
- A single nationwide process for MCOs to follow to make fraud referrals

Many States identified different types of nationwide guidance and processes, listed above, that may be helpful in their efforts to improve the volume and/or quality of MCOs' fraud referrals; this input could be useful to CMS as it drafts future guidance materials or updates existing guidance. For example, CMS could recommend standard criteria for MCOs to use to determine whether to make a fraud referral. Similarly, CMS could consider recommending a benchmark for States to use to evaluate the volume of MCOs' referrals. Such guidance could help States operate more efficiently and effectively within their own resource constraints.

AGENCY COMMENTS AND OIG RESPONSE

In its comments on our draft report, CMS affirmed its commitment to partnering with States to strengthen monitoring and oversight of Medicaid managed care programs and to combat fraud, waste, and abuse. CMS described actions it takes to do so, including its program integrity reviews of States' managed care programs; UPIC audits of MCO's program integrity activities; and education and training given to States on Medicaid program integrity issues, such as through the prompt referrals toolkit.

CMS concurred with our first recommendation and stated that it will work with States to ensure that States' contracts require MCOs to refer fraud promptly, as well as that States quantify "promptly" within those contracts.

CMS also concurred with our second recommendation and stated that it will encourage States to specify sanctions in their contracts to address MCOs' noncompliance with provider fraud referral requirements.

CMS did not explicitly concur or nonconcur with our recommendation to work with States to expand the feedback provided to MCOs about provider fraud referrals. CMS noted that its State-specific program integrity reviews have encouraged States to provide frequent feedback to MCOs regarding their referrals and, therefore, it requests that OIG close this recommendation as implemented. OIG appreciates CMS's past and ongoing efforts to increase State feedback to MCOs. OIG looks forward to CMS providing in its Final Management Decision specific information on what steps it has taken or plans to take with the 22 States that reported to OIG that they did not provide feedback to MCOs about referral volume and/or quality as of 2024. OIG also continues to recommend that CMS update its "Prompt Referrals of Potential Fraud, Waste, or Abuse" toolkit to specify that States should provide feedback to MCOs about the volume and quality of the provider fraud referrals they make to the State.

CMS also did not explicitly concur or nonconcur with our recommendation to assess the feasibility of Federal program-wide actions that States identified as potentially beneficial for improving MCOs' provider fraud referrals and implement those that CMS determines are most promising. CMS indicated that it has undertaken such an assessment and implemented, or plans to implement, those actions that it identified as most promising. OIG appreciates CMS's efforts and looks forward to additional information from CMS regarding its assessment and the implementation of the practices it determined are most promising.

For the full text of CMS's comments, see Appendix C.

APPENDICES

Appendix A: Contract Provisions and Other Practices Related to MCOs' Provider Fraud Referrals That States Had Not Implemented

Of the 43 States that contracted with 1 or more MCO(s) in December 2024 and responded to our information request, this appendix provides information about the States that reported that they did not implement certain contract provisions and/or practices related to MCOs' provider fraud referrals as of 2024 for any of their MCOs.

Exhibit A-1: Contract provisions and practices related to MCOs' provider fraud referrals that States had not implemented as of 2024

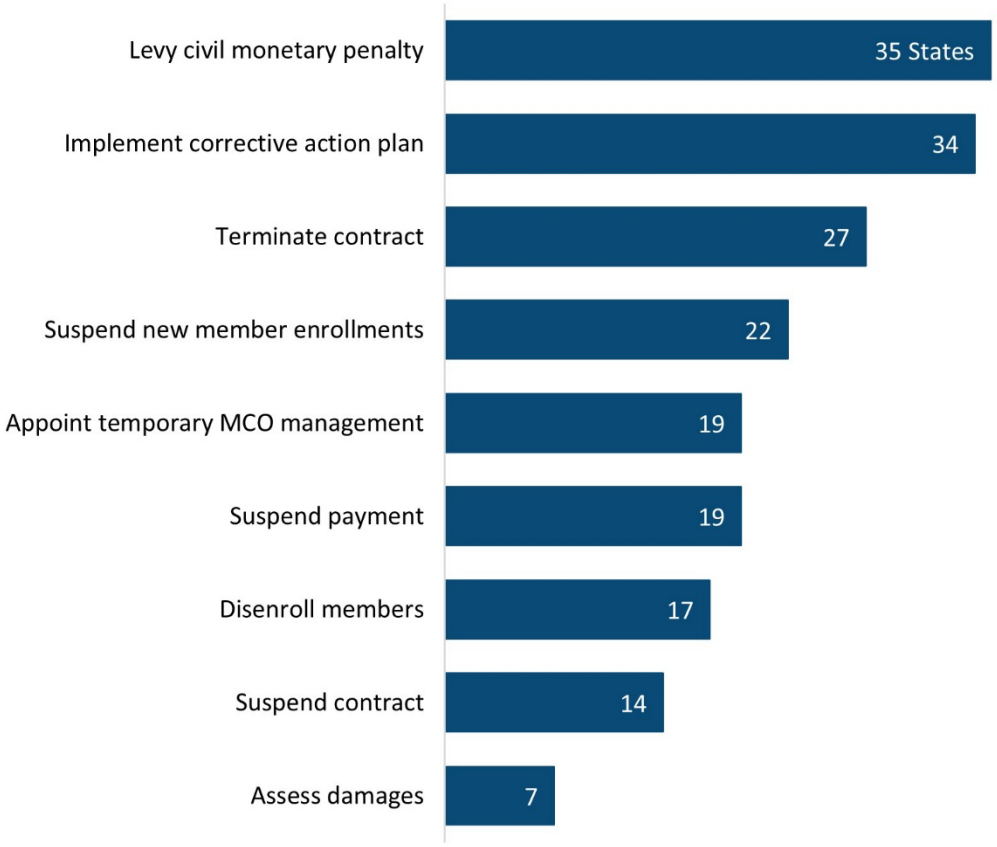
State	No Contract Timeframe for MCOs to Refer Fraud	No Actions for MCO Noncompliance in Contract	No Training on Fraud Referral Process for MCO Staff	No Feedback About Referral Volume or Quality to MCOs
Arizona		●		
Arkansas			●	
Hawaii			●	
Idaho			●	●
Indiana	●			
Iowa				●
Kansas				●
Kentucky	●			
Maryland		●		
Nebraska			●	
North Carolina			●	
North Dakota			●	
Oklahoma				●
Puerto Rico		●	●	●
Utah			●	●
Total	2 States	3 States	8 States	6 States

Source: OIG analysis of State information request data, 2025.

● State reported that it had not implemented the contract provision or practice for any of its MCOs.

Appendix B: Contractual Actions States Could Take If MCOs Did Not Comply With Provider Fraud Referral Requirements in Their Contracts

Exhibit B-1: The number of States that reported their contracts specified each action for addressing MCO noncompliance with provider fraud referral requirements



Source: OIG analysis of State information request data, 2025.

Appendix C: Agency Comments

Following this page are the official comments from CMS.

DATE: May 28, 2026

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *States Have Missed Some Opportunities to Improve Medicaid Managed Care Organizations' Provider Fraud Referrals, OEI-03-23-00340*

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to partnering with states to help strengthen the monitoring and oversight of Medicaid managed care programs, and to crush fraud, waste, and abuse.

For nearly two decades, CMS has been conducting audits of states' Medicaid program integrity (PI) operations and processes to determine compliance with federal requirements, identify vulnerabilities and effective practices, and help states improve their PI efforts through implementation of corrective action plans (CAPs). Since 2014, CMS has focused these reviews on specific parts of the program, such as high-risk areas of managed care, Affordable Care Act provisions, personal care services, telehealth, and non-emergency medical transportation. During the Medicaid managed care PI audits, states must provide the total number of managed care plan referrals for potential fraud, waste, and abuse per managed care plan for the audit period, and that information is included in the final report. While there are no regulatory requirements that a plan make a specific number of referrals, CMS expects to see an overall number of referrals in the state that is proportional to the size of the state's Medicaid program, as well as commensurate with the degree of PI risks within that state. Where CMS identifies a low number of referrals, it notes that observation in the final report and encourages the state to identify ways to increase the number of referrals.

Through its Unified Program Integrity Contractors (UPICs), CMS also conducts Medicaid Managed Care Plan Audits to evaluate whether the managed care plans' activities safeguard the Medicaid program and provide appropriate services to beneficiaries. As part of these audits, CMS reviews managed care plans' investigative functions to ascertain whether those activities were adequate and appropriate, including whether the managed care plans referred instances of fraud, waste and abuse to the state Medicaid PI Unit or designated law enforcement entity, as specified by their contract. As noted above, there are no regulatory requirements that a plan make a specific number of referrals. However, CMS generally expects to see a number of referrals that is proportional to the size of the plan. Once these audits are finalized, CMS works

with states to improve the practices of managed care plans that do not appear to adequately or appropriately investigate their network providers.

CMS also regularly provides states education and training on Medicaid PI issues. CMS recently published a toolkit[1] that discusses the requirements that managed care plans promptly report, and establish clear timelines for referrals of, potential fraud, waste, or abuse to the state Medicaid PI Unit or Medicaid Fraud Control Unit (MFCU), as required by 42 CFR 438.608(a)(7), as well as the importance of states providing training to managed care plans on recent PI trends and schemes. CMS also provides opportunities for state PI education and training through the Medicaid Integrity Institute.[2,3]

As the immediate administrators of their Medicaid programs, states also play a pivotal role in the oversight of their Medicaid managed care plans. In accordance with federal requirements, states must require their plans to implement and maintain procedures to prevent and detect fraud, waste, and abuse, as well as monitor plan compliance.[4] Most Medicaid managed care plans establish a special investigation unit (SIU) to carry out these requirements. In addition, states conduct their own PI work, overseen by CMS' reviews described above. Each state also has a MFCU, independent from the State Medicaid agency, that conducts criminal and civil investigations. MFCUs are partially funded by federal grants overseen by HHS-OIG. HHS-OIG also recertifies each MFCU's application annually.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should work with States to ensure that all MCOs are contractually required to refer potential fraud promptly.

CMS Response

CMS concurs with this recommendation. States have the discretion to determine the timeline for "prompt" reporting by MCOs under § 438.608(a)(7). However, in the Prompt Referrals of Potential Fraud, Waste, and Abuse Toolkit, CMS encourages states to define "prompt" as within two business days.[5] CMS will work with states to ensure that they contractually require MCOs to refer potential fraud promptly, and that they quantify "promptly" within their contracts.

OIG Recommendation

CMS should urge States to ensure that their contracts with MCOs specify actions the State can take to address MCOs' noncompliance with provider fraud referral requirements.

CMS Response

CMS concurs with this recommendation. CMS will encourage states to specify sanctions the

[1] www.cms.gov/files/document/managed-care-fraud-referral.pdf
[2] https://www.cms.gov/medicaid-chip/medicare-coordination/integrity-institute
[3] https://www.medicaid.gov/medicaid/program-integrity/download/managed-care-fraud-ref-toolkit.pdf
[4] 42 CFR § 438.66, 438.602, and 438.608(a)
[5] https://oig.hhs.gov/documents/evaluation/10912/OEI-03-22-00410.pdf

state can impose to address MCOs' noncompliance with provider fraud referral requirements in their contracts with MCOs.

OIG Recommendation

CMS should work with States to expand the feedback provided to MCOs about provider fraud referrals.

CMS Response

As OIG notes in this report, CMS conducts focused program integrity reviews of state managed care programs. In these reports, CMS has encouraged states to work with MCOs to improve the quality and quantity of case referrals through frequent feedback to the MCOs regarding their case referral performance, among other recommendations. CMS requests OIG close this recommendation as implemented.

OIG Recommendation

CMS should assess the feasibility of Federal program-wide actions that States identified as potentially beneficial for improving MCOs' provider fraud referrals and implement those that CMS determines are most promising.

CMS Response

CMS has already considered these suggestions and has implemented, or plans to implement, those that are most promising. For example, the Medicaid Integrity Institute and Healthcare Fraud Prevention Partnership already exist as forums for communication across states and MCOs about provider fraud trends. CMS plans to issue guidance on forums for communication among states, MCOs, and program integrity entities across health programs, as well as referral best practices, such as how to evaluate the quality of MCOs' referrals, benchmarks for the volume of referrals, and standard criteria to evaluate when to make a referral. Other suggestions are not feasible, such as a single nationwide template for MCOs to use to make fraud referrals. OIG previously recommended that CMS institute a nationwide template in 2018, and CMS nonconcurred because state flexibility is an important feature of the Medicaid program and states design their programs to fit the unique needs of their populations. CMS requests OIG close this recommendation as implemented.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ENDNOTES

[1] KFF, "Total Medicaid MCO Spending" (Fiscal Year 2024). Accessed on Jan. 29, 2026.
[2] Comprehensive, risk-based MCOs are the most common form of Medicaid managed care. However, other types of managed care exist. For example, primary care case management programs are managed fee-for-service programs in which primary care providers are paid to provide both primary care and case management services. Some enrollees receive benefits through other types of limited-benefit risk-based plans, such as prepaid inpatient health plans and prepaid ambulatory health plans. KFF, "10 Things to Know About Medicaid Managed Care" (Feb. 27, 2024). Accessed on Oct. 24, 2025.
[3] 42 CFR § 438.608(a)(7).
[4] See OIG, *Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud (OEI-03-22-00410)*, Sept. 3, 2025. In that report, we used the term "plans" to refer to comprehensive, risk-based managed care plans, which are also known as MCOs. Throughout this report, we used the term "MCOs" to refer to the same type of entities.
[5] According to CMS, CMS enhanced the program integrity review process beginning in 2026 and now calls the reviews "program integrity audits." For examples of prior program integrity reviews of States' Medicaid Managed care programs, see the following CMS reports (accessed on Nov. 18, 2025):
Delaware Focused Program Integrity Review: Medicaid Managed Care Oversight, September 2025.
New York Focused Program Integrity Review: Medicaid Managed Care Oversight, August 2025.
Georgia Focused Program Integrity Review: Medicaid Managed Care Oversight, July 2025.
Oregon Focused Program Integrity Review: Medicaid Managed Care Oversight, July 2025.
Texas Focused Program Integrity Review: Medicaid Managed Care Oversight, July 2025.
Idaho Focused Program Integrity Desk Review: Medicaid Managed Care Oversight, May 2025.
[6] OIG analysis of State information request data, 2025, and Health Management Associates, "Medicaid Managed Care Enrollment Update: Q4 2024" (Apr. 10, 2025). Accessed on Feb. 12, 2026.
[7] See definition of capitation payment under 42 CFR § 438.2.
[8] MACPAC, "*Report to Congress on Medicaid and CHIP,"* Ch. 3, "Program Integrity in Medicaid Managed Care" (June 2017). Accessed on Oct. 24, 2025.
[9] 42 CFR § 438.608(a).
[10] 42 CFR § 438.608(a)(1)(vii).
[11] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."
[12] See OIG, *Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud (OEI-03-22-00410)*, Sept. 3, 2025.
[13] Social Security Act (SSA) § 1903(q). SSA § 1902(a)(61) requires each State to operate a MFCU or receive a waiver. MFCUs are funded in part through a Federal grant program, as described in SSA § 1903(a)(6). OIG oversees the MFCU grant program, which includes recertifying each MFCU's application annually.
[14] For more information about CMS's State program integrity reviews, see CMS, "State Program Integrity Reviews" (June 2025). Accessed on Oct. 24, 2025. CMS, "Focused Program Integrity Reviews by State or Territory" (June 2025). Accessed on Oct. 24, 2025.
[15] For more information about UPIC audits, see CMS, *Medicaid Program Integrity Manual,* Ch. 3, "Medicaid Investigations & Audits" (Oct. 11, 2024). Accessed on Oct. 24, 2025.

[16] 42 CFR § 438.608(a)(7). States had to include requirements for referring any potential fraud in their Medicaid managed care MCO contracts beginning on or after July 1, 2017. 81 Fed. Reg. 27498, 27499 (May 6, 2016).
[17] 42 CFR §§ 455.14 and 455.16.
[18] For more information about MFCU investigations, see OIG, *Medicaid Fraud Control Units Fiscal Year 2021 Annual Report* (OEI-09-22-00020), Mar. 15, 2022.
[19] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."
[20] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (June 16, 2025). Accessed on Dec. 18, 2025. The previous version of this toolkit (released in November 2023) that was available during the period of our review mentioned only training about recent program integrity trends and schemes (not training about the fraud referral process).
[21] CMS, "Medicaid Integrity Institute (MII)" (August 2025). Accessed on Nov. 3, 2025.
[22] See CMS, "Medicaid Integrity Institute (MII) 2026 Training Calendar." Accessed on Mar. 26, 2026.
[23] OIG, *Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud* (OEI-03-22-00410), Sept. 3, 2025.
[24] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (June 16, 2025). Accessed on Dec. 18, 2025. The previous version of this toolkit (released in November 2023) that was available during the period of our review mentioned only training about recent program integrity trends and schemes (not training about the fraud referral process).
[25] OIG, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse* (OEI-02-15-00260), July 11, 2018.
[26] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."
[27] OIG, *Medicaid Fraud Control Units Annual Report: Fiscal Year 2025* (OEI-09-26-00140), Mar. 20, 2026.
[28] Our evaluation focused solely on Medicaid MCOs. Therefore, our review did not include prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management programs, or programs of all-inclusive care for the elderly. Our review included 43 States rather than the 44 States mentioned on page 1 of this report because 1 State that contracted with MCOs in December 2024 did not respond to our information request.
[29] This State reported that it transitioned to a managed care delivery model partway through 2024, and that it did not expect to receive referrals immediately upon transition.
[30] 42 CFR § 438.608(a)(7).
[31] The other 23 States reported that MCOs were required to refer provider fraud to only the State and the State forwarded MCO referrals to the MFCU.
[32] 42 CFR § 438.608(a)(7).
[33] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."
[34] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."
[35] 42 CFR § 438.700.
[36] 42 CFR § 438.702(b).

[37] Notably, since the time of our review, CMS updated its prompt referrals toolkit to encourage States to provide "frequent, State-led trainings on program integrity trends and the fraud referral process" to MCOs. The agency also reported to OIG that in 2026 it expanded many of its Medicaid Integrity Institute trainings to include MCO staff.

[38] 42 CFR § 438.608(a)(7).

[39] CMS, "Medicaid and CHIP Managed Care Program Integrity Toolkit - 42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse §438.608(a)(7)" (Nov. 1, 2023). For the current version of this toolkit, visit "Medicaid and CHIP Managed Care Program Integrity Toolkit."

[40] 42 CFR § 438.702(b).

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