Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections

September 2025 | OEI-03-22-00410

Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud

REPORT HIGHLIGHTS

September 2025 | OEI-03-22-00410

Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud

Why OIG Did This Review

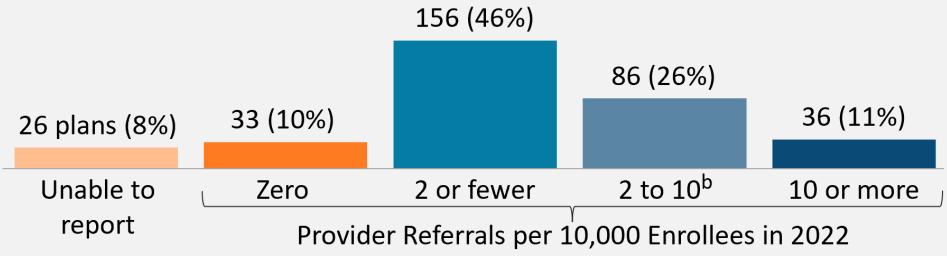
- Fraud, waste, and abuse in the Medicaid program deplete critical resources and may cause physical, emotional, and financial harm to enrollees.
- Medicaid managed care plans are required to identify and refer potential fraud, waste, or abuse—including provider fraud—to the State and/or Medicaid Fraud Control Unit (MFCU) for further investigation and enforcement.
- CMS and HHS-OIG have cited concerns about plans' efforts to combat fraud, including a lack of fraud referrals and few incentives to produce them.

What OIG Found

Ten percent of plans reported that they did not make any referrals of potential provider fraud, waste, or abuse in 2022. Combined, these plans covered 1.6 million enrollees and received $8 billion in payments from 13 States.

Of the plans that reported making provider referrals in 2022, more than half made 2 or fewer referrals per 10,000 enrollees.

Medicaid Managed Care Plans' Referrals of Potential Provider Fraud, Waste, or Abuse[a]



Source: OIG analysis of State Information Request and Plan Survey data, 2024.
[a]The percentages do not sum to 100 percent due to rounding.
[b]Plans reported making more than 2 but fewer than 10 referrals per 10,000 enrollees.

Plans that received training from the State or MFCU on the fraud referral process made more provider referrals. However, only half of plans reported that they received such training.

Plans with fraud referral staff dedicated solely to that Medicaid plan made more provider referrals than plans with staff working across programs. However, 78 percent of plans reported that their fraud referral staff shared program integrity responsibilities across programs (e.g., another health care line of business).

What OIG Recommends

CMS should (1) follow up with States that had Medicaid managed care plans with no referrals of potential provider fraud, waste, or abuse in 2022, and (2) encourage States to increase the number of Medicaid managed care plans that have received State-led training on the fraud referral process.

For the first recommendation, CMS did not explicitly concur or nonconcur but indicated that it has undertaken and plans to continue such follow-up. CMS concurred with the second recommendation.

TABLE OF CONTENTS

BACKGROUND

OBJECTIVES

1. To determine the number of referrals of potential provider fraud, waste, or abuse (hereinafter provider referrals) that Medicaid managed care plans made to State Medicaid agencies (hereinafter States), Medicaid Fraud Control Units (MFCUs), or other entities in 2022.
2. To identify the factors that influence whether managed care plans referred potential fraud.
3. To identify managed care plans' processes that support making fraud referrals.

Fraud, waste, and abuse in the Medicaid program depletes critical resources and may cause physical, emotional, and financial harm to enrollees. Medicaid managed care plans play a key role in safeguarding Medicaid program integrity by identifying and referring potential fraud—including provider fraud—to the State, MFCU, and other entities. While the amount of provider fraud in Medicaid managed care is unknown, GAO has estimated that—across government—direct annual financial losses from fraud total $233 billion to $521 billion.[1]

Managed care plans' efforts to prevent, detect, and refer fraud, waste, and abuse in Medicaid are essential, as managed care is the primary delivery system for Medicaid. In fact, comprehensive Medicaid managed care accounted for 52 percent of total Medicaid spending in fiscal year (FY) 2022.[2] Although Federal regulations require Medicaid managed care plans to make referrals of any potential fraud, waste, or abuse identified by plans to the State and/or MFCU, these regulations do not require plans to make a minimum number of referrals nor does CMS guidance establish such a benchmark.[3] However, numerous State-specific program integrity reviews conducted by CMS cited concerns about low numbers of referrals from plans.[4] In addition, the HHS Office of Inspector General (HHS-OIG) identified weaknesses in plans' efforts to identify and refer fraud or abuse and few incentives for plans to produce fraud referrals.[5] Further, the Medicaid and CHIP Payment and Access Commission found that States and MFCUs it interviewed reported that managed care plans regularly refer less potential fraud than is referred in the Medicaid fee-for-service program.[6]

Medicaid Managed Care

States offer Medicaid services through a fee-for-service model and/or by contracting with Medicaid managed care plans to provide coverage to enrollees. In 2022, 42

States (including the District of Columbia) reported that they contracted with comprehensive risk-based managed care plans (hereinafter plans) to provide services to 72 million Medicaid enrollees.[7] These plans provide a comprehensive benefits package to their enrollees. States pay plans 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 covered services each month. Managed care plans have the primary responsibility for processing, paying, and monitoring the claims of providers in their networks. Further, a single company can operate Medicaid managed care plans in multiple States.

Program Integrity in Medicaid Managed Care

Managed care plans, States, MFCUs, and CMS form a network of entities that work to identify and prevent fraud, waste, and abuse. According to Federal program integrity regulations for Medicaid managed care, States' contracts with managed care plans must require the plans to implement and maintain procedures to prevent and detect fraud, waste, and abuse.[8] In addition, managed care plans must dedicate staff to combatting fraud and abuse.[9] To meet this requirement, plans typically establish a special investigation unit (SIU). States also conduct program integrity activities, which CMS oversees and supports through managed care program integrity reviews. These CMS reviews report findings and recommendations to States. In addition, CMS conducts audits that focus on managed care plans' program integrity activities through the Unified Program Integrity Contractors (UPICs). Further, MFCUs operate in each State to investigate and prosecute Medicaid provider fraud as well as patient abuse and neglect.[10]

As part of Federal program integrity regulations, States' contracts with plans must include a provision for plans to promptly refer any potential fraud, waste, or abuse identified by plans to the State program integrity unit or any potential fraud directly to the MFCU.[11, 12] Upon receiving a fraud referral from a plan, States and MFCUs typically review the referral and may accept it for further investigation. Fraud referrals from managed care plans may not always lead to a finding of fraud by the State or MFCU. Exhibit 1 provides a brief description of plan, State, and MFCU responsibilities related to the referral of fraud in Medicaid managed care.

Exhibit 1: Plan, State, and MFCU responsibilities for combatting fraud in Medicaid

Medicaid Managed Care Plans	State Medicaid Agencies	Medicaid Fraud Control Units
Plans have staff that are responsible for program integrity activities, including identifying potential fraud and making fraud referrals to States, MFCUs, and other entities. Plans may also undertake other activities to prevent and detect fraud, such as pre- and post-payment reviews of claims. Plans may organize program integrity staff into SIUs. These staff can operate within one State or across multiple States.	States monitor plans' compliance with the program integrity provisions in their contracts, including referring potential fraud. States determine whether potential fraud reflects a "credible allegation of fraud" and refer such cases to MFCUs. Upon a credible allegation of fraud, States ensure that provider payments are suspended.	MFCUs must be separate from the State Medicaid agency and are most often a part of the State's Office of Attorney General. MFCUs conduct criminal or civil investigations to determine whether to indict or file a civil fraud action. MFCUs refer providers they identify for investigation to States for payment suspension.

Source: Federal regulations at 42 CFR §§ 438.602(a), 438.608(a), 455.2, 455.15(a)(1), 455.23(a), 1007.7, 1007.9(a), 1007.9(e), and 1007.11(a) and OIG analysis of State Information Request and Plan Survey data, 2024.

Related OIG Work

A 2018 HHS-OIG report surveyed a sample of Medicaid managed care organizations and found weaknesses in their efforts to identify cases of potential fraud and refer them to States.[13] In addition, this report found that managed care plans may lack incentives to identify and refer cases of potential fraud to the State. HHS-OIG recommended that CMS work with States to improve plans' identification and referral of cases. CMS implemented this recommendation through the publication of toolkits, including one that that provides guidance to States on the prompt referral of potential fraud, waste, and abuse.[14] CMS also implemented HHS-OIG's recommendation that CMS improve coordination between plans and other State program integrity entities. Finally, HHS-OIG recommended standard reporting of fraud referrals across all plans in a State. However, CMS did not concur with this recommendation.

A 2022 HHS-OIG report found that UPICs conducted minimal program integrity activities in Medicaid managed care.[15] This report recommended that CMS implement a plan to increase UPICs' Medicaid program integrity activities, particularly related to managed care. CMS concurred with this recommendation. CMS reported to OIG that it was implementing a strategy for more robust audits of Medicaid managed care plans' program integrity activities.

The HHS-OIG FY 2024 MFCU Annual Report highlights MFCUs' activities including a high-level summary of the total number of fraud referrals from managed care plans

that MFCUs reported receiving from 2021 to 2024.[16] The referral information in the MFCU Annual Report differs from the referral information in this report because the MFCU report information is not limited to comprehensive risk-based plans, analyzed at the plan level, nor standardized by enrollment.

Methodology

To address our objectives, we used data from (1) an information request sent to all States and (2) a self-administered online survey sent to all comprehensive risk-based Medicaid managed care plans. We used information from States to identify all comprehensive risk-based plans in each State, the number of enrollees in each plan, and the payments made to each plan in calendar year (CY) 2022. We received survey responses from 337 of 388 eligible plans. We reviewed and summarized plans' responses regarding (1) the number of provider referrals that plans made to States, MFCUs, and/or other entities in CY 2022; (2) the factors that influenced whether plans referred potential fraud; (3) plans' processes for referring potential fraud; and (4) challenges plans faced in making fraud referrals.

Please see the detailed methodology on p. 12.

Limitations

We did not independently verify the self-reported information from States or plans. For example, we did not verify whether plans' referrals were accepted by the entities to which they were sent, led to open investigations, and/or constituted fraud. However, we followed up with States and plans to clarify responses when needed.

Standards

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

FINDINGS

Ten percent of Medicaid managed care plans reported that they did not make any referrals of potential provider fraud, waste, or abuse in 2022

Despite requirements for plans to refer potential fraud to the State and/or MFCU, 33 of 337 plans (10 percent) reported that they did not make any provider referrals to any entity in CY 2022. Combined, these 33 plans covered 1.6 million enrollees and received $8 billion in payments from 13 States. While the exact amount of health care fraud is unknown, estimates range from 3 to 10 percent of annual health care expenditures.[17] Therefore, reporting zero provider referrals in a year raises concerns that these plans may not be adequately detecting or referring potential provider fraud, waste, or abuse as required.[18] Although plans may take other internal actions to address potential provider fraud, waste, or abuse (such as pre- and post-payment reviews of claims), it is crucial that they *also* refer these cases to the State and/or MFCU to effectively protect Medicaid across plans and States.

An additional 8 percent of plans were unable to report the number of provider referrals they made in 2022

An additional 26 of the 337 plans (8 percent) were unable to report to HHS-OIG the number of provider referrals they made to the State, MFCU, or other entities in 2022.[19] These 26 plans covered 6 million enrollees and received $31.6 billion in payments from 11 States in that year. These plans' inability to report whether they made provider referrals raises concerns that Federal and State oversight entities are not able to properly monitor this key indicator of plans' program integrity activities.

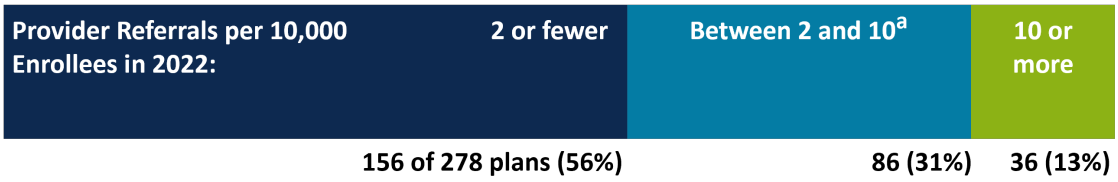
Together, the 26 plans that were unable to report the number of provider referrals they made—along with the 33 plans that reported they did not make any provider referrals—covered 7.7 million enrollees and received $39.5 billion in payments in 2022. These 59 plans operated across 21 States. The remaining 278 of the 337 plans (82 percent) reported that they did make provider referrals in 2022.[20]

Of the plans that reported making provider referrals in 2022, more than half made 2 or fewer referrals per 10,000 enrollees

Our analysis of plans' reported referrals indicates that many plans may be making few provider referrals. In fact, 156 of the 278 plans (56 percent) that reported making referrals in 2022 made 2 or fewer referrals per 10,000 enrollees, as shown in Exhibit 2. Another 86 plans made more than 2 but fewer than 10 referrals per 10,000 enrollees in that year. The remaining 36 plans made 10 or more referrals per 10,000

enrollees. Although Federal regulations and CMS guidance do not require plans to make a minimum number of referrals, CMS has also cited concerns about low numbers of referrals from plans in numerous State-specific program integrity reviews.

Exhibit 2: Of the plans that reported making provider referrals in 2022, 56 percent made 2 or fewer referrals per 10,000 enrollees



Source: OIG analysis of State Information Request and Plan Survey data, 2024.
[a]These plans reported making more than 2 but fewer than 10 referrals per 10,000 enrollees.

For information about the criteria plans considered and the timeframes plans followed when they made fraud referrals, please see Appendixes A1 and A2.

Plans that received training from the State or MFCU made more provider referrals than plans that did not receive training

As a group, plans that indicated they received training from the State and/or MFCU on the fraud referral process had a higher provider referral count per 10,000 enrollees in 2022 than plans that reported they were not trained by either entity. Yet, only about half of plans reported that they received such training.

Specifically, 167 of 337 plans reported that they received training from the State and/or MFCU, and 170 plans reported that they did not. As a group, plans that received training reported making a total of 2.10 provider referrals per 10,000 enrollees, while the group of plans that did not receive training made 1.31 provider referrals per 10,000 enrollees, as shown in Exhibit 3.

Exhibit 3: Plans that indicated they received training from the State and/or MFCU on the fraud referral process made more provider referrals

Source: OIG analysis of State Information Request and Plan Survey data, 2024.

Plans that received training. Nearly all of these plans indicated that they received training from the State and/or MFCU at least annually. Collectively, these 167 plans operated across 31 States. Some of these plans (17 percent) indicated that future training on making referrals also would be useful.

Plans that did not receive training. These 170 plans operated across 34 States. Thirty percent of these plans indicated that future training from the State or MFCU would improve their ability to make fraud referrals.

Plans with fraud referral staff dedicated solely to that Medicaid plan made more provider referrals than plans with staff working across programs

Only 75 plans (22 percent) had staff who were responsible for making fraud referrals for just that one Medicaid managed care plan (i.e., dedicated staff). As a group, plans with dedicated staff had a higher provider referral count per 10,000 enrollees in 2022 than plans whose staff worked across programs. Specifically, plans with dedicated staff reported making a total of 2.70 provider referrals per 10,000 enrollees compared to 1.41 referrals per 10,000 enrollees for plans without dedicated staff.

The remaining 262 plans (78 percent) reported that they did not have dedicated staff responsible for making fraud referrals. These plans described different ways their staff shared program integrity responsibilities across programs, including having responsibilities for:

- Another health care line of business, such as Medicare (90 percent);
- More than one plan under the same parent company (63 percent); and
- Plans in more than one State (36 percent).

For more information about plans' staffing related to making fraud referrals, please see Appendix A3.

Fifty-two percent of plans indicated that a single nationwide referral process would improve their ability to make fraud referrals

In response to questions about what would improve plans' ability to make fraud referrals in the future, a majority of plans (176 of 337) indicated that a single nationwide process would do so. Specifically, many of these plans (100 of 176) indicated interest in CMS providing a nationwide template for plans across all States to use when submitting fraud referrals. These 176 plans—including some whose fraud referral staff operate across multiple States—expressed interest in a nationwide template regardless of whether the State already required them to use a fraud referral template.[21]

Over half of plans reported that they did not receive any feedback from States on the quality or volume of fraud referrals

Overall, 59 percent of plans (200 of 337 plans across 37 States) reported that they did not receive any feedback from States on the quality or volume of fraud referrals they made in 2022.[22] Nearly half of these 200 plans (46 percent) indicated that feedback from the State on the quality (88 plans) and/or volume (48 plans) of their fraud referrals would improve their ability to make referrals in the future.

Of the 137 plans (across 32 States) that reported they had received such feedback in 2022, 39 percent of these plans (54) received feedback on only the quality of their referrals, 27 percent of plans (37) received feedback on only the volume, and 34 percent of plans (46) received feedback on both characteristics. Overall, these 137 plans reported receiving positive and negative feedback from States. Examples of negative feedback included that plans' referrals may have been incomplete or lacked sufficient detail, or that the volume of referrals was low compared to States' expectations.

CONCLUSION AND RECOMMENDATIONS

Medicaid managed care plans' efforts to identify and refer fraud—including provider fraud—are essential to safeguarding the Medicaid program. As the primary entities responsible for contracting with and paying providers to deliver health care services to enrollees, plans are best positioned to identify provider fraud. If plans do not identify and refer instances of potential fraud by providers, States and MFCUs cannot investigate such providers or take corrective actions, as warranted. This could lead to wasted Medicaid funds and cause harm to enrollees. Further, if plans do not make fraud referrals, suspect providers may continue to defraud other Medicaid managed care and/or fee-for-service plans.

Our report provides new evidence that many plans may be making few provider fraud referrals, with some plans reporting that they made no referrals at all. To address this, we offer recommendations to improve plans' efforts to make fraud referrals.

We recommend that CMS:

Follow up with States that had Medicaid managed care plans with no referrals of potential provider fraud, waste, or abuse in 2022

CMS should follow up with the 21 States that had plans that (1) reported they did not make any provider referrals or (2) were unable to report the number of provider referrals they made to ensure that States are taking appropriate actions to hold plans accountable for identifying and reporting potential provider fraud. When plans do not make any provider referrals or are unable to report whether they have made any, it raises concerns that plans may not be adequately performing or monitoring this key program integrity activity. For 7 of these 21 States, CMS has issued reports of its managed care program integrity reviews of FY 2022 or later. Further, CMS may have managed care program integrity reviews, UPIC audits, and/or other follow-up activities underway in other States. CMS should follow up with the remainder of the 21 States that have not been subject to a recent or ongoing managed care program integrity review, UPIC audit, or other follow-up activity to ensure that these States are taking appropriate actions to hold plans accountable for referring potential provider fraud.

Encourage States to increase the number of Medicaid managed care plans that have received State-led training on the fraud referral process

CMS should encourage States to increase the number of plans that receive State-led training on the fraud referral process. Appropriate and continual training is essential to plans' ability to make provider fraud referrals. We found that plans that received such training had higher referral rates overall. Nearly all of these plans indicated that they received training on the fraud referral process from the State and/or MFCU at least annually. However, 170 of 337 plans (across 34 States) reported that they did not receive any training on the fraud referral process from States or MFCUs.

CMS's November 2023 toolkit (42 CFR 438 Subpart H: *Prompt Referrals of Potential Fraud, Waste, and Abuse* § 438.608(a)(7)) states that States should train plans on *recent program integrity trends and schemes*. Our findings indicate that CMS should also take steps to encourage States to increase the number of plans that receive training on *the fraud referral process* (e.g., the successful elements of fraud referrals, responsibilities of plans' staff in the fraud referral process, and States' criteria for making fraud referrals). For example, CMS could update the November 2023 toolkit to also specify that States should provide training to plans on the fraud referral process and notify States of this update. As another example, CMS could encourage States to require plans to attend State-led training on the fraud referral process and monitor plans' participation in trainings.

In September 2024, HHS-OIG issued performance standards suggesting that MFCUs train plans' staff, as appropriate, on the successful elements of fraud referrals.[23] HHS-OIG will oversee the MFCUs' implementation of these standards, including monitoring whether MFCUs provide such training to Medicaid managed care plans. HHS-OIG will also encourage MFCUs to provide feedback to plans on the referrals they receive, as this serves as ongoing training.

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 reviews of States' program integrity processes; providing training and education to States; and UPIC audits of Medicaid managed care plans' activities.

CMS did not explicitly concur or nonconcur with our recommendation to follow up with States that had Medicaid managed care plans with no referrals of potential provider fraud, waste, or abuse in 2022. CMS indicated that it has undertaken and plans to continue to undertake such follow-up through UPIC audits of Medicaid managed care plans, and therefore requests that OIG close this recommendation. In addition, CMS noted that while there are no regulatory requirements for a managed care plan to make a specific number of referrals, CMS generally expects a plan's referrals to be proportional to the size of the plan. CMS stated that if a UPIC audit identifies a plan that makes proportionally low numbers of referrals, CMS will notify the plan's State.

OIG appreciates CMS's past and ongoing actions to strengthen Medicaid managed care plans' program integrity activities, including referrals of potential provider fraud. OIG recognizes that, since the period of our review, CMS has issued reports of its managed care program integrity reviews for at least 7 of the 21 States that had plans that (1) reported they did not make any provider referrals or (2) were unable to report the number of provider referrals they made in 2022. For the remaining States, OIG will continue to work with CMS to obtain information on CMS's follow-up activities, including (but not limited to) managed care program integrity reviews and UPIC audits. OIG looks forward to confirming that CMS has followed up with the remaining States and will close this recommendation upon such confirmation.

CMS concurred with our second recommendation to encourage States to increase the number of Medicaid managed care plans that have received State-led training on the fraud referral process. CMS stated that it will update its November 2023 *Prompt Referrals of Potential Fraud, Waste, and Abuse Toolkit* to encourage States to provide training to plans on the fraud referral process and will notify States of this update.

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

DETAILED METHODOLOGY

To address our objectives, we used data from (1) an information request sent to all States and (2) a self-administered online survey sent to all comprehensive risk-based Medicaid managed care plans.[24]

State Information Request. In January 2023, we sent an information request to all 51 State Medicaid agencies. We received responses from all 51 States and analyzed data provided by the 42 States that reported they contracted with comprehensive risk-based Medicaid managed care plans in 2022. We reviewed and summarized each State's data regarding (1) the number of plans in the State, (2) the number of enrollees in each plan, and (3) the total payments the State paid to each plan in CY 2022.

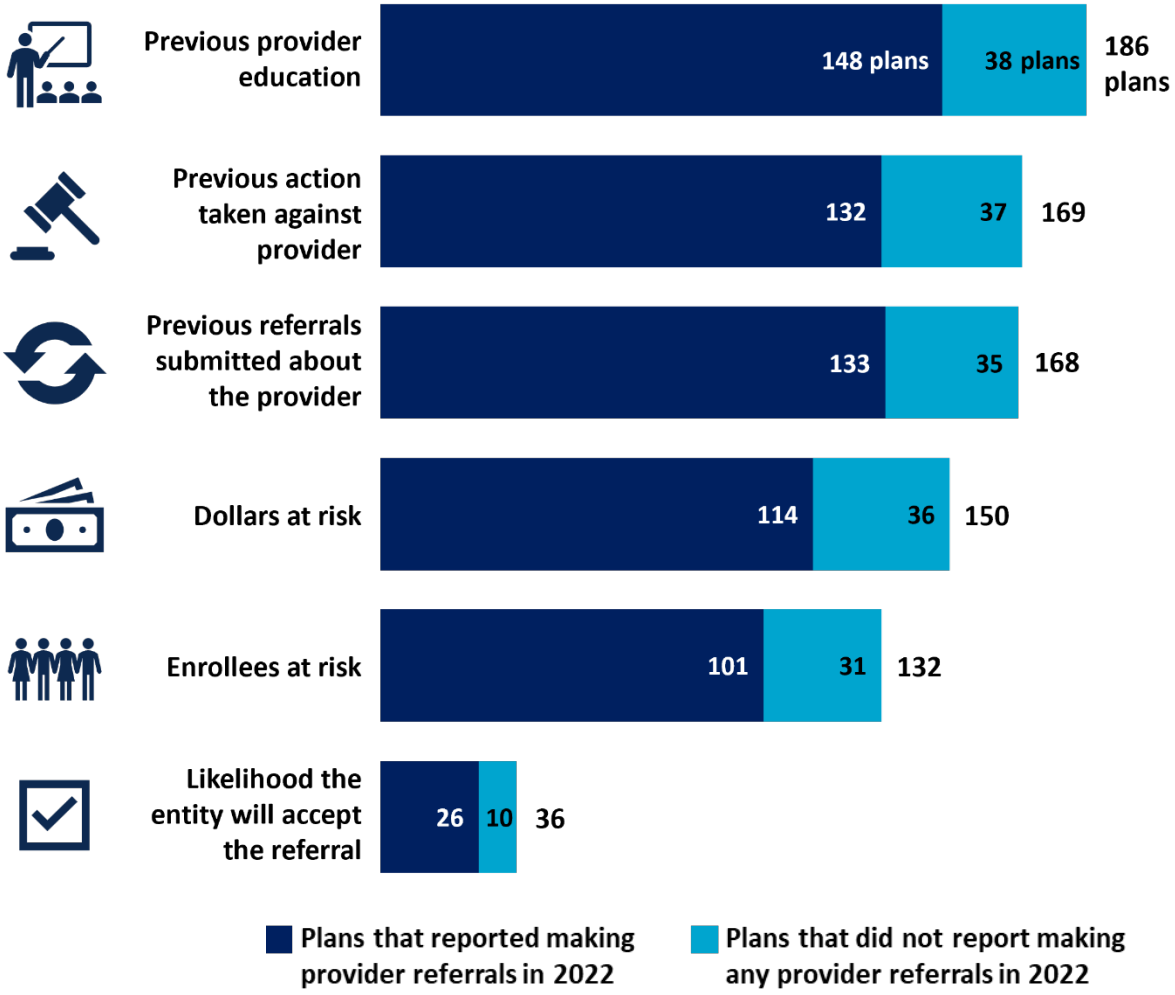
Managed Care Plan Survey. We developed and sent a self-administered online survey to the 394 comprehensive risk-based managed care plans that States identified in the information request. We received responses from 337 of 388 eligible plans—an 87-percent response rate.[25] We reviewed and summarized plans' responses regarding (1) the number of provider referrals that plans made to States, MFCUs, and/or other entities in CY 2022; (2) the factors that influenced whether plans referred potential fraud; (3) plans' processes for referring potential fraud; and (4) challenges plans faced in making fraud referrals.

Provider Referral Analysis. We analyzed the number of provider referrals managed care plans reported they made to States, MFCUs, and other entities in CY 2022. First, we summed the provider referrals each plan made to all entities. Next, we used the number of plan enrollees that States provided in response to HHS-OIG's information request to calculate the ratio of provider referrals each plan made per 10,000 enrollees.[26] Then, we identified the range of provider referrals per 10,000 enrollees across plans. In addition, we compared the number of provider referrals per 10,000 enrollees by specific groupings of plans.[27] For example, we compared provider referrals per 10,000 enrollees for plans that reported they were trained by States and/or MFCUs on the fraud referral process to the same ratio for plans that reported they were not trained.[28]

Appendix A: Overview of Plan-Reported Criteria, Timeframes, and Staffing For Making Fraud Referrals

A1—Criteria. Over 90 percent of all plans (305 of 337)—including 254 of the 278 plans that reported making provider referrals in 2022—reported that they considered at least one specific criterion when determining whether to make a fraud referral to States, MFCUs, and other entities. Such criteria included whether a provider under review for potential fraud had previously been educated about the issue, whether previous action had been taken against a provider regarding fraud, and whether the plan had previously submitted referrals about a provider, as shown in Exhibit A-1.

Exhibit A-1: Most plans reported they considered one or more criteria when making fraud referrals, including plans that did not make any provider referrals in 2022



Source: OIG analysis of Plan Survey data, 2024.

A2—Timeframes. Most plans reported that—in 2022—States and MFCUs required them to submit fraud referrals within a given timeframe after plans identified potential fraud. However, few plans reported required timeframes that would have met the 2-day referral timeframe that CMS encouraged in 2023—after HHS-OIG collected data from plans for this review. For 2022, specific referral timeframes ranged from 1 day to 270 days, with a median timeframe of 7 days.

A3—Staffing. Almost all plans' staff responsible for making fraud referrals were organized in SIUs. Specifically, 95 percent of plans had an SIU, and 91 percent of plans tasked their SIU staff with making fraud referrals. However, half of plans had an SIU with less than 1 staff member per 10,000 enrollees. For 173 plans, all their staff responsible for making fraud referrals had previously worked in health care program integrity or health care criminal investigations.

Fourteen percent of plans (46 of 337) reported a challenge with making fraud referrals related to low staffing and/or indicated that more staff would improve their ability to make fraud referrals. All but 2 of these plans had an SIU, but 73 percent of the remaining 44 plans had SIUs with less than 1 staff member per 10,000 enrollees.

Appendix B: Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: June 20, 2025

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections

FROM: Dr. Mehmet Oz
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud (OEI-03-22-00410)

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 combat fraud, waste, and abuse.

For nearly two decades, CMS has been conducting reviews of states' Medicaid program integrity processes to determine compliance with Federal requirements, identify vulnerabilities and effective practices, and help states improve their program integrity efforts. 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, and non-emergency medical transportation. These reviews have traditionally been conducted annually[1] and each state is reviewed every three years. During these reviews, states must provide the total number of 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. 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 their 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 Program Integrity (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, but CMS generally expects to see a number of referrals that

[1] https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/stateprogramintegrityreviews

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 program integrity issues. CMS recently published a toolkit[2] 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 Program Integrity (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 program integrity trends and schemes. CMS also provides opportunities for state program integrity education and training through the Medicaid Integrity Institute.[3,4]

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.[5] Most Medicaid managed care plans establish a special investigation unit (SIU) to carry out these requirements. In addition, states conduct their own program integrity 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 follow up with States that had Medicaid managed care plans with no provider referrals of potential fraud, waste, or abuse in 2022.

CMS Response

CMS has already undertaken this work and plans to continue doing so through its UPIC audits of Medicaid managed care plans, and therefore requests that OIG close this recommendation as implemented. As part of this work, CMS reviews open and closed investigations to assess whether investigative activities were adequate and appropriate, including provider referrals for potential fraud, waste, and abuse. As noted above, while there are no regulatory requirements for a managed care plan to make a specific number of referrals, CMS generally expects to see a number of referrals that is proportional to the size of the plan. As CMS's audits identify states with managed care plans that make proportionally low numbers of referrals, CMS will notify those states.

OIG Recommendation

CMS should encourage states to increase the number of Medicaid managed care plans that have received State-led training on the fraud referral process

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

CMS Response

CMS concurs with this recommendation. CMS will update its Prompt Referrals of Potential Fraud, Waste, and Abuse Toolkit[6] to encourage states to provide training to plans on the fraud referral process and will notify states of this update.

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

[6] www.cms.gov/files/document/managed-care-fraud-referral.pdf

ENDNOTES

[1] GAO, *Fraud Risk Management – 2018-2022 Data Show Federal Government Loses an Estimated $233 Billion to $521 Billion Annually to Fraud, Based on Various Risk Environments*, April 2024. Accessed on November 19, 2024.

[2] KFF, *10 Things to Know About Medicaid Managed Care*, 2024. Accessed on November 21, 2024.

[3] 42 CFR § 438.608(a)(7).

[4] See, for example, CMS's focused program integrity reviews of the following States' Medicaid Managed Care programs (accessed on April 30, 2025):
Illinois Focused Program Integrity Review: Medicaid Managed Care Oversight, July 2024;
Minnesota Focused Program Integrity Review: Medicaid Managed Care Oversight, July 2024;
Washington Focused Program Integrity Review: Medicaid Managed Care Oversight, May 2024;
Indiana Focused Program Integrity Review: Medicaid Managed Care Oversight, September 2023;
California Focused Program Integrity Review: Medicaid Managed Care Oversight, September 2023;
Colorado Focused Program Integrity Review: Medicaid Managed Care Oversight, May 2023;
Arizona Focused Program Integrity Desk Review: Medicaid Managed Care Oversight, May 2023;
Mississippi Focused Program Integrity Review: Medicaid Managed Care Oversight, May 2023;
Maryland Focused Program Integrity Review, July 2022;
Nevada Focused Program Integrity Review, June 2022;
Utah Focused Program Integrity Review, June 2022;
Michigan Focused Program Integrity Review, June 2022;
Wisconsin Focused Program Integrity Review, May 2022;
Kentucky Focused Program Integrity Review, May 2022;
Rhode Island Focused Program Integrity Review, April 2022.

[5] OIG, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse*, OEI-02-15-00260, July 2018.

[6] MACPAC, *Program Integrity in Medicaid Managed Care*, June 2017. Accessed on March 4, 2025.

[7] OIG analysis of State information request data, 2024.

[8] 42 CFR § 438.608(a).

[9] 42 CFR § 438.608(a)(1)(vii).

[10] The Social Security Act § 1903(q)(3)–(4), generally, requires each State to effectively operate a MFCU. MFCUs are funded in part through a Federal grant program. HHS-OIG oversees the MFCU grant program, which includes recertifying each MFCU's application annually.

[11] 42 CFR § 438.608(a)(7). States had to include requirements for referring any potential fraud in their Medicaid managed care plan contracts beginning on or after July 1, 2017. 81 Fed. Reg. 27498, 27499 (May 6, 2016).

[12] Although States have discretion to define what timeframe constitutes a "prompt" referral, CMS encourages States to define prompt as within two business days. 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), November 2023. Accessed on October 7, 2024.

[13] OIG, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts To Identify and Address Fraud and Abuse*, OEI-02-15-00260, July 2018.

[14] 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)*, November 2023. Accessed on October 7, 2024.

[15] OIG, *UPICs Hold Promise To Enhance Program Integrity Across Medicare and Medicaid, But Challenges Remain*, OEI-03-20-00330, September 2022.

[16] OIG, *Medicaid Fraud Control Units Annual Report: Fiscal Year 2024*, OEI-09-25-00090, March 2025.

[17] National Health Care Anti-Fraud Association, *The Challenge of Health Care Fraud*. Accessed on January 21, 2025.

[18] 42 CFR § 438.608(a).

[19] Of the 26 plans, 15 were unable to report the number of provider referrals made to at least one entity and reported making zero provider referrals to other entities. The remaining 11 plans were unable to report the number of provider referrals they made to any entity.

[20] Of the 278 plans that made provider referrals in 2022, 3 reported making referrals to some entities but were unable to report the number of provider referrals made to 1 other entity.

[21] Most plans (264 of 337) used a State-required template to submit fraud referrals.

[22] Seventeen of these 200 plans reported that feedback was not applicable to their plan. For example, feedback from the State may not have been applicable because a plan did not make any referrals to the State in 2022.

[23] 89 Fed. Reg. 76431-76434 (September 18, 2024).

[24] Our evaluation focused solely on comprehensive risk-based Medicaid managed care plans. Therefore, our review did not include prepaid inpatient health plans, prepaid ambulatory health plans, primary care case management plans, or programs of all-inclusive care for the elderly.

[25] We excluded 6 of the 394 comprehensive risk-based Medicaid managed care plans that received the survey because they did not have any enrollees or receive any payments in CY 2022.

[26] Ninety-two plans were able to report only an aggregate number of provider referrals for all the Medicaid managed care plans under their parent company within a single State. In these cases, we assigned the aggregate number of provider referrals to each plan proportionately, based on the number of enrollees in each plan.

[27] These analyses included 326 of the 337 plans that responded to our survey. Fifteen of the 326 plans that we included were unable to report the number of provider referrals made to at least one entity and reported making zero provider referrals to all other entities. We considered these 15 plans to have made zero provider referrals. We did not include 11 plans in these analyses because they were unable to report whether they made any referrals to any entity in 2022.

[28] For these analyses, we determined provider referrals per 10,000 enrollees by summing the total provider referrals and enrollees in each group (i.e., plans that received training and plans that did not). Then, we calculated the ratio of the number of provider referrals each group made per 10,000 enrollees.

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