

Strengthening Medicaid Fraud Referrals: Quality, Timeliness, and Outcomes

AUTHORITY	LAST UPDATED	
42 CFR §§ 455.13-15, 455.21, 438.608(a)(7), 457.925, and 457.1285	[10/23/2026]	

The Centers for Medicare & Medicaid Services (CMS) developed this Medicaid Fraud Referral toolkit to provide State Medicaid Agencies (SMAs), Children’s Health Insurance Program (CHIP) agencies, Managed Care Plans (MCPs),¹ and their program integrity partners with actionable guidance to improve the quality, timeliness, and outcomes of referrals submitted to law enforcement entities such as Medicaid Fraud Control Units (MFCUs). This toolkit applies to all Medicaid fraud referrals (i.e., fee-for-service (FFS) and managed care).

Introduction

Why This Matters

SMAs, MCPs, and CHIP agencies are required under federal law and regulations to identify and refer suspected fraud, waste, and abuse to law enforcement entities, such as MFCUs. This obligation positions SMAs, MCPs, and CHIP agencies on the frontline of crushing fraud within the Medicaid and CHIP programs. With the continued growth of enrollment in Medicaid managed care, the MCPs play a critical role in detecting suspicious billing patterns or unusual provider behavior when processing and paying provider claims. SMAs, MCPs, and CHIP agencies should have open lines of communication to share information about potential fraud, waste, and abuse to ensure compliance with referral requirements under §§ 455.13-15, 455.21, 438.608(a)(7), 457.925, and 457.1285.

CMS has observed gaps between the volume of state and MCP fraud referrals submitted to law enforcement and the number accepted for investigation. It is insufficient to simply refer large quantities of unactionable information to law enforcement entities. A fraud referral with limited detail, insufficient corroboration, and/or no clear legal basis is unlikely to be accepted or acted upon by law enforcement entities. Fraud referrals should meet minimum quality and timeliness standards to produce actionable outcomes. A quality fraud referral begins with a clear factual basis and sufficient preliminary investigative steps. Upon receiving an initial complaint or other data alerts, the steps taken and evidence collected to substantiate the information should be incorporated into the referral narrative to support a subsequent investigation and potential prosecution by law enforcement.

¹ For these purposes, MCPs includes Managed Care Organizations, Pre-Paid Ambulatory Health Plans, and Pre-Paid Inpatient Health Plans as defined at 42 CFR 438.2.

Note: This toolkit does not contain an exhaustive list of all federal requirements. The contents do not have the force and effect of law and are not meant to bind the public in any way unless specifically incorporated into a contract. This toolkit may be revised periodically to reflect statutory, regulatory, and other policy changes.

Regulatory Framework: What Federal Law Requires

The following federal regulations govern Medicaid fraud referral requirements. Understanding their applicability and relationship supports effective fraud referral oversight.

Citation	Who it applies to	What it requires	Applicable standards
§ 455.13	SMAs	Requires SMAs to have procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials.	N/A
§§ 455.14-15 and 457.925	SMAs and CHIP Agencies	Requires SMA and CHIP programs to conduct a preliminary investigation when it receives complaints of Medicaid or CHIP fraud or abuse from any source or identifies questionable practices.	If the findings of a preliminary investigation give the SMA or CHIP program reason to believe that an incident of fraud or abuse has occurred, it must refer to its MFCU, or in states with no MFCU or in cases where no referral to the State MFCU is required per regulatory requirements, conduct a full investigation and refer the case to an appropriate law enforcement entity.
§ 455.21	SMAs	Requires SMAs to refer cases of suspected fraud to their MFCU.	Referrals of all suspected fraud.
§ 438.608(a)(7) and through cross reference at § 457.1285	MCPs	Requires states to include in MCP contracts a provision that MCP promptly refer any potential fraud, waste, or abuse to the state Medicaid or CHIP PI Unit, or any potential fraud directly to the MFCU.	Any potential fraud, waste, or abuse; referral must be prompt.

IMPORTANT

The aforementioned SMA authorities apply to suspected provider fraud or abuse identified after the SMA conducts an investigation under §§ 455.14-15 and makes a referral under § 455.21.

SMAAs are also required to make fraud referrals to MFCUs after initiating a payment suspension under § 455.23(d), which is outside the scope of this toolkit. States should not use the “credible allegation of fraud” standard² under § 455.23 as the basis for referrals under § 455.21 in MFCU Memoranda of Understanding (MOUs). CMS has found that when this threshold is used as a § 455.21 referral standard, it imposes a higher evidentiary bar than federal regulations require and can suppress the volume of actionable referrals to MFCUs and other law enforcement entities. This toolkit's readiness checklist (see "Before You Submit: Is Your Case Ready," below) is a recommended quality practice for § 455.21 fraud referrals.

² The credible allegation of fraud standard described in the Regulatory Framework and Timeliness sections, and the fact that it triggers separate payment suspension procedures, is drawn from § 455.2 and CMS's sub-regulatory toolkit, *42 CFR 438 Subpart H: Payment Suspensions Based on Credible Allegations of Fraud*. <https://www.cms.gov/files/document/managed-care-payment-suspensions.pdf> November 2023

Background

What the Data Tells Us about Medicaid Managed Care Referrals

Federal managed care program integrity requirements help States and MCPs prevent, detect, and address fraud, waste, and abuse. Under 42 CFR Part 438, MCPs must maintain procedures to detect fraud and promptly refer any potential fraud, waste, or abuse to the state Medicaid or CHIP PI Unit or MFCU, consistent with § 438.608(a)(7). States are responsible for ensuring MCP adherence to these program integrity requirements.

A recent Department of Health and Human Services (HHS) Office of Inspector General (OIG) review found significant variation in referral activity among MCPs.³ These findings indicate opportunities for states to strengthen oversight activities.

SOURCE: HHS OIG, OEI-03-22-00410

10%	8%	46%
MCPs that reported no provider fraud referrals during the review period.	MCPs that could not report referral volumes	MCPs that reported two or fewer referrals per 10,000 enrollees

MCPs that received state or MFCU training on the fraud referral process reported higher referral volumes than those without training.

States that monitor referral volume, quality, capacity, and outcomes are better positioned to identify underperformance and target technical assistance.

Volume vs. Quality: Measuring What Actually Matters

Referral volume alone does not indicate fraud prevalence. However, a low volume of referrals could indicate that an MCP, SMA, or CHIP agency is not adequately detecting and acting on suspicious conduct. Extremely low referral rates may point to weak detection processes, limited investigative resources, insufficient training, or inadequate referral procedures. Alternatively, high volumes of low-quality referrals can burden investigators and significantly delay action.

³ HHS Office of Inspector General, <https://oig.hhs.gov/documents/evaluation/10912/OEI-03-22-00410.pdf>. September 2025.

A Framework for Evaluating Referral Standards and Processes

There are four domains that govern effective fraud referral standards and processes, which provide a more complete understanding of referral effectiveness.

VOLUME

WHAT TO LOOK AT

Detection activity and referral trends

EXAMPLE MEASURES

- Preliminary/full investigations conducted per quarter
- Referrals per 10,000 enrollees
- Referral trends by quarter

QUALITY

WHAT TO LOOK AT

Completeness, timeliness, actionability

EXAMPLE MEASURES

Percentage of referrals containing all required referral elements:

- Subject and contact information
- A clear allegation and legal basis
- Representative claim examples
- Supporting evidence
- Witness information, when applicable
- Estimated financial impact
- Documentation of actions already taken.

OUTCOMES

WHAT TO LOOK AT

Whether referrals lead to administrative action, investigation, and/or prosecution

EXAMPLE MEASURES

States should establish a process, in coordination with their MFCUs or CHIP PI units to track referral dispositions. Measures may include:

- Referral acceptance or declination
- Investigation status
- Recoveries, exclusions, or other administrative actions

States should use these data to identify referral quality trends and opportunities for technical assistance.

CAPACITY

WHAT TO LOOK AT

Organizational ability to detect and refer

EXAMPLE MEASURES

- Special Investigations Unit (SIU) staffing levels
- Analytics capabilities
- Staff training

Before You Make a Referral: Is Your Case Ready?

For SMAs and CHIP agencies, a referral should meet basic data and information requirements to be considered a quality referral. Before a referral is submitted, the state Medicaid agency should be able to answer ‘yes’ to each item below.

For MCPs, this checklist **should not** be used to delay a referral required under § 438.608(a)(7). When the applicable referral threshold has been met but all checklist elements are not yet available, the MCP should make the required initial referral in accordance with state-defined procedures and supplement the referral as additional information is developed. The checklist describes the elements of a fully developed referral, not prerequisites that supersede applicable reporting requirements.

☐ **Reliable evidence:**

More substantive than solely a billing anomaly or data outlier

☐ **Corroborated:**

Verified by at least one independent source

☐ **Specific allegation:**

The provider, conduct, and time period are clearly identified

☐ **Legal basis identified:**

The applicable statute, regulation, or policy is cited

☐ **Financial impact estimated:**

Payment history reviewed for at least three years (if available)

☐ **Cross-program screening requested from the SMA or MFCU (see Multi-Program Considerations):**

Indicate where financial exposure may extend beyond your program, if applicable

☐ **MFCU jurisdiction confirmed:**

Verify whether the case falls within MFCU authority

☐ **Deconfliction completed:**

Coordinate with the MFCU or appropriate law enforcement partner to determine whether another agency is investigating the same provider or conduct. An existing investigation does not necessarily eliminate the referral obligation; follow the receiving agency’s direction regarding whether, when, and how the information should be submitted or coordinated.

DECONFLICT

Deconfliction should occur early, ideally immediately after initial detection. Confirm with your MFCU or law enforcement partner that no other agency is already investigating the same provider. Skipping this step risks duplicating work already underway and potentially can compromise an existing investigation.

Core Data Elements

Each fraud referral should include the elements below.

#	Element	Description
A	Contact information	Include the submitter's and investigator's contact information, such as their full name, title/role, organization, telephone number, and email address. Identify the primary point of contact for follow-up and, if different, an alternate contact. Include a mailing address when required by the receiving agency or referral process.
B	Subject information	Provider full name, address, NPI, Medicaid provider number, license; beneficiary ID if applicable
C	How you found out	Describe how the issue was identified and disclose any potential conflicts
D ★	What happened	Provide a clear narrative, three to five claim examples, the legal basis, relevant dates, and the estimated financial impact
E ★	Supporting evidence	Provide organized, relevant documents and highlight the strongest supporting evidence
F ★	Witness information	Describe each witness' role, key statements, and how the interview was documented
G	What the referring entity identified	Summarize prior provider training/outreach, audits that identified the issue, and any recurrence of the conduct
H ★	Legal analysis	Identify the applicable laws and explain how the evidence supports the violation
I	Actions already taken	Investigation summary; corrective steps taken or planned; other agencies notified
J	Cross-program scope	Does the provider bill FFS or other MCPs? Note potential program impacts you cannot access or quantify.

★ = Most critical elements to a quality referral

CAUTION

Always check with your MFCU, CHIP PI unit, or law enforcement partner before taking administrative action, such as provider termination. Alerting a suspect too early can compromise the investigation. This is one of the most common reasons cases are declined. However, if a fraud referral is declined, the SMA should remain ready to quickly take administrative action to stop the behavior.

Evidence and Witness Documentation

Prioritize clarity over volume. Law enforcement entities require clear access to key evidence, not large volumes of unorganized materials. Select three to five key claims and summarize their significance. The underlying data should be a supporting exhibit.

■ Strongest evidence

Evidence type	Description	Example
Information that contradicts medical records	Information that differs materially from documented services indicates potential fraud	<i>Claims show 60-minute therapy sessions billed on days the provider was out of state.</i>
Internal communications showing intent	Emails, texts, or written instructions showing the provider or billing staff knew the billing was wrong or were directed to bill incorrectly.	<i>Billing manager instructs staff to always bill a higher-level code regardless of visit length.</i>
Records that appear altered, duplicated, or fabricated may indicate intentional misconduct	Identical clinical notes across multiple beneficiaries on different dates; notes dated after billing; corrections that obscure original entries.	<i>Progress notes for 47 beneficiaries contain identical language word for word.</i>
Prior audit findings for the same issue	Repeat findings after prior corrective action strongly support willfulness	<i>Provider signed a corrective action plan for identical upcoding two years ago. Same pattern resumed six months later.</i>

■ Supporting evidence — useful but not sufficient on its own

Evidence type	Description	Example
Statistical billing pattern analysis	Peer comparisons showing outlier billing support further review but are not conclusive	<i>Provider bills the highest-complexity office visit code for 98% of patients vs. a 12% peer average.</i>
Services billed for deceased or absent individuals	Claims for dates when the beneficiary was deceased, hospitalized, or incarcerated, or claims under a provider NPI during suspension or inactive licensure.	<i>Claims billed under a provider's NPI while that provider was serving a license suspension.</i>

■ Weak on its own

Evidence type	Description	Example
Billing anomalies without context	Data anomalies alone should not be used as the basis for a referral	<i>Claims analysis shows the provider bills significantly more units per beneficiary than peers, but no medical records, interviews, or other evidence have been reviewed to explain or corroborate the variance.</i>

■ Handle carefully

Evidence type	Description	Example
Single-source allegations	Single-source allegations should have independent corroboration before referral	<i>A whistleblower complaint is a starting point, not a completed investigation.</i>

What Corroboration Means

Corroboration means verification of the allegation by at least one independent source. Not all corroboration carries the same weight.

Type of corroboration	Strength	Notes
Claims data independently confirming the billing pattern	Strong	Stands on its own and does not rely on the original source to interpret
Medical records directly contradicting what was billed	Strong	Documentary evidence that the service was not rendered as claimed
Second witness with direct, independent observation of the conduct	Strong	Must be independent of the first source and have firsthand knowledge
Site visit confirming service could not have been rendered as billed	Strong	Provider absent, facility not equipped, and beneficiary not seen
Statistical peer comparison showing outlier billing	Moderate	Supports the allegation but does not independently confirm fraud
Second source who heard the account secondhand	Moderate	Less reliable than direct observation or documentary evidence
Source with financial interest in the outcome, unverified	Insufficient alone	Conflicts must be disclosed and independent verification obtained before referral

Witness Documentation: What a Law Enforcement Entity Needs to Know

Thorough witness documentation strengthens investigative and prosecutorial review. For each person interviewed, document the following.

Information needed	What to document	Why it matters
Who was interviewed	Full name, title or role, and relationship to the subject	Establishes whether the witness's account is plausible given their position and access
Interview date and format	Date, location, whether recorded or memorialized in writing	Contemporaneous notes are more reliable than summaries created significantly later
Key admissions	Quote or closely paraphrase the most significant statements made	General descriptions are insufficient; key statements should be clearly documented
Subject status warning	Document whether the witness was advised they could be a subject of the investigation before being interviewed	Documenting subject status advisement is important to avoid legal complications
Witness credibility	Note anything that may affect credibility, including prior disciplinary history, financial interest, or prior inconsistent statements	Law enforcement needs to know whether this witness will hold up under cross-examination
Corroborating documents	Note any documents the witness produced, identified, or confirmed, and reference where they appear in the referral package	A witness who can point to a document is far more useful than one relying on memory alone

CAUTION

Do not interview the target without first coordinating with the MFCU, CHIP PI Unit, or law enforcement. Interviewing the target before law enforcement has had a chance to do so can alert them, give them time to build a defense, and, in some cases, compromise the investigation. If you have already interviewed the subject, document everything that was said and disclose it fully in the referral.

Multi-Program Considerations: Cross-Program Fraud

Each program, whether FFS or MCP, only sees its own portion of a provider's billing activity. No single program sees the complete billing picture. Referrals based solely on one program's data may understate financial impact.

Providers frequently participate in FFS billing and one or more MCP networks simultaneously, and CMS encourages states to share fraud referral information broadly across plans and programs to mitigate risk system-wide.

IN YOUR REFERRAL

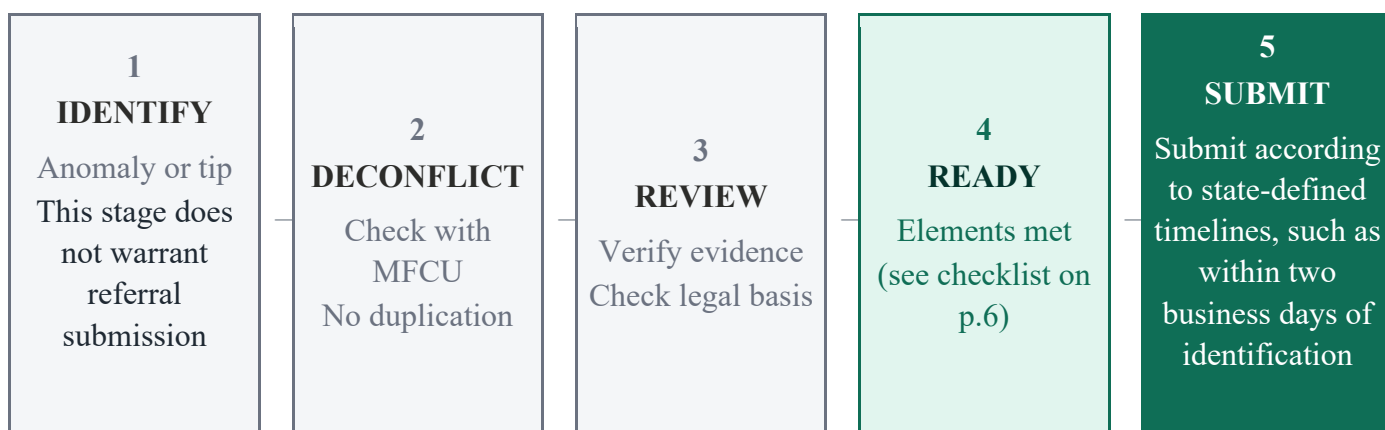
What to include in your referral: Indicate whether the provider participates in FFS as well as MCP networks to support cross program review. Clarify that financial impact estimates reflect only accessible program data and may be higher across other programs. Request cross program claims review when additional exposure is likely.

States vary widely in how they currently share fraud referral information across MCPs. CMS recommends each state implement a clear process for cross-program fraud referral coordination, whether it is a regular all-MCP meeting with the MFCU or CHIP PI unit, a shared tracking log, or a standing data-sharing provision built into MCP contracts. States should build safeguards, such as limiting the details shared on active investigations, so coordination does not put ongoing law enforcement work at risk.

Timeliness: When to Submit a State Referral

Timely referrals should be balanced with complete and accurate case development. Submitting a referral prematurely, before establishing a sufficient evidentiary basis, risks exhausting limited law enforcement resources. Conversely, delaying submission can allow fraudulent billing to continue. Internal screening processes should support referral submission once key readiness elements found in the "Before You Submit: Is Your Case Ready?" checklist on page 6 are met.

FIVE-STEP FLOW: IDENTIFY, DECONFLICT, REVIEW, READY, SUBMIT WITHIN 2 BUSINESS DAYS



Medicaid Managed Care Referral of Potential Fraud, Waste, or Abuse Guidance

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

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

SMAs have the discretion to determine the timeline for “prompt” reporting by MCPs under § 438.608(a)(7) and 457.1285. States should establish clear timelines in the MCP contract for prompt reporting of potential fraud, waste, and abuse. In the context of reporting fraud referrals, based on CMS’ fraud investigations and promising practices received from states, CMS encourages “prompt” to be defined as within two business days⁴ of the identification of potential fraud, waste, or abuse.

B. Referring Potential Fraud (§ 438.608(a)(7) and 457.1285)

Under CMS regulations, states must require in their contracts that MCPs promptly refer any potential fraud, waste, or abuse to the state Medicaid and CHIP PI Unit or any potential fraud directly to the MFCU. Within this framework, SMAs have some discretion to specify to whom MCPs must refer potential fraud, waste,

⁴ § 438.608(a)(7) requires only that MCP reporting be “prompt.” The two-business-day definition comes from CMS’s sub-regulatory toolkit, *42 CFR 438 Subpart H: Prompt Referrals of Potential Fraud, Waste, or Abuse*, and reflects CMS’s stated encouragement based on its fraud investigations and promising practices reported by states, not a binding numeric requirement. <https://www.cms.gov/files/document/managed-care-fraud-referral.pdf> June 2025

and abuse, depending on the facts of the investigation as well as the format and level of detail required as part of the referral. SMAs may choose from one of the following options:

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

Although states may permit MCPs to report potential fraud directly to the MFCU, CMS encourages states to require concurrent MCP reporting to the Medicaid or CHIP PI Unit. That would allow the SMA to assess whether potential fraud is referred promptly under §438.608(a)(7) and 457.1285 and better coordinate provider oversight efforts. CMS encourages states to provide frequent, state-led trainings on program integrity trends and the fraud referral process to managed care plans. State-led trainings have been shown to increase provider fraud referral rates and optimize program integrity.

Effective managed care program integrity requires close collaboration between the Medicaid or CHIP PI Unit, MFCU, MCP Special Investigations Unit (SIU) (when applicable), and other law enforcement stakeholders. Such relationships are critical to ensuring all parties optimally exchange information and collaborate to determine the best course of action for suspected cases of fraud.

C. SMA Actions upon Receiving a Referral of Potential Fraud or Abuse (§§ 455.14 and 457.925)

For any potential Medicaid fraud or abuse that is referred to the Medicaid or CHIP PI Unit, CMS regulations at § 455.14 specify that the Medicaid or CHIP PI Unit must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. For a separate CHIP, § 457.925 requires the State agency to conduct a preliminary investigation or take otherwise appropriate action within a reasonable period of time. For potential Medicaid fraud referrals, the Medicaid or CHIP PI Unit must also cooperate with the MFCU as required under § 455.21. The SMA is responsible for determining whether there is a credible allegation of fraud for purposes of § 455.23.

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

Regardless of the approach states adopt, they should have policies and procedures in place to evaluate the quality and thoroughness of MCP SIU investigations, which states can evaluate via standalone audits or as part of periodic broader state MCP reviews. Such reviews can be helpful in informing states how to structure future contractual requirements on managed care fraud investigations and referrals.

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

Common Problems and How to Fix Them

Problem	Why it matters	What to do
The referral does not identify the statute or regulation that has allegedly been violated	To build an actionable case, law enforcement needs to be able to allege violation of a statute or regulation	Train staff to identify applicable statutes and/or regulations before submitting any referral
Narratives fail to include clear descriptions and specific claim examples	Law enforcement cannot assess scope or assign priority	Require a plain-language narrative with 3 to 5 specific examples before supervisor approval
Supporting documents aren't clearly labeled and accompanied by a concise summary	Buries the evidence; investigators will not dig through disorganized data	Lead with a plain-language summary; flag key documents; use labeled exhibits
Financial estimates are not developed using at least three years of claims data, where available	Depending on the nature of the allegations, law enforcement may use "dollar amounts at risk" among their metrics to help gauge whether a case warrants allocation of resources	Always run a payment history query covering at least three years (if available); note if cross-program exposure is likely higher
Witness summaries don't include key statements, role, and documentation method	Makes law enforcement reconstruct interviews without context	For each witness, document role, key admissions, subject status warning, and credibility concerns
Targets are interviewed prior to law enforcement coordination	Alerts the subject and may put an entire investigation and interviewer at risk	Coordinate with MFCU before entertaining the possibility of interviewing the target; if already done, document everything and disclose fully
Referrals fail to specify whether cross-program checks are needed	Understates financial impact; may cause the case to be deprioritized	Always flag FFS enrollment and other MCP participation and request the check; note what you cannot access
Corrective action occurs without coordination with law enforcement or the MFCU	May alert the target and compromise the investigation	Always coordinate with MFCU or law enforcement contact before taking any action against the target

Supporting Effective Referral Processes

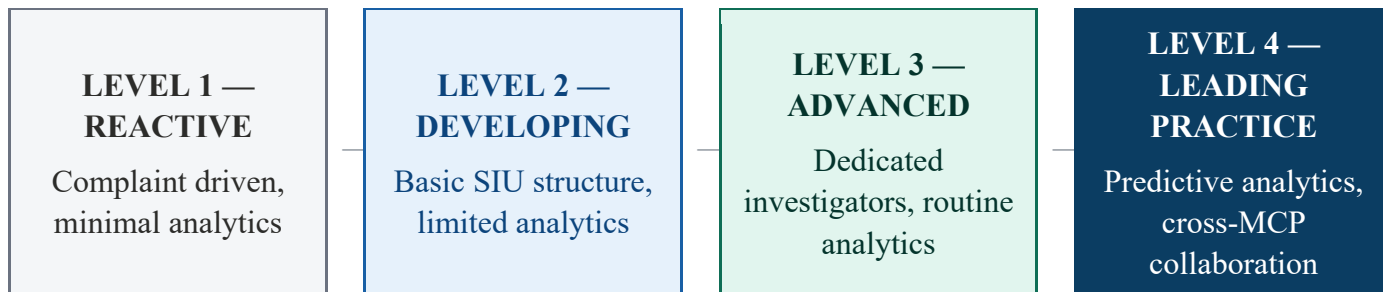
State oversight and MCP investigative units work in tandem to support effective referral processes. In many states, MCPs submit fraud referrals to the SMA or CHIP Program Integrity Unit before they reach the MFCU. The PI Unit serves as the initial screening entity and plays a central role in referral quality.

States that invest in training and collaborative relationships with their MFCU see stronger referral outcomes. Additionally, SMAs should develop and implement training programs for MCPs to improve the quality and quantity of provider fraud referrals. Low referral rates or a complete lack of referrals from an MCP are rarely a sign that fraud does not exist; rather, they tend to signal underlying weaknesses in detection, staff training, or investigative capacity.

Domain	Assessment & oversight criteria	Recommended state/MFCU actions
Staffing & caseloads	SIU staffing levels and ratios; dedicated fraud investigators vs. general compliance staff; investigator caseload volume	Assess staffing gaps that may delay referral processing
Strategic training	Annual fraud referral training; emerging fraud scheme awareness; referral quality workshops	States should hold periodic joint trainings with the MFCU and MCPs focused on referral quality. Medicaid Integrity Institute (MII) courses are also available for state, MCP, and MFCU trainings.
Analytics & data sharing	Claims analytics and outlier detection; provider peer comparison tools; predictive analytics capability	States may share de-identified referral outcome data to identify systemic issues
Processes & feedback loops	Internal referral review and QA processes; referral tracking systems; coordination protocols with PI Units and MFCUs	States should request feedback from the MFCU on declined referrals to inform quality improvements
Compliance assessment	Periodic, at minimum annual, review of both MCP and SMA/PIU compliance with referral regulations and MOU terms	States should establish clear accountability mechanisms for referral compliance

Maturity Model: Where Does Your Program Stand?

Many programs fall between Levels 2 and 3 on the maturity scale. The goal is steady movement toward Level 4.



Level	What it looks like
Level 1 — Reactive	Level 1 programs reflect limited referrals and absent SIU structures
Level 2 — Developing	Level 2 programs demonstrate moderate referral activity and developing analytic capacity
Level 3 — Advanced	Level 3 programs consistently produce high-quality referrals supported by regular training
Level 4 — Leading Practice	Level 4 programs use predictive analytics and structured cross program collaboration

Best Practices

Fraud detection and referral submission require shared responsibility across CMS, states, MCPs, and law enforcement entities. A well-built referral supports investigative efficiency and resource stewardship. It requires reliable and corroborated evidence, a clear legal basis, witness documentation an investigator can use, a financial impact estimate that accounts for cross-program exposure, and a referral package organized so the receiving agency can act without having to start over. These best practices result in actionable outcomes.

<https://www.cms.gov/files/document/managed-care-fraud-referral.pdf><https://www.cms.gov/files/document/managed-care-payment-suspensions.pdf><https://www.cms.gov/files/document/managed-care-fraud-referral.pdf><https://www.cms.gov/files/document/managed-care-payment-suspensions.pdf><https://www.medicaid.gov/medicaid/program->

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