

MFCU Coordination Best Practices under 42 CFR 455.21

AUTHORITY	LAST UPDATED	
42 CFR §§ 455.21, 1007.9	10/23/2026	

Introduction

This guidance outlines best practices for coordination between State Medicaid Agencies (SMAs) and State Medicaid Fraud Control Units (MFCUs) for fraud referrals and other oversight activities. This guidance is specific to the MFCU cooperation regulations found at 42 CFR 455.21 and 42 CFR 1007.9, and is supplemental to CMS' Strengthening Medicaid Fraud Referrals¹ and Managed Care Payment Suspensions² toolkits.

Because the MFCU operates independently from the SMA's own program integrity (PI) Unit, effective coordination depends on the SMA proactively structuring the relationship rather than treating referral and data sharing as a one-way, one-time event. Recent engagements with States, MFCUs, and the Department of Health and Human Services' Office of Inspector General (HHS-OIG) have indicated that there is a need for more guidance from CMS on this relationship and the regulations found at 42 CFR §§ 455.21 and 1007.9.

Note: CMS' Strengthening Medicaid Fraud Referrals toolkit addresses referral requirements, including those specific to the state's contracts with managed care plans (MCPs) under 42 CFR § 438.608(a)(7) — the "prompt" timeline, referral-routing options, MCP Special Investigation Unit obligations, and MCP record retention rules. For more information on managed care-related payment suspensions and the procedures in place to suspend payment when there is a credible allegation of fraud, consistent with requirements found in 42 CFR 438.608(a)(8), please see our [Managed Care Payment Suspensions](#) toolkit.

¹ Link to be added once available

² <https://www.cms.gov/medicare/medicaid-coordination/states/resource-library/managed-care-payment-suspensions-toolkit>

Regulatory Framework: What Federal Law Requires

Citation	Who it applies to	What it requires	Applicable standards
§§ 455.14-15	State Medicaid Agencies	Requires SMAs to conduct a preliminary investigation when it receives complaints of Medicaid fraud or abuse from any source or identifies questionable practices.	If the findings of a preliminary investigation give the SMA reason to believe that an incident of fraud or abuse has occurred, it must refer to case to its MFCU, or in states with no MFCU, conduct a full investigation and refer the case to an appropriate law enforcement entity.
§ 455.21	State Medicaid Agencies	Requires SMAs to refer cases of suspected provider fraud to their MFCU.	Referrals of all suspected provider fraud.
§ 438.608(a)(7)	Managed Care Plans	Requires states to include in MCP contracts a provision that MCPs promptly refer any potential fraud, waste, or abuse to the state Medicaid PI Unit or directly to the MFCU.	Any potential fraud, waste, or abuse, intended to move information quickly.
§ 455.23	State Medicaid Agencies	Requires the SMA to suspend Medicaid payments to a provider upon determining there is a credible allegation of fraud, absent good cause not to, and requires the PI Unit to cooperate with the MFCU in making that determination, consistent with § 455.21.	Any credible allegations of fraud.
1007.9	MFCU Requirements	Sets forth the requirements regarding the relationship and agreement between the MFCU and state Medicaid agency.	A written agreement between the Unit and the Medicaid agency covering matters such as referral procedures and mutual cooperation.

Regulatory Requirements & Best Practices

- 1. Formalize the referral relationship in writing per 42 CFR 455.21(c) and 42 CFR 1007.9.** Maintain a current memorandum of understanding (MOU) or agreement (which must be

reviewed and updated, if necessary, no less frequently than once every 5 years) with the MFCU establishing regular meetings and specifying referral format, required supporting documentation, expected response times, and points of contact on both sides. To ensure a prompt feedback loop between the SMA and MFCU, CMS encourages states to make sure this includes a MFCU referral response time of 30 calendar days or less and should specify whether a case was accepted, rejected, or more information is needed to make a determination.

2. **Coordinate payment suspension decisions closely with the MFCU.** Because § 455.23 requires payment suspension upon a credible allegation of fraud, and because premature or public action can compromise an active investigation, the SMA should notify and coordinate timing with the MFCU before or concurrent with suspension and document the good-cause analysis if suspension is delayed or not imposed.
3. **Provide the MFCU direct, efficient access to all State Medicaid claims and provider data as required at 42 CFR 455.21(a)(2) for use in data mining activities and investigations, in accordance with State laws.** The SMA should establish a standing process (not an ad hoc records request each time) for MFCU staff to obtain claims data, encounter history, prior audit reports, and enrollment/screening records for referred providers.
4. **Hold regular case-status meetings.** Periodic (e.g., monthly or quarterly) meetings between SMA PI/audit staff, MCPs (if applicable), and MFCU staff help surface referrals that have stalled, align on case prioritization, and identify emerging fraud patterns visible in FFS claims data that the MFCU should be aware of even before a formal referral is finalized.
5. **Maintain records consistent with retention requirements at 42 CFR 455.23(g).** Documentation supporting referral decisions, credible allegation determinations, and payment suspension actions should be retained and readily retrievable for as long as an MFCU investigation or related litigation may run, consistent with applicable state and federal retention standards.
6. **Consider implementing a Medicaid Fraud War Room.** Using CMS guidance found here, create a standing meeting involving SMA program integrity staff and the MFCU to act on potentially fraudulent Medicaid providers in real time.