State and Territory Medicaid Programs Share the Federal Government's Interest and Urgency around Medicaid Program Integrity

NAMD
National Association of Medicaid Directors

Over 2026, Medicaid leaders across the country will be staging a complex portfolio of work with important implications for the federal/state-territory partnership on which the program is premised. This portfolio includes implementation of Medicaid provisions of H.R. 1, the One Big Beautiful Bill Act (OBBBA, also referred to as the Working Families Tax Cut legislation) as well as responding to priorities billboarded by the Center for Medicare & Medicaid Services (CMS) leadership; notably, a program-wide focus on strengthening efforts to address Medicaid fraud, waste and abuse (FWA).

State and territory Medicaid teams have strong common interest with the federal government in ensuring that the program is as lean, efficient and accountable as possible. That said, achieving that goal will not be possible without differentiating among the three components of FWA and identifying the best available means of addressing each of them. And while **fraud** – intentional gaming of the program by health care providers for their own financial benefit – is justifiably top of mind, federal and state/territory Medicaid officials could also be focusing more actively on **abuse**, where services beyond what is medically necessary may have been provided, as well as **waste** of Medicaid resources that results from not addressing leading cost drivers in the program.

While state and territory programs are actively combating FWA through a range of tools and strategies, they could use more help from CMS. Specifically, CMS can help states/territories to:

- **prevent and remedy fraud** by 1) using Transformed Medicaid Statistical Information System (T-MSIS) data to perform predictive data analytics and identify key areas of concern on which programs should be focusing; 2) accelerating the time frames in which CMS is responding to reports of fraud raised by state attorneys general and Medicaid Fraud Control Units (MFCUs); and 3) continuing to use corrective action plans (CAPs) that are mutually agreed to and acted on by states and the federal government to investigate, remedy and prevent further instances of fraud;
- **avoid abuse** by partnering with states to create national toolkits around assessment, utilization management and quality standards for Medicaid-covered services that have rapidly arisen out of advocacy by families and provider organizations, CMS guidance, and coverage mandates enacted by state legislatures, all focused on addressing the needs of historically underserved people – two leading examples of this are services for people with autism spectrum disorder (ASD) and people with mental health conditions or substance use disorder (MH/SUD); and
- **reduce waste** by:
    - avoiding the historical phenomenon of "first dollar" spending on eligibility and payment processing systems in each individual Medicaid program, as CMS' recent announcement around partnerships with tech vendors has helpfully begun to address, with an immediate focus on equipping states to implement systems-related aspects of the OBBBA as cost-effectively as possible and avoiding expensive future re-work;

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste is the inappropriate utilization of services and misuse of resources that result in unnecessary cost to the program (e.g., duplication of tests). Waste is not an intentional or criminal act.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/section-455.2

- continuing to bring the influence and purchasing power of the federal government to bear on controlling the cost and rate of growth of Medicaid covered prescription drugs, as the administration and the Centers for Medicare and Medicaid Innovation (CMMI) have proposed to do with several new demonstrations (Cell and Gene Therapy Access Model, GENEROUS and BALANCE); and
- supporting state Medicaid programs in "rebalancing" long-term services and supports (LTSS) for older adults and people with disabilities from more costly institutional settings to home and community-based settings.

Why and How States and Territories are Addressing FWA

Medicaid celebrated its 60th anniversary in 2025 and continues to be the subject of considerable constructive tension: demonstrably viewed positively by the American public and the people whom it serves, but also a program whose expanded footprint, cost trends and increasing share of state general fund budgets has explicably attracted considerable attention. And while the proportion of federal funding for the program has been reduced from the enhanced levels that were authorized by Congress during the pandemic, overall federal spending remains significant.

Among other notable indicators, the National Association of State Budget Officers recently reported that Medicaid reflects an average of 30.7% of total state expenditures – the largest total spending category - and 20.0% of general fund expenditures – the second highest category. Further, while national health expenditure data continues to show that Medicaid grew at a lower rate (6.6%) in 2024 than either Medicare (7.8%) or private insurance (8.8%), those increased costs remain significant. In a landscape in which many states are facing serious budget constraints, Medicaid cost trends and scope are a necessary, perennial area of focus.

In addition to the proportion of state and territory budgets attributed to Medicaid spending, state and territory Medicaid programs share the federal government's interest and urgency around reduction of FWA because:

- they want to ensure that federal and state/territory funds support needed benefits that improve health outcomes for eligible people, as opposed to lining the pockets of bad actors who are defrauding the program;
- many across the country have, over the last ten years, implemented new, gap-filling services for two historically underserved populations – Applied Behavioral Analysis (ABA) for people with ASD and supportive housing services for people with mental health (MH) conditions or substance use disorder (SUD) – that were well intended and much needed but, because of exponential growth, now need careful attention to ensure that needs assessment standards and utilization management guardrails safeguard against overuse, abuse or outright fraud by unscrupulous providers; and
- many states and territories are facing serious budget constraints.

Medicaid agencies use a robust set of program integrity tools today to prevent, reduce and address **fraud and abuse** in their programs, including:

Audits and ongoing reviews of eligibility processes. Federal law and regulations establish detailed requirements that states must follow for how and when eligibility is determined and regularly verified through redetermination of coverage. This involves criteria that include, but are not limited to, citizenship, state residency, income, assets (for some coverage groups), and household composition. Applicants and those renewing eligibility are also required to 1) provide information on changes of status in these criteria; and 2) assign to the state their rights to support and payment by a third party for medical care (the "third-party liability" or TPL process). Strategies that support compliance with these requirements include:

- hotlines through which potential fraud can be reported;
- state inspectors' general;
- reviews by state auditors of compliance with federal standards;

- state CAPs arising out of findings from CMS' Payment Error Rate Measurement Program (PERM) audits, which assess and make findings on adherence to standards;
- robust federal and state examination of the accuracy and efficiency of state systems that support eligibility and renewal processes, and related systems updates and fixes, during the "unwinding" of COVID-19 public health emergency continuous coverage requirements; and
- lean process reviews of renewal processes through partnerships between the United States DOGE Service (USDS) and states.

State oversight of Medicaid managed care organization (MCO) contracts. Contracts under which Medicaid programs make capitation payments to private MCOs are the predominant delivery model in the country, with almost 80% of beneficiaries enrolled in managed care arrangements. Medicaid programs use numerous tools including procurement standards, public transparency, and contract accountability features to ensure that MCOs are performing consistent with contract standards, delivering value for taxpayers' dollars and preventing and remedying fraud. These tools include requirements for plans to have internal program integrity units, corrective action plans, liquidated damages, withholds, monetary penalties, and, as needed, debarment and suspension. Note that MCOs themselves use numerous strategies to combat fraud, including use of compliance teams; monitoring and auditing using analysis of claims and encounter data, chart reviews, billing assessments and provider site visits; enhanced provider screening; and referrals to state MFCUs.

Provider credentialing, enrollment and re-enrollment processes. Medicaid programs are required to use a range of tools to ensure that providers are properly credentialed and eligible to enroll as Medicaid performing providers. This includes the federal Data Exchange System, which provides access to the Social Security Administration's Death Master File and the Medicare Exclusion Database. These databases help Medicaid agencies verify that they are not covering services for deceased individuals and are not paying providers who have been excluded from other federally funded health care programs. OBBBA will strengthen these existing processes. Programs must also periodically re-enroll providers and focus particular attention on those that are identified as being at high risk for fraud.

Utilization management standards. All Medicaid programs implement an array of utilization management (UM) standards, including prior authorization, diagnostic criteria, and caps on type or frequency of services. An applied example of this is adoption of provider credentialing and UM standards for behavioral health services as well as use of American Society for Addiction Medicine (ASAM) guidelines for substance use disorder (SUD) services. Medicaid agencies implement such standards through publication of provider guidelines and system edits that intercept non-compliant claims prior to payment.

Documentation of services delivered. Programs also use a range of tools through which services that are delivered outside of traditional health care settings must be documented. An important recent example of this is implementation of Electronic Visit Verification (EVV) for home health and personal care services received by older adults and people with disabilities, to help ensure that the services that are ordered through care plans are provided as billed.

Systemic review and individual post-payment audits. Medicaid programs analyze their claims patterns to identify patterns and outliers that signal potential areas of provider fraud and abuse. They also use post-payment audits that yield findings of inadequate documentation as well as improper billing, and result in recoupment of claims paid. Many states also contract with recovery audit contractors that are incentivized on a contingency basis for identifying fraud.

Medicaid Fraud Control Units (MFCUs). MFCUs are responsible for investigating referrals related to fraud and patient abuse or neglect by Medicaid-enrolled providers and assessing which of those should be pursued for criminal prosecution and/or civil penalties. In its Medicaid Fraud Control Unit Fiscal Year 2024 Annual Report, the Office of the Inspector General (OIG) detailed that MFCUs reported 1,151 convictions and $1.4 billion in total recoveries in the latest publicly reported period, FY 2024.

PARIS matches. Since 2009, states have been required to participate in the Public Assistance Reporting Information System (PARIS) as a condition of receiving enhanced federal support for their Medicaid systems. PARIS data checks allow states to identify whether an individual is receiving Medicaid or other public assistance in other state programs, thereby reducing potential duplication of benefits. OBBBA will also enhance this process.

Staff training on program integrity. Medicaid agency program integrity staff receive training from the Medicaid Integrity Institute to continuously enhance their strategy and operations.

Medicaid programs also use diverse strategies to reduce **waste** in the program, with a focus on leading cost drivers (hospital services, nursing home care and prescription drugs) as well as administrative expenses. Several important examples of this are:

- **Medicaid managed care accountability** strategies including Medical Loss Ratios and quality withholds as well as review of claims patterns and use of systems controls to prevent improper payments;
- **value-based payment arrangements**, ranging from pay-for-performance approaches that link Medicaid reimbursement to outcomes on identified quality and cost measures to models under which providers are held accountable for the total cost of care;
- **initiatives to control and reduce Medicaid spending on prescription drugs**, including managed care carve-outs and/or carve-outs of one or more drug classes (e.g. hemophilia products, spinal muscular atrophy agents, other cell and gene therapies and/or high-cost specialty drugs) from MCO capitation, new or preferred drugs lists, and value-based arrangements (VBAs); and
- **automation of eligibility redeterminations using *ex parte* processes** that have preserved accountability while reducing staff time and the need to request supporting documentation from Medicaid members.

What CMS Can Do to be of Additional Help with FWA

CMS has helpfully signaled an agency-wide commitment to addressing FWA. Over and above the auditing processes that are currently being prioritized, CMS has additional opportunities to be of help to state and territory Medicaid programs in addressing each component of FWA.

Strategies to Help States Reduce Fraud

States and territories have well-defined accountabilities in stewarding use of federal and state Medicaid funds. As noted above, for years they have shouldered the primary responsibility of establishing and cueing providers to utilization management standards, using a range of strategies including pre- and post-payment audits, and collaborating with offices of attorneys general and law enforcement to investigate and prosecute fraud. Given the increasing sophistication and brazenness of bad actors and the scope and severity of their fraud schemes, however, CMS and other federal agencies remain essential partners in preventing and addressing provider fraud.

Additional ways in which CMS can be of assistance to states and territories include:

- cueing states and territories to federal FWA best practice materials (e.g. a provider enrollment self-assessment and process recommendations previously published by the CMS Center for Program Integrity, CPI)
- creating routine, rapid means of sharing fraud findings and provider disqualifications made by other public payers (e.g. Medicare and the VA) with Medicaid programs;
- accelerating the time frames in which CMS is responding to reports of fraud raised by state attorneys general and MFCUs;
- retaining and strengthening the procedural pathways through which states and territories can surface findings of FWA and work collaboratively with CMS on mutually negotiated CAPs that encourage open sharing of data, additional research and investigation, and a holistic orientation that ensures adherence to required provider qualifications and performance standards but also continued access to vital services by eligible Medicaid members – an excellent example is CMS' approach with a large-scale fraud scheme identified by the state of Arizona;
- resourcing a Medicaid analytics-specific component of the CPI and using T-MSIS data to engage in predictive analytics and flag patterns of potential fraud on a national basis;
- as will be required under OBBBA, strengthening the technical capacity and timeliness of federal hubs and matching functions, including PARIS and the various existing sources of provider data; and

- providing access for both state/territory program integrity staff and also their policy counterparts to technical assistance sessions and materials produced by the Medicaid Integrity Institute.

Strategies to Help States Reduce Abuse

Over the past decade, states have expanded Medicaid coverage for services such as ABA for people with ASD and supportive housing interventions for people with MH and SUD largely in response to advocacy by families and providers, CMS guidance, coverage mandates enacted by state legislatures, and evolving interpretations of the Early and Periodic Screening and Treatment (EPSDT) requirement as well as federal mental health parity law. Implementing these new services was well intended as a means of addressing unmet needs, but as utilization has rapidly increased, programs are now examining experience and outcomes as well as assessing the standards under which these services are being provided to safeguard against overuse or outright fraud by unscrupulous providers. CMS could helpfully partner with states to develop national toolkits for both service types that articulate:

- best practice standards for assessment of needs, as well as template assessment tools;
- standard service definitions, not just for the services that quickly became the exclusive focus for coverage but also other, potentially lower cost, services that could benefit these populations;
- provider credentials and scopes of work;
- utilization management standards (e.g. tiering of service according to the acuity and complexity of an individual's needs; circumstances under which the service can be delivered remotely, if at all); and
- guidance on interplay with and avoidance of duplication with related services; e.g.:
    - in the case of ABA services, guidelines for how Medicaid coverage relates to school-based coverage under Individual Education Plans (IEPs); and
    - in the case of supportive housing services, guidelines for how Medicaid coverage relates to traditional housing-based supports such as resident services coordinators.

Strategies to Help States Reduce Waste of Medicaid Funds

Systems spending. Another key opportunity for reduction of waste in Medicaid is public spending on Medicaid eligibility and claims processing systems. Under federal law, the federal government contributes 90% of the costs of procuring, designing and implementing those systems, and 75% of the costs of maintaining them ongoing. Notwithstanding this significant equity interest, and federal policy direction around reuse of solutions, the most typical scenario for Medicaid systems is a bespoke, state-by-state, first dollar approach that is rarely amenable to scaling to other states/territories or even adaptation. Further, the vendors that are responsible for designing these systems typically remain engaged over time to modify the systems through costly change orders, necessitating a dependence that does not ultimately drive toward state self-management.

Ways in which CMS could be of further support with this include:

- partnering with states on alternatives to the traditional multi-year, multi-component Advance Planning Document (APD) process, including means of supporting agile procurement and implementation models;
- producing model business requirements for federal policy-related systems changes that states and territories could elect to adopt; and
- addressing systems-related implementation challenges associated with OBBBA, notably:
    - resolving outstanding questions related to policy interpretation (e.g. around exemptions from work and community engagement requirements) that will equip states to move ahead with systems work and avoid expensive re-work in the future;
    - building on CMS' recent work in achieving cost concessions and signals around procuring support from new IT vendors through the federal GSA Schedule;
    - working with the federal Food and Nutrition Service (FNS) to align how like SNAP and Medicaid policy requirements are operationalized – an applied example is how household size is counted;

- integrating additional data sources (e.g. Veteran's Administration data) into the Federal Data Hub to help routinize adjudication of exemptions;
- use of the federal government's purchasing power and influence to reduce the per transaction cost of using the Federal Data Hub and other related sources; and
- identifying and scaling information technology solutions that can either layer on existing systems or be implemented as modules (e.g. for verification of various features of CE requirements for which we currently lack current interoperability between Medicaid systems and other data sources).

Pharmacy spending. As noted above, despite significant work by states to control the rate of Medicaid cost growth, pharmacy spending remains a significant cost driver for the Medicaid program. Per KFF, between FY 2017 and FY 2023, Medicaid spending net of rebates on prescription drugs grew by 72% and in FY 2023, prescription drugs accounted for approximately 6% of total Medicaid spending.

Simply put, states do not have sufficient leverage to intercept the overall cost trend, much less accommodate emerging extraordinary costs for such interventions as anti-obesity medications and cell and gene therapies. Historically, the federal government has relied on the longstanding structure of the Medicaid Drug Rebate Program and otherwise delegated responsibility for Medicaid cost controls (e.g. purchasing compacts, utilization management strategies) to the states. Given the above cost trends, but also the co-occurring interest in enabling access to promising but costly obesity treatments and cell and gene therapies, this is untenable ongoing.

State and territory programs are grateful for renewed federal interest in this area. The Cell and Gene Therapy Access Model, in which 32 states, the District of Columbia and Puerto Rico are participating, as well as the recently announced GENEROUS and BALANCE models, have promise in acting on the federal government's influence and purchasing power to reduce costs through Most Favored Nation pricing and/or increased rebates. Other potential ideas to help states and territories with drug costs include:

- enhancing federal Medicaid match for a given class of drug/CGT;
- mandating additional rebates under the Medicaid Drug Rebate Program;
- developing risk corridors or reinsurance approaches;
- creating a stand-alone coverage group for people with specified conditions (e.g. sickle cell disease) that is associated with enhanced federal match; and/or
- developing a distinct program as Congress did for coverage of HIV/AIDS drugs under the Ryan White program.

"Rebalancing" long-term services and supports. Medicaid currently pays for 1 in 2 dollars spent in the US on long-term services and supports (LTSS). LTSS includes nursing home services as well as an array of home and community-based services on which 9.7 million (2023) Medicaid beneficiaries rely. The latest annual report on national spending that is prepared by Mathematica for CMS, Trends in Users and Expenditures for Home and Community-Based Services as a Share of Total Medicaid LTSS Users and Expenditures, 2023, indicates that:

- In 2023, national Medicaid LTSS expenditures totaled $228.6 billion, with HCBS accounting for $145.9 billion and institutional services accounting for $82.7 billion.
- The average LTSS expenditure per LTSS user in 2023 was $23,620, compared to $22,109 in 2022. People who received institutional services continued to have much higher average expenditures ($54,462 per user) than people who received HCBS ($17,298 per user).
- From 2022 to 2023, HCBS users as a percentage of total Medicaid LTSS users grew by 7.5% from 79.64 to 87.14 percent. Similarly, HCBS expenditures as a percentage of total Medicaid LTSS expenditures increased by 12.8% from 51.01 to 63.81 percent in that period.

Rebalancing has been defined by the Centers for Medicare and Medicaid Services (CMS) as, "achieving a balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care." This is intended to give Medicaid members greater choice in where they live and from whom they receive LTSS. It is also a key means of optimizing state spending on LTSS and freeing up resources for other priorities.

While significant progress has been made in increasing the proportion of members who receive Medicaid LTSS in non-institutional settings, continuing to shift the share of expenditures in that direction requires additional attention and effort. An action that CMS could readily take is to expand and reissue the Long-Term Services and Supports Rebalancing Toolkit that was last updated in 2020. This provides a capsule of the history and trends of the rebalancing effort, outlines Medicaid authority pathways, and billboards case examples of state best practice, but could usefully be expanded to include current day strategies to better integrate services and supports for people who are eligible for Medicaid and Medicare ("duals") as well as to articulate strategies for "right sizing" nursing home beds to account for lower demand.

Conclusion

In this watershed year of OBBBA/WFTC implementation, as well as renewed focus on program accountability, state and territory Medicaid programs will benefit from guidance and support from CMS in the mutual aim of continuing to enable access to high quality health services for all people who are eligible for the program, while exerting every possible lever to control costs and ensure adherence to all standards around beneficiary eligibility as well as proper provision of services by health care providers who are enrolled in the program. CMS has important opportunities to use its influence, partnerships with federal agency peers, and purchasing power to support programs in their efforts to control costs and to ensure program integrity.