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Beyond Minnesota

Four Medicaid Services Vulnerable to Fraud and the Case for Stronger CMS Enforcement

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In December 2025 and January 2026, citizen journalist and YouTuber Nick Shirley ignited a national firestorm with multiple videos alleging welfare fraud in Minnesota that have attracted more than 148 million views on X alone. The federal government had been investigating welfare program fraud in Minnesota for years. In October, Assistant U.S. Attorney for Minnesota Joe Thompson suggested that fraud may have siphoned at least half of the $18 billion spent in Minnesota since 2018 in the 14 Medicaid programs viewed as high risk for abuse.[1] Thompson called it "industrial-scale fraud" and emphasized that these schemes put services at risk for people who need them. Minnesota has halted the enrollment of new providers into those 14 services.[2]

Medicaid fraud is not unique to Minnesota. Rather, the scandal illustrates structural weaknesses that exist across the Medicaid program nationwide. In recent years, waste, fraud, and abuse have accelerated across government programs. As Paragon's previous research has shown,[3] Medicaid's financing structure rewards states for spending more federal taxpayer dollars while imposing few fiscal consequences for improper payments, creating powerful incentives for weak oversight and abuse. The COVID-19 pandemic put this dynamic on steroids. Public programs — particularly Medicaid — experienced massive growth, with spending still well above pre-pandemic levels. States have commonly expanded funding through waivers for social determinants of health, which are often non-

KEY TAKEAWAYS

Waste, fraud, and abuse are rampant in Medicaid as Washington sends more money to states with no limit and entities within states benefit financially from improper expenditures.

Home- and community-based services and non-emergency medical transportation are especially vulnerable to fraud because decentralized care delivery, self-direction, low barriers to provider entry, and weak verification make it difficult to ensure services are actually provided as billed, particularly when Medicaid allows payments to family members with minimal oversight.

Applied behavioral analysis services for autism and substance use disorder services have experienced explosive spending growth driven by expanded coverage mandates, overlapping federal funding streams, and fragmented oversight, despite limited evidence of effectiveness and widespread improper billing.

CMS should consistently use its existing authorities, including Sections 1903 and 1904, to withhold federal funds, recover misspent dollars, and ensure states lose money — not gain — when waste, fraud, and abuse occur.

clinical services such as housing. These services, including those discussed in this brief, raise significant program integrity risks, because they are often not provided by medical professionals.

The One Big Beautiful Bill (OBBB) contains provisions to address improper payments. But given how Medicaid's design incentivizes fraud and waste—and the seemingly unchecked growth on the program during the Biden administration—further reforms are necessary.

This brief discusses four other areas ripe with improper payments and fraud: (1) home and community-based services (HCBS), (2) non-emergency medical transport, (3) applied behavioral analysis for autism spectrum disorder, and (4) substance abuse disorder services and treatments. Lawmakers should take immediate action to stem waste and abuse in these four areas. All four areas are especially vulnerable, because they combine open-ended federal funding with weak verification of service delivery and fragmented oversight responsibilities between states and the federal government.

(1) Home- and Community-Based Services

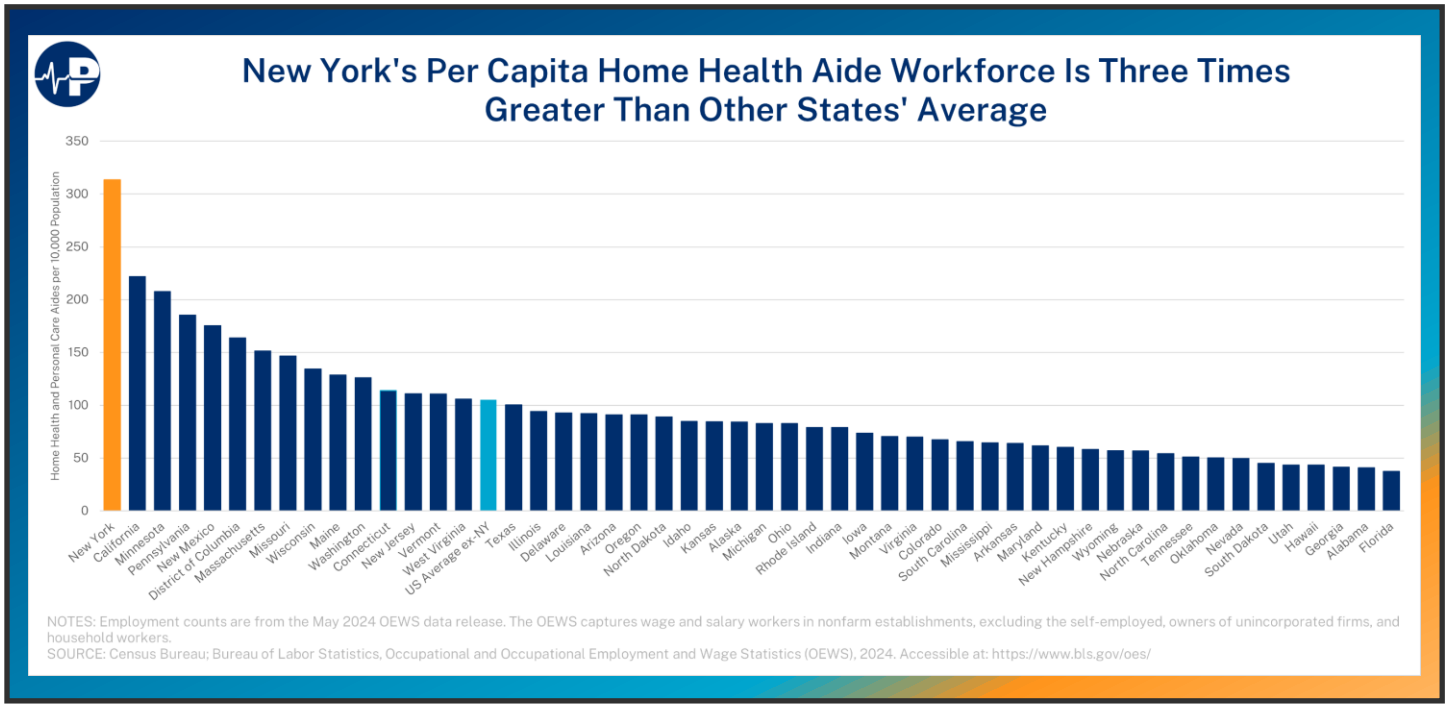
Medicaid's HCBS program—funded through Section 1915(c) waivers—was intended to serve as a safety net for individuals with disabilities and seniors to receive long-term care services and supports outside institutional settings. These services are meant to be lower-cost alternatives that help individuals who have difficulty with daily activities receive care at home. Unfortunately, rapid expansion—combined with perverse financial incentives and chronically weak oversight—has made HCBS one of Medicaid's most fraud-prone benefit categories.[4] In Minnesota, several of the state's high-risk provider types offer HCBS.[5]

Improper payments are common in HCBS.[6] In response to reports of increased fraud in Medicaid-financed services, Minnesota has paused licensing for new HCBS providers.[7]

Unlike institutional care, which is subject to more centralized regulation and where oversight is easier, HCBS often relies on decentralized networks of caregivers and state-administered payment systems. These differences create conditions that are ripe for abuse. HCBS is particularly difficult to monitor, because the care is delivered in homes by caregivers who are often relatives or friends. Many states permit "self-direction," under which beneficiaries effectively control Medicaid funds and hire family members as paid caregivers—dramatically weakening safeguards against false claims, inflated hours, and non-delivery of services.

Another vulnerability in HCBS policy is how some states increase their HCBS rates by including room and board costs. This practice is against the law, as the statute does not allow Medicaid to reimburse room and board costs.[8] However, the Department of Health and Human Services Office of Inspector General (HHS OIG) audited four states—Maryland, New York, Missouri, and South Carolina—and found that their state agencies had claimed $85 million by including room and board costs in the HCBS payment rates over multiple years.[9]

Oversight failures are not confined to any single Medicaid payment model. State governments have very little incentive to oversee spending on HCBS under fee-for-service (FFS) Medicaid. But the same is often true under managed care, in which state Medicaid programs contract with managed care organizations (MCOs) to manage



enrollees' benefits. If the state provides HCBS under managed care, it sometimes tasks the MCOs with monitoring compliance with HCBS regulations.[10] This creates a potential conflict of interest, because MCOs are paid for each beneficiary they serve, so they do not face a strong incentive to cut ineligible individuals.[11] Federal government agencies have raised concerns that states lack reliable mechanisms to verify service delivery and that documentation requirements are inconsistent or weak.[12]

These oversight failures are particularly alarming given the sheer scale of HCBS spending and workforce growth. The Centers for Medicare and Medicaid Services (CMS) found that Medicaid HCBS spending in 2019 amounted to $95 billion.[13] In just the state of New York, there are three times more home health and personal care aides per resident than the average of all other states: 314 per 10,000 residents versus just 105 for the rest of the country.[14] Home health and personal care aides accounted for 38 percent of New York's job growth from 2023 to 2024. There are almost three times as many of these workers as there are in retail sales—or nearly 7 percent of the nearly 10 million New Yorkers working in nonfarm jobs. California—the state with the second-largest concentration of these workers—has 222 per 10,000 residents, almost a third fewer than New York.

Increases in HCBS spending and commensurate waste, fraud, and abuse almost certainly got worse during the pandemic after Congress gave states a 10 percent increase in their Federal Medical Assistance Percentage (FMAP) if they increased spending on certain services in HCBS.[15] While states can no longer qualify for that extra funding, many states are still spending the funds today.[16]

HCBS fraud also rarely occurs in isolation. HCBS interacts with other areas discussed below: non-emergency transport, behavioral health, and

substance use disorder providers. So a fraudulent or unscrupulous HCBS provider may refer patients to other unscrupulous or fraudulent providers of other services.

(2) Non-Emergency Medical Transport (NEMT)

CMS listed NEMT as another one of the 14 high-risk provider types in Minnesota.[17] In addition to ambulances, Medicaid also reimburses NEMT, such as car rides to and from medical appointments.[18] As a result, individuals with minimal credentials or infrastructure can effectively become Medicaid providers, often with little upfront screening or ongoing verification. As such, this area of Medicaid is particularly susceptible to fraud.

On January 14, Nick Shirley released a second video in which he visited NEMT providers only to find that they were not located at the addresses listed on the government website, potentially indicating fraud.[19] On October 9, 2025, Michigan authorities settled with NEMT providers whom the state had charged with Medicaid fraud. These NEMT providers had used an app to "effectively trick a phone into thinking it was someplace it was not and submitted reimbursement requests for trips that never took place."[20] In June 2025, an investigation resulted in 16 New York transportation companies paying more than $13 million back to the state's program and the conviction of two individuals whose transportation companies defrauded Medicaid.[21]

In fiscal year 2018, total Medicaid NEMT spending was $2.6 billion (not including spending by managed care plans).[22] CMS noted that between 2018 and 2021, approximately 3–4 million individuals used NEMT, although the data is incomplete.[23] KFF noted in 2016 that NEMT use had particularly increased among the Affordable Care Act Medicaid expansion population and were most often used for "mental health and substance abuse treatment services."[24] States receive a 90 percent FMAP for expansion enrollees, which is a significant incentive for wasteful and fraudulent spending. Moreover, much of the available data is from before the pandemic, so spending and beneficiaries have likely increased significantly since then.

Congress required that state Medicaid programs cover NEMT services in the 2021 Consolidated Appropriations Act. CMS subsequently chose to pay for such transportation either as an "administrative activity" that receives a 50 percent match or as an optional medical service matched at the "applicable federal" FMAP.[25] In a 2022 report, the Government Accountability Office noted that NEMT is highly vulnerable to fraud.[26] From 2015 to 2020, there were more than "200 criminal convictions, civil settlements, and judgments against transportation providers" across 25 states.[27] The report found that some states failed to conduct sufficient oversight of provider and vehicle screening, pre-trip approval, post-trip validation, and contractor requirements.[28]

(3) Applied Behavior Analysis (ABA) for Autism Spectrum Disorder

CMS lists "Early Intensive Developmental and Behavioral Intervention" as one of its fourteen high-risk services, which includes ABA.[29] Spending on ABA for autism spectrum disorder has increased dramatically since 2014.[30] That year, CMS clarified that states are required to cover medically necessary services in their state plans under the statutory Early and Periodic

Screening, Diagnostic, and Treatment (EPSDT) requirement.[31] The statute's EPSDT provision requires Medicaid to cover certain services for Medicaid-eligible children under the age of 21.[32] Because many states classified ABA as "medically necessary," CMS's guidance effectively made ABA a mandatory Medicaid benefit for children under EPSDT. That same year, CMS also provided states with greater flexibility to pay for autism spectrum disorder services under waivers for HCBS through Sections 1915 and 1115.[33]

Notably, this increase in coverage for ABA followed the publication of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders in 2013.[34] Some researchers have criticized the manual's overly broad definition of *autism* as the basis for a subsequent 266 percent increase in autism prevalence, indicating potentially high rates of misdiagnosis.[35] Research showing that behavioral health diagnoses fluctuate with changes in public program funding raises serious concerns that non-clinical incentives are influencing diagnostic patterns.[36]

Since then, spending on providing ABA services has increased. However, the evidence to support the practice remains limited. In 2020, the Department of Defense released the results of the Comprehensive Autism Care Demonstration, which provided ABA services for autism spectrum disorder to beneficiaries eligible for TRICARE, the Pentagon's health care program. The report noted that "the published reliable evidence does not reflect any consensus as to whether the reported improvements are clinically significant; very few studies reported on the clinical significance of findings."[37] Furthermore, the report noted that "research literature available regarding ABA services predominantly consists of single-case design studies which do not meet criteria for 'reliable evidence' under TRICARE standards."[38]

Despite limited and mixed evidence of clinical effectiveness, state Medicaid spending on ABA has expanded rapidly—often without corresponding improvements in oversight. For example, Indiana—one of the earliest states that passed a law mandating that insurance cover ABA[39]—found that its Medicaid program spending on ABA rose 30-fold from 2017 ($21 million) to 2023 ($611 million).[40]

This rapid increase in spending coincided with significant improper payments. In the past two years, HHS OIG released audits of Wisconsin[41] and Indiana—[42] with five more audits forthcoming. These audits found $185 million and $56 million, respectively, in improper payments for ABA services to treat individuals with autism. HHS OIG has noted "questionable billing patterns by some ABA providers" as well as "payments for unallowable services."[43] In Indiana, the audit found that 95 out of 100 sampled enrollee months did not meet the documentation requirements, making them improper, and 98 did not include session notes, which indicated that they may be improper.[44] However, these audits were limited to FFS and did not examine managed care claims. Paragon has previously identified that managed care claims are a significant gap in HHS oversight.[45]

(4) Substance Use Disorder (SUD) Services and Treatment Centers

CMS's high-risk provider types list includes several providers involved in substance use disorder services and treatment.[46] Over the past decade, Medicaid dramatically expanded SUD coverage. This was primarily done using Section 1115 waivers for SUD. Today, 36 states and the District of Columbia have SUD 1115 waivers.[47] In addition to Medicaid, SUD services are financed

through federal grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), creating overlapping funding streams with inconsistent oversight and accountability. SAMHSA grants go to state agencies, which are responsible for program management, while HRSA grants go directly to health centers, for which state agencies do not have oversight responsibilities but do provide coordination.

Auditors and law enforcement generally recognize Medicaid-financed addiction services as particularly vulnerable to fraud, waste, and abuse. States lack incentives to properly oversee Medicaid SUD funding. In 2021, HHS OIG found that 77 percent of 4,546 providers of Medication Assisted Treatment for opioid use disorder did not report the number of patients they served. Further, HHS OIG sampled 100 health centers nationwide from 2017 through 2019, finding that 67 of them did not use their HRSA grants in accordance with federal requirements.[48] In 2024, ProPublica reported how in Arizona, at least 40 Native Americans died between 2022 and 2024 at "sober living homes and treatment facilities" after "thousands of patients [were] recruited into sham treatment programs."[49] The Arizona Health Care Cost Containment System "acknowledged the fraud cost taxpayers as much as $2.5 billion."[50]

Paragon has previously written on how adopting the ACA's Medicaid expansion may have made it harder for traditional enrollees in Medicaid states to access treatment, as states prioritized expansion enrollees.[51] To fix this, lawmakers should target grantmaking to distribute funds more effectively.

How CMS Is Combating Fraud

CMS Administrator Mehmet Oz has placed renewed and overdue emphasis on combating fraud, waste, and abuse in Medicaid, particularly abuses tied to provider taxes, state-directed payments, and long-running schemes in states such as Minnesota and California.[52] To the extent that fraud has been magnified by legalized Medicaid "money laundering" arrangements that exploit the program's open-ended federal match, CMS's implementation of the enforcement provisions of OBBB represents a significant shift from tolerance to accountability.

But the most consequential step CMS has taken is not new guidance or technical assistance. It is the agency's renewed willingness to withhold federal funds, as required under Section 1904, when states fail in their most basic stewardship obligations. On January 14, 2026, CMS formally notified Minnesota that its Medicaid State Plan is out of compliance with Section 1902(a)(64), which requires states to maintain effective mechanisms to receive, compile, and analyze reports of fraud, waste, and abuse.

Importantly, CMS has multiple, distinct enforcement tools that serve different but complementary purposes. Withholding under Section 1904 is a prospective, systemic compliance mechanism that places future federal matching funds at risk to compel states to correct ongoing failures. Disallowances under Section 1903 are retrospective and transactional, allowing CMS to deny or recoup federal matching funds for specific improper expenditures. Recoveries occur when misspent federal funds are ultimately repaid or offset, typically following disallowances or audit findings. Effective enforcement requires forcing compliance, correcting past violations,

and ensuring states do not retain improper federal funds.

Unless the state can demonstrate substantial compliance, CMS may partially withhold federal financial participation, potentially totaling up to $515 million per quarter.[53] CMS further noted that the 14 high-risk Medicaid service categories in Minnesota represent approximately $3.75 billion in combined federal and state spending.[54]

By initiating proceedings under Section 1904 of the Social Security Act, the agency has moved beyond the collaborative, corrective-action-only model that has dominated Medicaid oversight for decades and has failed to result in meaningful state action. Critics have called this the "nuclear option," but this ignores just how pervasive fraud in Medicaid has become due to massive increases in spending from COVID and states' accelerated deployment of money laundering tactics, fueled by the ACA's much higher matching rate for the expansion population, to obtain more federal dollars with limited actual state cost exposure. Real enforcement is the most compassionate and effective solution to fraud because it will encourage states to take greater care to reduce fraud and improper payments, thus preserving the program for those who need it most.

By using Section 1904 authority to withhold funds, the Trump administration has signaled that it is serious about protecting taxpayer dollars from being lost to organized crime, fraud rings, and negligent state management. The additional recommendations outlined below would further the agency's mission in combatting fraud.

Recommendations

The most effective long-term reform, requiring legislative action, would be to cap federal Medicaid funding so that spending above the cap is borne entirely by states. This would force states to internalize the cost of waste and fraud. While Congress has pursued such reforms in other welfare programs, it has failed to do this for Medicaid. To its credit, in OBBB, Congress restricted states' ability to engage in some legalized money laundering schemes to maximize federal money for minimal actual state contribution. But much more work is needed to protect Medicaid for the truly needy and the American families whose taxes finance the program.

This brief highlighted four areas vulnerable to abuse: HCBS, NEMT, ABA services, and SUD treatment. For each of these services, the same structural weaknesses occur: open-ended federal funding, limited real-time verification of service delivery, fragmented oversight between states and the federal government, and inadequate scrutiny of managed care claims. These weaknesses were exacerbated after the Biden administration expanded the program significantly during the pandemic and made it easier for ineligible people to stay enrolled by loosening guardrails.[55]

For decades, states have been permitted to operate Medicaid programs with little fear of financial consequence, even as improper payments mounted and basic program management deteriorated. CMS should be far more aggressive in combating waste, fraud, and abuse, and recent actions under Administrator Oz represent an important step. Here are targeted recommendations for further action by CMS and states:

- Within its legal authority, CMS should further restrict the remaining legalized Medicaid financing schemes—such as

provider taxes[56] and intergovernmental transfers[57] — that allow states to maximize federal funds while contributing little, if any, of their own funds.

- Federal law already requires HHS to disallow funds when a state's improper payment rate exceeds 3 percent.[58] Historically, HHS Secretaries have failed to enforce this requirement. While OBBB narrows the Secretary's discretion to waive mandatory disallowances, enforcement will be effective only if HHS consistently applies these penalties.
- CMS's recent willingness to use its statutory authorities signals that federal oversight will no longer be limited to guidance and technical assistance. Credible enforcement is essential for states to rein in waste, fraud, and abuse. CMS should continue to pursue real recoveries when states fail to meet their obligations. Section 1904 should be treated not as a rarely invoked procedural backstop but as a core enforcement tool to compel state compliance and recover federal funds when systemic failures persist. Credible deterrence depends not on any single enforcement mechanism, but on their coordinated use. Withholding future funds compels states to correct systemic failures, while disallowances (through Section 1903) and recoveries ensure that states do not benefit financially from past improper payments. When applied together, these tools change state incentives by making fraud, waste, and abuse financially costly rather than fiscally rewarding.
- CMS should treat Payment Error Rate Measurement (PERM) findings as enforceable triggers for these disallowances rather than advisory metrics. To ensure accurate error rate measurements, CMS should strengthen the PERM program by expanding and improving audits, then using those findings to disallow federal funds for states with persistent and egregious improper payments. CMS can most effectively couple PERM with its disallowance authority under Section 1903, which does not require a formal finding that a state has violated the law or failed to comply with its state plan. Absent sustained commitment by each HHS Secretary to apply these disallowances, states will continue to face little incentive to invest in program integrity.
- States and CMS should increase oversight of managed care claims. Medicaid overseers should collect data to evaluate eligibility and claims accuracy and curtail funds from MCOs that refuse to comply. CMS should include managed care claims audits in the PERM program, which currently examines claims data only for FFS.
- States and CMS should investigate, curb, and consider prohibiting Medicaid payments to family members for caregiving services. Services with high family-based billing, including home health and NEMT services, have been repeatedly linked to improper payments, because transactions among family members, using taxpayer dollars, are much more prone to abuse. Normally, providers either deliver

adequate service or face customer backlash. If they commit fraud, licensed providers run the risk of whistleblowing. But when the caregiver is a family member who uses the funding as an income stream, there is a greater incentive for both the recipient and the family member to inflate hours or service intensity for greater reimbursement.

- CMS should include HCBS-specific statistics in the PERM program. It should also create a new regulatory definition of *room and board* to help auditors better identify which costs are allowable for Medicaid reimbursement.

States should apply meaningful copayments, particularly for non-emergency services received in emergency rooms. Congress should explore whether further legislative flexibility is needed to the statute's current limits on cost sharing.

Conclusion

Waste, fraud, and abuse persist in Medicaid because the program's financing structure rewards spending rather than results. States receive more federal funding when they spend more, while the fiscal consequences of improper payments fall largely on federal taxpayers. This dynamic has allowed states to act with near impunity—raising costs, neglecting basic oversight, and tolerating industrial-scale abuse—while shifting the financial burden of those failures to federal taxpayers. Absent sustained enforcement and real financial consequences, Medicaid's incentive structure will continue to reward spending volume over program integrity and patient outcomes.

While recent media attention has focused on Minnesota, these vulnerabilities exist in every state Medicaid program. The above recommendations focus on restoring accountability by aligning incentives, strengthening enforcement of existing law, and closing oversight gaps—particularly in managed care.

Meaningful reform begins with exposure: Lawmakers rarely act until the scale and mechanisms of abuse are made unmistakably clear. This effort begins by examining the four program areas that are particularly vulnerable to fraud with the aim of documenting systemic failures and building the case for stronger oversight and fundamental reform.

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