

Limiting Medicaid Waste, Fraud, and Abuse

A Checklist for States to Protect Medicaid for the Vulnerable and the Taxpayers Who Finance It

Medicaid waste, fraud, and abuse arise from several primary sources: legalized money laundering schemes and resulting corporate welfare; ineligible enrollees in the program; eligibility errors that allow ineligible individuals to enroll and remain enrolled; vulnerable service categories with weak oversight that create opportunities for fraud; and limited transparency, particularly in managed care. The following is a menu of policy options for states to pursue to curb waste, fraud, and abuse in their Medicaid programs and preserve the program for the truly needy.

I. Reducing Legalized Medicaid Money Laundering and Corporate Welfare

States are becoming increasingly reliant on federal sources to finance Medicaid. They utilize financing schemes, such as provider taxes and intergovernmental transfers, to draw down additional federal funding. These financing mechanisms result in large payments to providers funded by federal deficit spending. With a growing national debt and reduced political autonomy, states face significant risks from this increased federal dependency. These schemes also force taxpayers nationwide to subsidize bad policy and wasteful spending in states like California and New York. Much of this spending has funded welfare expansions for the wealthy and undocumented immigrants. Although the One Big Beautiful Bill curbed some of these abuses, every state risks introducing perverse incentives into its health care system through these schemes.

Overpaying providers increases costs without improving quality. Too often, providers are paid based on their relationships with managed care organizations (MCOs) or hospital systems rather than the value of the services they provide — driving consolidation and reducing patient choice. Fraud proliferates in environments with surplus dollars that are no longer aligned with Medicaid's original mission. Rising federal spending fuels inflation and threatens the program's sustainability for the truly vulnerable.

States should take the following actions to reduce dependency on federal deficit financing and promote program integrity:

- Equalize payments between public and private providers for the same service so there are no preferential payment rates or treatment of providers due to their public or private ownership status.
- Phase down provider taxes in compliance with the One Big Beautiful Bill.
- Phase down state-directed payments so that total Medicaid payments through managed care do not exceed Medicare rates (and 110 percent of Medicare rates in non-expansion states).
- Ensure Medicaid does not pay more for the same service in a hospital than in an ambulatory surgical center or physician office.

- Require public reporting of intergovernmental transfer (IGT) flows and provider tax arrangements.
- Curb mission creep by directing state agencies to focus federal reimbursements on clinical services.

II. Strengthening Eligibility Integrity to Reserve Medicaid for the Truly Vulnerable

For Medicaid to sustainably serve the truly vulnerable, it must be reserved for those who are eligible. The absence of cross-checks against available databases allows ineligible individuals to enter the program. Once enrolled, lax redetermination processes allow individuals to remain on the program despite no longer qualifying.

States should take the following actions to strengthen eligibility integrity:

- Conduct quarterly data cross-checks against other databases for determining eligibility, using information from the state revenue department, the state corrections department, Social Security Administration, U.S. Department of Health and Human Services, U.S. Postal Service, U.S. Department of Housing and Urban Development, Federal Bureau of Investigation, Internal Revenue Service, Systematic Alien Verification for Entitlements (SAVE) program, and Department of Homeland Security.
- Reject self-attestation for eligibility criteria such as household size, income, and residency.
- Verify all exchange-to-Medicaid eligibility transfers from HealthCare.gov prior to enrollment.
- Implement a “three-strikes” presumptive eligibility policy.
- Limit presumptive eligibility to federal minimum eligibility standards.
- Conduct recurring eligibility audits (e.g., secret shopper studies).
- Require biannual eligibility determinations for able-bodied, working-age enrollees, supplemented with monthly wage data checks using sources such as the National Directory of New Hires.
- Automatically terminate coverage when income exceeds eligibility thresholds.
- Prohibit retroactive eligibility beyond 30 days.
- Ensure asset limits for Medicaid long-term care eligibility align with federal minimum standards.
- Expand estate recovery efforts to preserve Medicaid resources for long-term care rather than enabling wealth transfers to heirs.

III. Reducing Outright Medicaid Fraud

As Medicaid has expanded to cover more services and populations, including nonclinical services, certain areas have become especially vulnerable to fraud and abuse. In some cases, Medicaid pays for services that are difficult to verify and may never be delivered. Weak documentation requirements, limited oversight, and fragmented administration create opportunities for providers and intermediaries to bill for services that taxpayers finance but beneficiaries never receive. These vulnerabilities are especially pronounced in

nontraditional care settings, where verification of service delivery is inherently more difficult.

States should prioritize oversight in high-risk service categories and take the following actions:

Home- and Community-Based Services (HCBS) and Personal Care Services

- Prohibit payment to relatives or household members for HCBS or personal care services.
- Require electronic visit verification (EVV) to confirm service delivery type, quantity, and timing are delivered according to the approved plan of care.
- Cap daily service hours at eight unless medically justified.
- Require in-person eligibility assessments and service determinations.
- Require periodic reassessment of care plans.
- Audit HCBS rates to ensure they exclude room and board and other non-reimbursable expenses.

Skilled Nursing Facilities

- Require electronic documentation of therapy sessions with timestamped notes cross-checked against billing claims.
- Implement independent utilization reviews to confirm continued medical necessity criteria for skilled nursing services.
- Require daily electronic census reporting that is automatically reconciled with claims and hospital admission and discharge data.

Non-Emergency Medical Transportation (NEMT)

- Prohibit payment to relatives or household members.
- Impose nominal copayments to deter abuse.
- Limit standing ride authorizations.
- Restrict NEMT use for telehealth-eligible services.
- Require EVV-type verification of pickup and destination locations.
- Require disclosure of ownership and corporate structure.
- Require fingerprinting and background checks for providers.
- Prohibit non-medical transportation under Section 1115 demonstrations.
- Conduct periodic on-site verification that vehicles exist and are actively used.
- Establish a national database of sanctioned NEMT brokers that states must check before awarding contracts.
- Require independent secret shopper audits of NEMT and include that cost in the price of the contract.
- Cap billable transportation hours per individual for each day and week.

Interpreter Services

- Require interpreter certification.
- Require audio or digital verification of services.

Autism and Early Intervention Programs

- Require documentation standards to verify that autism and early intervention services billed were actually delivered.
- Establish utilization controls, including guardrails for very high weekly service volumes, telehealth-only delivery, and out-of-state providers.
- Require parental or caregiver participation as a condition of authorization for intensive autism and early intervention services when clinically appropriate.
- Prohibit financial incentives tied to diagnosis volume.

Substance Use Disorder Services

- Require auditable documentation for all substance use disorder services under waivers and demonstration programs.

Consumer-Directed Services

- Require background checks for personal care attendants.
- Prohibit simultaneous employment of multiple family caregivers.
- Require real-time service verification.
- Require a single state designated fiscal agent.

Expand Medicaid Fraud Control Unit Funding and Authority

- Conduct randomized provider audits annually.
- Require annual program integrity reports to legislatures and the public.
- Establish whistleblower protections for Medicaid fraud reporting.
- Suspend providers upon credible evidence of fraud, subject to due process.

Cross-State Fraud Alert System

- Participate in interstate provider sanction and fraud alert systems to prevent bad actors from relocating across programs or states.

IV. Promoting Transparency in Program Spending

Medicaid lacks sufficient transparency and enforcement mechanisms to effectively prevent waste, fraud, and abuse. Current Payment Error Rate Measurement (PERM) methodologies fail to capture the full extent of improper payments.

States should take the following actions:

- Require enhanced transparency from MCOs, including:
 - Encounter-level reporting for all managed care spending.
 - Disclosure of payments to related-party entities (e.g., PBMs, hospital systems, specialty pharmacies, parent companies).
 - Public reporting of state-directed payments by provider and amount.
 - Reporting of zero-claim enrollees by plan and eligibility group.
 - Reporting of medical loss ratios and administrative expenses by MCO.
- Establish state-level improper payment measurement programs.



- Require MCO medical loss ratios and administrative expense reporting to be verified through independent audited financial statements.
- Require reporting of payment error rates in managed care.
- Develop public dashboards showing Medicaid spending by provider and service category.
- Require capitation rates to be developed or reviewed by independent actuaries without financial ties to the MCO or its affiliates.
- Require disclosure of all MCO, subcontractor, and network provider related-party relationships and transactions — including payments to affiliates, subsidiaries, parent companies, PBMs, and provider organizations.
- Improve Medicaid provider screening:
 - Require annual recertification for providers in high-risk categories, with a biennial recertification requirement for all other Medicaid providers.
 - Require enhanced screening for high-risk provider types.
 - Require ownership disclosure for providers and subcontractors.
 - Remove and permanently bar providers with fraud convictions or civil settlements.
 - Require site visits and revalidation every three years.
 - Require competitively bid managed care contracts every two years.