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Advising Congress on
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March 30, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary, Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Request for information related to comprehensive regulations to uncover suspicious healthcare (CRUSH)

Dear Secretary Kennedy and Administrator Oz,

On behalf of the Medicaid and CHIP Payment and Access Commission (MACPAC), I am pleased to offer these comments in response to your request for information (RFI) on combatting fraud, waste, and abuse (FWA) in federal health care programs. MACPAC is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). MACPAC appreciates this opportunity to share insights from our extensive body of work on Medicaid program integrity (PI). The Commission believes that PI is an important component of Medicaid: effective PI activities ensure that taxpayer dollars are spent appropriately on delivering high-quality and necessary care within a health insurance program that served almost 99 million beneficiaries and totaled $908 billion in federal and state spending in fiscal year (FY) 2024. To that end, the Commission has conducted research and issued recommendations to improve the efforts of and tools available to the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and other federal and state agencies that engage in the continuum of PI activities.

During the course of prior MACPAC work, we reviewed federal rules and requirements for Medicaid PI, reviewed publicly available reports, interviewed state and federal officials as well as other stakeholders, and engaged panels of experts during Commission meetings. Our analyses focused on Medicaid PI approaches for preventing and detecting provider fraud and abuse and the roles of the federal and state entities with authority and responsibility for Medicaid PI. We also conducted an in-depth examination of state, federal, and MCO PI activities to assess the scope of current efforts, and their perceived effectiveness. As a result of this research, the Commission issued four recommendations to promote effective PI practices while phasing out those that no longer demonstrate value.

Medicaid and CHIP Payment
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Additionally, since its inception, MACPAC has engaged in projects designed to improve the transparency and accuracy of Medicaid and CHIP financing and payment data, which are essential for accurately assessing whether payments are consistent with the statutory goals of economy, efficiency, quality, and access. MACPAC has made recommendations on the need for transparent data on all payments, including supplemental and state directed payments, made to hospitals and nursing facilities at the provider level. Most recently, the Commission made two recommendations to require states to collect and publicly report information on the sources of non-federal share Medicaid spending, including financing methods, state-level financing amounts, and provider-level financing amounts for all services.

CMS's RFI seeks stakeholder input on Medicaid PI through questions focused on strategies and technologies CMS can use to identify, prevent, and combat FWA in Medicaid. The Commission offers comments in four areas where we have evidence-based findings and recommendations on policy issues that overlap with the questions in the RFI: identifying and eliminating ineffective or redundant PI activities and requirements, promoting high-value PI activities, barriers to PI in managed care, and payment and financing transparency. This comment letter will provide background on Medicaid PI and present an overview of the Commission's findings and recommendations in these four areas.

Background on Medicaid PI

Program integrity refers to the activities undertaken to prevent FWA, and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. Though PI was not an original feature of the Medicaid program, legislation has added safeguards to protect the program from FWA. These additions have given the federal government, states, and health plans many PI roles and responsibilities, including provider screening, investigating and prosecuting fraud and abuse, and recovering overpayments.

FWA are distinct, but linked concepts in health care. Fraud occurs when a party makes false or misleading statements to benefit themselves or someone else (42 CFR 455.2). Abuse occurs when a party engages in practices that are not medically or fiscally sound and result in unnecessary costs to the Medicaid program (42 CFR 455.2). Waste is any practice that directly or indirectly results in unnecessary costs. Unlike fraud and abuse, waste is not intentional, not exploitative, and does not involve deception (CMS 2022). Improper payments are any payments that should not have been made or were made in the wrong amount under statutory, contractual, administrative, or other legally applicable requirements. Improper payments may be the result of fraud, but they may also be the result of unintentional errors, such as missing documentation (CMS 2020).

Federal data indicate that known instances of FWA account for less than 1 percent of program spending. These data do not capture FWA that was undetected, unrecovered, or could not be prevented. It is possible that more FWA occurred during this period, but there are not enough data to determine its total amount. Between 2019 and 2023, CMS reported that its PI activities prevented or recovered $9.6 billion of FWA in the federal share of Medicaid spending, or 0.4 percent of federal Medicaid spending. Halted or recovered federal matching funds for unallowable state Medicaid expenditures accounted for the majority ($6.6 billion) of FWA prevented or recovered during this period (MACPAC 2025b). Over this same period, Medicaid Fraud Control Units (MFCUs) recovered $6.9 billion of state and federal Medicaid funds from criminal and civil investigations of Medicaid fraud perpetrated by health care providers. This number accounts for 0.2 percent of state and federal spending between 2019 and 2023 (MACPAC 2025a).

Prior MACPAC Recommendations

The RFI asks how CMS can better leverage or expand existing authorities to prevent FWA in Medicaid and CHIP; what changes to policies, processes, and requirements could promote PI; what tools and guidance CMS can provide to states to promote PI; what practices states should implement when responding to recovery audit contractor (RAC) findings; and what statutory or regulatory changes are needed to strengthen states ability to reduce FWA. The following MACPAC findings and recommendations answers these questions.

In 2012, the Commission found that states conduct PI activities that may not be effective in preventing and combatting FWA, and recommended that Congress and CMS act to identify and eliminate ineffective PI activities. The Commission's research identified both policy and operational factors that contribute to this problem. First, states and the federal government have been given an increasing number of PI responsibilities by statute, regulations, and administrative initiatives over time. Some of these responsibilities are duplicative. For example, different state and federal oversight agencies may conduct audits at the same time, sometimes on similar or identical topics (MACPAC 2012). Duplicative activities such as these can lead to unnecessary effort and investment for the agencies involved. Furthermore, there have been few evaluations of the effectiveness of these activities; thus, states may be required to invest in PI initiatives that deliver minimal benefits (MACPAC 2012). Ineffective PI activities may allow preventable FWA to occur, threatening both beneficiaries and spending. Furthermore, activities that are ineffective may lead to federal and state funds being spent on services that are unnecessary or fail to achieve their goals.

The Commission issued two recommendations to address these issues. In 2012, the Commission recommended that the Secretary should ensure that current PI efforts make efficient use of federal resources and not place an undue burden on states or providers. This recommendation identified several activities to support this aim, including: creating feedback loops to simplify and streamline regulatory requirements; determining which current federal PI activities are most effective; and taking steps to eliminate programs that are redundant, outdated, or not cost-effective. The recommendation promotes administrative simplification by expanding successful initiatives, and eliminating programs that are redundant, outdated, or not cost-effective.

CMS has taken steps to address elements of this recommendation, including shifting the focus of the National Medicaid Audit Program from independent audits to collaborative state audits; temporarily replacing the eligibility components of the Payment Error Rate Measurement and Medicaid Eligibility Quality Control programs with a pilot program; developing a revised eligibility review approach to reduce the burden for states; suspending collection of a redundant program integrity dataset; and using existing data to support federal audits.

In 2019, the Commission recommended that, to provide states with flexibility in choosing effective PI strategies, Congress should amend the Social Security Act (the Act) to make the requirement that states establish a RAC program optional. This recommendation was supported by findings that the RAC program is not effective in all states, and has become an administrative burden for states due to the time and resources it takes to solicit a RAC vendor, manage procurements (many of which have failed), and prepare waiver applications and renewals.

Identifying and Promoting Effective PI Activities

The RFI asks how CMS can better leverage or expand existing authorities to prevent FWA in Medicaid and CHIP; what changes to policies, processes, and requirements could promote PI; what tools and guidance CMS can provide to states to promote PI; what PI best practices can states replicate; and what statutory or regulatory changes are needed to strengthen states ability to reduce FWA. The following MACPAC findings and recommendations answers these questions.

In 2019, the Commission found that CMS does not regularly identify and promote state practices that are successful in preventing FWA. State Medicaid programs have the primary responsibility for PI, which includes a wide range of dedicated PI activities, such as investigations and overpayment recoveries, as well as general program functions, such as individual and provider enrollment. States must make their own choices about how to invest limited resources; however, they have little information on which approaches are most effective. The federal government can provide states with direction, but CMS has not focused efforts on helping states understand which policy design and implementation approaches lead to successful PI outcomes.

The Commission found that states face barriers to measuring the return on investment (ROI) of PI activities, and the federal government has not made efforts to reduce these barriers. Without information on ROI, states may underinvest in effective PI approaches and overinvest in those that are ineffective. Through interviews, MACPAC found that states have little incentive to calculate ROI because many PI activities are federally required, a part of general program functions, or generate benefits that are not easily quantifiable (MACPAC 2019). The federal government can incentivize and assist state calculation of ROI; however, CMS officials have not developed a methodology or guidance for calculating ROI in Medicaid, citing the complexity and variation across state Medicaid programs and payment systems (MACPAC 2019).

The Commission also found that the federal government does not regularly identify and promote successful state PI practices. States may be less likely to replicate the successes of other states' PI approaches absent a centralized source of information, such as the federal government. For example, the Washington State Health Care Authority reported over $70 million in cost avoidance attributed to its Public Assistance Reporting Information System-Veterans Benefit Enhancement program, which identifies Medicaid beneficiaries receiving long-term services and supports who are eligible for but not enrolled in veterans' benefits. However, states interviewed by MACPAC were either unaware of the Washington results or had only learned about it directly from that state (MACPAC 2019). The federal government can play a role in sharing best practices; however, CMS has not focused on measuring the effectiveness of state PI approaches or sharing information about successful approaches across states.

It is the Commission's view that the federal government should take a leading role in developing and disseminating information on the effectiveness of Medicaid PI approaches and issued two recommendations toward this goal. In 2012, the Commission recommended that, to enhance the states' abilities to detect and deter fraud and abuse, the Secretary should: develop methods for better quantifying the effectiveness of PI activities; assess analytic tools for detecting and deterring fraud and abuse and promote the use of those tools that are most effective; improve dissemination of PI best practices; and enhance PI training programs to provide additional distance learning opportunities and additional courses that address managed care PI.

CMS has taken steps to address elements of this recommendation, including launching a workgroup to identify best practices and provide input to strengthen program oversight; providing a secure online platform for states to exchange best practices and documents on program integrity; publishing guidelines to promote best practices; and creating a new program integrity curriculum, professional program of study, and distance learning webinars.

In 2019, the Commission issued a similar recommendation that the Secretary, under the Medicaid Integrity Program, conduct a rigorous examination of current state PI activities to identify the features of policy design and implementation associated with success, and that the Secretary should also use this authority to establish pilots to test novel strategies or improvements to existing strategies. Information gleaned from such examinations and pilots should be shared with states to enable the replication of effective PI activities.

Barriers to PI in Managed Care

The RFI asks what tools or guidance CMS can give to states to enhance PI in Medicaid and CHIP managed care and fee-for-service (FFS) delivery systems. The following MACPAC findings do not directly respond to this question, but they do identify barriers to PI in Medicaid managed care that could be addressed by CMS tools or guidance. The Commission has found that PI in Medicaid managed care has received less attention than Medicaid FFS, despite managed care covering the majority of enrollees. In FY 2023, almost three-quarters (74.1 percent) of Medicaid enrollees were enrolled in a comprehensive Medicaid managed care plan, and in FY 2024, over 50 percent of total Medicaid benefit spending went to managed care (MACPAC 2026a,b). However, a 2017 MACPAC study found that PI activities in managed care at that time lacked the sophistication of those for FFS and were not an area of focus for many states (MACPAC 2017). Furthermore, RACs and Unified Program Integrity Contractors conduct fewer investigations into managed care than FFS (OIG 2022, GAO 2023).

The Commission has identified potential barriers to ensuring PI in managed care. First, many states have separate units for their managed care program and PI. Managed care units oversee all aspects of managed care contracts, including PI, while PI units generally focus on oversight of individual providers. There may be overlap between managed care oversight and PI responsibilities that requires additional coordination between units. Furthermore, coordination between managed care plans, and state agencies and MFCUs is sometimes limited. In interviews with MACPAC staff, MFCUs and state PI staff noted that managed care plans typically refer fewer cases of potential fraud than the FFS program. State personnel, particularly staff of MFCUs, expressed concern that limited reporting from managed care plans hinders their ability to exclude FWA perpetrators from the system, thereby posing a risk to Medicaid beneficiaries enrolled in FFS or other managed care plans (MACPAC 2017).

Limited reporting may reflect some managed care plans' reluctance to invest in PI activities. In addition to their contractual responsibilities to prevent improper payments, plans have a financial incentive to prevent FWA because they are at risk for any losses if the costs associated with covering Medicaid enrollees exceed capitation payments, including any costs from FWA. However, there are also costs associated with PI activities, such as the staffing and technology needed to implement PI operations. Plans also face compelling non-financial costs, including provider frustration with delayed payments and the suspension or removal of providers, both of which can affect network adequacy. These costs may discourage managed care plans from investing in and pursuing PI activities (MACPAC 2017).

Finally, the Commission found that there is limited information on the effectiveness of various managed care PI approaches and that CMS does not promote successful state approaches. State staff interviewed by MACPAC identified many practices perceived to be effective but noted that there are few mechanisms for measuring the ROI of PI activities or for sharing best practices. This reflects general findings that measurement of ROI and promotion of best practices in PI is limited (MACPAC 2017).

The Commission has not issued any recommendations specific to PI in managed care, but has identified areas of interest:

- how states validate their encounter data for future rate setting;
- best practices across states that provide incentives for managed care plans to make investments in prepayment auditing as well as postpayment reviews;
- how to improve mechanisms for sharing provider screening data among states and programs; and
- how to measure the effectiveness and impact of program-related activities and best practices.

Payment and Financing Transparency

The RFI asks how CMS improve the prevention, identification, and resolution of FWA related to non-federal share financing sources; how CMS can better prevent FWA associated with the differential payment of public and private providers; and how CMS can help states better prevent, identify, and address FWA related to supplemental payments. The following MACPAC findings and recommendations answers these questions.

The RFI asks about preventing FWA related to non-federal share financing sources and supplemental and directed payments. The Commission has found that CMS does not collect information on the sources of non-federal share in a comprehensive manner, resulting in data that are fragmented, incomplete, and not always publicly available (MACPAC 2024a). Without reliable data on what providers are paying to finance the non-federal share of Medicaid expenditures and what they are retaining after accounting for those costs, it is difficult to assess whether payments are consistent with the statutory goals of economy, efficiency, quality, and access.

Under the Medicaid statute, states have broad flexibility to design their own FFS payment methods. The two broad categories of FFS payments are: (1) base payments for services, which are payments for services provided to individual beneficiaries, and (2) supplemental payments, such as disproportionate share hospital (DSH) and non-DSH payments subject to upper payment limits (UPL), which are typically made in a lump sum for a fixed period. All FFS payment methods must be included in the Medicaid state plan and subject to CMS approval. DSH payments are subject to independent certified audits to ensure payments to individual hospitals were within the specified limits (§ 1923(g), (j) of the Act). States must submit annual demonstrations for non-DSH supplemental payments to CMS to ensure compliance with the regulatory requirements of the UPL.

Federal rules do not allow states to make supplemental payments for services provided in managed care; however, CMS has allowed states to direct payments to providers under certain circumstances, which are known as state directed payments. Although CMS does not classify state directed payments as supplemental payments, many of these arrangements are similar in that the payments are made in a lump sum for a fixed period. CMS must approve most state directed payment arrangements annually (42 CFR 438.6(c)(2)).

MACPAC has found that these supplemental and state directed payments can make up a substantial proportion of total Medicaid payment to providers. For example, MACPAC estimated that about half of FFS payments to hospitals were made through supplemental payments, and in managed care, about one third of payments to hospitals were made through state directed payments (MACPAC 2024b).

Medicaid statute permits states to raise the non-federal share of Medicaid expenditures through multiple sources, such as intergovernmental transfers (IGTs), certified public expenditures (CPEs), and health care-related taxes (also known as provider taxes). These financing arrangements must meet specific requirements in Medicaid statute and regulations to be considered a permissible source of non-federal share. CMS currently collects information on state financing methods when it reviews state plan amendments that make changes to Medicaid payment methods. Specifically, CMS requires states to answer a standard set of five funding questions. These questions require states to describe how the non-federal share of each type of payment is funded.

States are increasingly relying on IGTs, CPEs, and provider taxes, in lieu of general revenues, to fund the non-federal share of Medicaid expenditures. Between state fiscal year (SFY) 2008 and SFY 2018, the use of state general funds declined from 75 to 68 percent of the non-federal share, and the use of health care-related taxes more than doubled, from 7 to 17 percent of the non-federal share (GAO 2021, 2014). States often rely on providers to finance the non-federal share of supplemental payments through IGTs or provider taxes (GAO 2018). Similarly, MACPAC found that the largest directed payment arrangements are typically targeted to hospitals and financed by provider taxes or IGTs paid by these providers (MACPAC 2024c).

The amount providers pay in health care-related taxes, IGTs, and CPEs can be seen as additional costs that effectively reduce the gross payments. As such, the net payment that providers can use to cover the cost of providing services is lower than the gross amount initially received. For example, assuming that DSH hospitals pay provider taxes and contribute local funds at the same rate as other providers, MACPAC estimated that these costs reduced total gross Medicaid payments to DSH hospitals by 11 percent in 2011 (Nelb et al. 2016). Accounting for the costs of provider contributions to the non-federal share can affect assessments of Medicaid payment adequacy, making it difficult to understand true net payment to providers and thus whether the payments are economical and efficient in meeting access and quality goals.

Information needed to calculate both total Medicaid payments, including base, supplemental, and state directed payments, to individual providers is either fragmented across multiple federal data systems or incomplete. Furthermore, CMS has not collected information on the sources of non-federal share tied to these payments in a comprehensive manner. To address these gaps, the Commission has consistently recommended that CMS collect complete data on all Medicaid payments that providers receive, as well as data on financing of the non-federal share necessary to calculate net Medicaid payments at the provider level. In 2016, MACPAC recommended that CMS collect provider-level data on the sources of non-federal share necessary to calculate net Medicaid payments to hospitals, and in 2023, the Commission similarly recommended that CMS collect provider-level financing data necessary to calculate net payments to nursing facilities (MACPAC 2023a, 2016). Because provider-financed supplemental payments account for such a large share of Medicaid payments to hospitals and nursing facilities, collecting provider-level financing data is necessary to enable more accurate analyses of Medicaid payment amounts for these providers.

In June 2024, the Commission expanded on these prior recommendations to address all types of Medicaid financing for all types of providers, not just hospitals and nursing facilities. The Commission recommended that Congress amend Section 1903(d)(6) of the Act to require states to submit an annual, comprehensive report on their Medicaid financing methods and the amounts of the non-federal share of Medicaid spending derived from specific providers, and further recommended that Congress extend these same requirements to CHIP by amending Section 2107(e) of the Act (MACPAC 2024).

Conclusion

MACPAC is appreciative of CMS's efforts to protect the Medicaid program from FWA. Common themes from MACPAC's research on PI topics include the importance of measuring the ROI of PI activities and the need for the federal government to promote effective PI practices. The Commission supports CMS and Congress acting to strengthen Medicaid PI by identifying and promoting effective activities. The Commission also supports CMS and Congress acting to increase the transparency of the non-federal share of Medicaid financing and supplemental and state directed payments.

While we did not dedicate a section of our response to provider enrollment, this is a topic of interest for MACPAC. MACPAC will publish a chapter in our June 2026 Report to Congress on provider enrollment. This chapter will describe federal provider enrollment and credentialing policy, state approaches to the enrollment and credentialing processes, and challenges impacting these processes. This chapter describes the options available to states to use data from Medicare and other states' Medicaid programs to screen providers for FWA risk. This chapter does not examine PI issues specifically, however Commissioners expressed interest in exploring the relationship between provider enrollment and credentialing and PI in future work.

The Commission remains committed to publishing research and recommendations that promote the integrity of the Medicaid program. Future work on this topic includes an issue brief to be published this spring, and research on the federal government's role in assisting state PI activities.

Sincerely,

Verlon Johnson, MPA
Chair

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