

April 10, 2026

Medicaid Program Integrity

Introduction to Program Integrity

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Medicaid and CHIP Payment and Access Commission

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Overview

- Background on program integrity (PI) and fraud, waste, and abuse (FWA)
- Medicaid PI roles and responsibilities
- Issues in Medicaid PI



The background features a dark blue gradient with several overlapping, semi-transparent shapes in lighter shades of blue and white. These shapes include a large white circle on the left, a vertical white bar in the center, and various blue and white curved and rectangular forms that create a layered, geometric effect.

Background

Medicaid PI

- PI includes activities undertaken to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care, and to prevent FWA in Medicaid
- PI activities include:
 - Fraud prevention, detection, and investigation
 - Overpayment recovery
 - Provider and beneficiary screening
- States and the federal government share program integrity responsibilities

FWA

- **Fraud:** acts of intentional deception or misrepresentation for financial gain or other benefits (42 CFR 455.2)
 - Example: billing for services that were never delivered
- **Abuse:** acts that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs (42 CFR 455.2)
 - Example: intentionally billing for services that were delivered, but were not necessary
- **Waste:** any act that directly or indirectly results in unnecessary costs
 - Example: mistakenly ordering duplicative tests

FWA's Impact on Medicaid

- Known instances of FWA make up a small portion of overall program spending, but the full scale of FWA is unknown

TABLE 1. Prevented or recovered Medicaid fraud, waste, and abuse, FYs 2019-2024

Year	MFCUs		CMS	
	Recovered FWA	Recovered FWA as a percentage of state and federal Medicaid spending	Recovered or prevented FWA	Recovered or prevented FWA as a percentage of federal Medicaid spending
Total	\$8,263,496,858	0.18%	\$11,125,000,000	0.34%
2019	1,931,590,598	0.30	1,085,800,000	0.27
2020	1,024,135,707	0.15	1,512,200,000	0.33
2021	1,680,182,494	0.22	2,007,900,000	0.39
2022	1,050,087,348	0.12	2,645,700,000	0.45
2023	1,209,430,035	0.13	2,329,700,000	0.38
2024	1,368,070,676	0.16	1,543,700,000	0.23

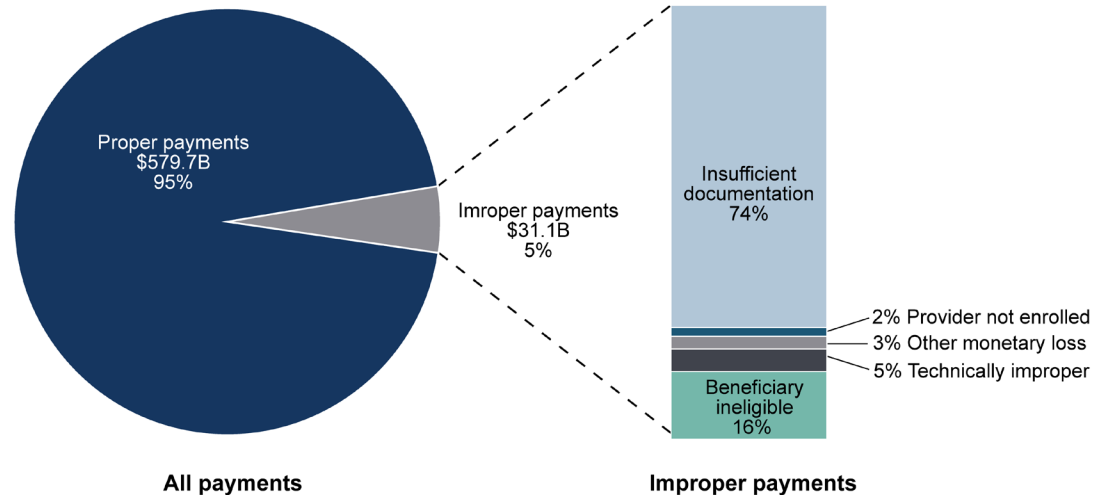
Notes: FWA is fraud, waste, and abuse. MFCUs are Medicaid Fraud Control Units. CMS is the Centers for Medicare & Medicaid Services. N/A indicates that data has not been reported for that As of April 2026, CMS has not released numbers for recovered or prevented FWA for FY 2025.

Sources: HHS OIG Annual Reports on MFCUs 2019 - 2025, MACSTATs 2019 - 2025, CMS Annual Reports to Congress on Medicare and Medicaid Program Integrity 2019 - 2026, CBO Historical Budget Data February 2026.

FWA's Impact on Medicaid

- The Payment Error Rate Measurement (PERM) program does not identify fraud and abuse
 - Most improper payments are due to administrative errors
- Fraud can harm Medicaid beneficiaries
 - For example, some personal care services attendants who defrauded the Medicaid program also abused or neglected their patients

FIGURE 2: PERM Estimates, Review Year 2024



Notes: B denotes billions. PERM is Payment Error Rate Measurement. Improper payments occur when a payment is made in an incorrect amount under statutory or other legally applicable requirements. Technically, improper payments mean a payment to the right recipient for the correct amount, but the payment process did not comply with applicable regulations and statutes. Review year 2024 includes all 50 states reviewed across three cycles between July 2020 and June 2023.

Prior MACPAC PI Work

- In 2012, the Commission made recommendations to improve the efficiency of PI and enhance state PI abilities:
 - Simplify and streamline regulatory requirements; determine which current federal PI activities are most effective; and eliminate programs that are redundant, outdated, or not cost-effective
 - Develop methods for better quantifying the effectiveness of PI activities; assess and promote analytic tools for detecting and deterring fraud and abuse; improve dissemination PI best practices; and enhance PI training programs
- In 2019, the Commission made recommendations that targeted improving effectiveness of state PI activities:
 - Conduct a rigorous examination to determine policy design and implementation features in state PI programs associated with success
 - Establish pilots to test novel strategies or improvements
 - Make the use of the recovery audit contractor (RAC) program optional to provide flexibility for states

MACPAC's Current PI Work

- Research objectives:
 - Identify how the federal government assists state PI functions
 - Identify and analyze barriers that limit the federal government's ability to assist states
 - Identify areas where states need additional assistance, or areas where assistance overlaps with state activities
- Research phases:
 - Phase I: federal policy scan, literature review, and issue brief
 - Phase II: project focused on federal assistance to state PI functions



Program Integrity Roles and Responsibilities

Federal Roles and Responsibilities

- Majority of federal PI responsibilities fall under the Department of Health and Human Services (HHS)
 - The Center for Medicare & Medicaid Services (CMS) and HHS Office of the Inspector General (OIG) carry out most of HHS's PI responsibilities
 - Other HHS agencies and Department of Justice (DOJ) also play a role in PI
- Federal PI responsibilities defined in statute
 - Medicaid Integrity Program (MIP, § 1936 of the Social Security Act (the Act))
 - Healthcare Fraud and Abuse Control Program (HCFAC, § 1128C of the Act)
 - PERM (Improper Payments Information Act, P.L. 107–300)

Federal Roles and Responsibilities

CMS

- Training and technical assistance (TA)
 - Delivers training through Medicaid Integrity Institute (MII)
 - Provides ad-hoc TA to states, facilitates technical advisory groups
 - Publishes guidance and resources, shares data with states
- Investigations and audits
 - Contracts Unified Program Integrity Contractors (UPICs) to conduct audits and investigations of FWA
- Oversight
 - Identifies state expenditures that are unallowable
 - Reviews state program integrity functions
 - Oversees PERM

Federal Roles and Responsibilities

HHS OIG

- Oversight
 - Conducts audits to improve economy and efficiency of programs, evaluations to identify vulnerabilities in programs
 - Medicaid Fraud Control Units (MFCUs) evaluation and grant management
- Investigations
 - Conducts administrative, civil, and criminal investigations into fraud and abuse
 - Excludes providers from federal health care programs
- Guidance and alerts
 - Publishes advisory opinions and establishes safe harbors for health care practices
 - Provides FWA education to providers, plans, and beneficiaries

Federal Roles and Responsibilities

Other federal departments and agencies

- Other HHS agencies
 - Administration for Children and Families maintains the Public Assistance Information Reporting System
 - Health Resources and Services Administration maintains the National Practitioner Databank
- DOJ
 - Investigates major Medicaid fraud cases
 - Coordinates federal, state, and local law enforcement efforts alongside HHS OIG
 - Operates health care strike forces and Health Care Fraud Prevention and Enforcement Team

State Roles and Responsibilities

- States carry out the majority of day-to-day program integrity operations
- State responsibilities are split between state Medicaid agencies and MFCUs
 - State agencies prevent FWA, detect and conduct preliminary investigations, oversee managed care plans
 - MFCUs investigate fraud and patient abuse and neglect cases involving Medicaid providers

State Roles and Responsibilities

State Medicaid Agencies

- Prevention
 - Provider screening
 - Beneficiary eligibility determination
 - Provider and beneficiary education
- Detection, preliminary investigations, and recoveries
 - Operate surveillance and utilization review subsystem to detect FWA in payment and claims data
 - Conduct preliminary investigations; report substantiated allegations of provider fraud to MFCUs
 - Suspend providers and recover overpayments
- Oversight of managed care plans

State Roles and Responsibilities

MFCUs

- States must operate MFCUs pursuant to § 1902(a)(61) of the Act
- Investigate and prosecute provider-perpetrated cases of fraud and patient abuse/neglect
 - Receive referrals from state agency, managed care plan, or other state/federal agency
 - Pursue civil and criminal action against providers, may make recoveries
 - Do not investigate beneficiary-perpetrated fraud

State Roles and Responsibilities

Other state responsibilities

- States must participate in PERM once every three years
 - Submit data to PERM contractors, give contractors access to data systems
 - Designate point of contact, maintain communications with CMS and contractor
 - Create corrective action plan in response to deficiencies identified in PERM review
- States must conduct Medicaid Eligibility Quality Control pilots between PERM years
 - Evaluate the accuracy of Medicaid and State Children’s Health Insurance Program eligibility determinations
 - Must submit report to CMS identifying root causes of errors and corrective actions

Health Plan Roles and Responsibilities

- Prevention, detection, and investigation
 - Must have mechanisms to identify and report suspected fraud
 - Must verify that beneficiaries receive services
 - Some states require managed care plans to operate special investigation units (SIUs)
- Overpayment reporting and recovery
 - Managed care plans must report identified and recovered overpayments within 30 days, and submit annual overpayment recovery report
 - Managed care plans must have a mechanism for network providers to report and return overpayments
- Internal oversight and reporting
 - Plans must have internal mechanisms to prevent FWA in their organization

Issues in Medicaid Program Integrity

Issues in Medicaid Program Integrity

- Federal oversight, assistance, and investigations
 - UPICs engage in limited Medicaid PI activities, few involve Medicaid managed care
 - CMS communication of promising state practices is limited
 - Insufficient resources at MII
 - Limited use of state single-audit findings
- Managed care
 - State and federal agencies have limited insight into FWA occurring in managed care networks
 - Managed care plans refer few cases of fraud, report few overpayments
 - Some plans' SIUs are under-resourced
 - Plans may be disincentivized to pursue FWA

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Conclusion

Key Takeaways

- Although FWA occurs in Medicaid, known FWA accounts for a small portion of program spending and its scale and impact is difficult to measure
- Federal government, states, and health plans have a significant number of statutory and regulatory PI responsibilities
- Key issues in PI include federal-state collaboration and PI in managed care

Next Steps

- Commissioner feedback on policy scan findings and areas for exploration during stakeholder interviews
- Staff will return next analytic cycle with interview findings
- Discussion questions:
 - Are there federal activities that are of particular interest for the next phase of research?
 - Are there state PI needs that are of particular interest for the next phase of research?

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