

Medicaid Program Integrity

The Medicaid program covers over 99 million Americans and accounts for 18 percent of total U.S. health care spending (MACPAC 2026a, 2026b). Fraud, waste, and abuse (FWA) in Medicaid diverts program funds from their intended purpose, affecting both spending and beneficiary care. FWA encompasses acts of intentional deception (fraud), exploitation of care or payment systems (abuse), and unnecessary use of health care resources (waste). FWA occurs in both privately-funded health care and government-funded health care programs such as Medicare and Medicaid (CMS 2022). Providers, plans, and beneficiaries can all engage in FWA, but only a small minority of providers are responsible for the vast majority of FWA (NHCAA n.d.).

The total amount of FWA in Medicaid is unknown, but documented instances account for a small portion of program spending. In 2024, Medicaid Fraud Control Units (MFCUs), state-run bodies that investigate and prosecute Medicaid fraud, recovered \$1.3 billion from civil and criminal cases of fraud (OIG 2025a). The same year, the Centers for Medicare & Medicaid Services (CMS) prevented or recovered \$1.5 billion in Medicaid FWA (CMS 2025a).¹ Each of these efforts accounted for less than 1 percent of the \$800 billion spent on Medicaid that year, but these estimates may not capture all FWA that occurs in the program. Measuring fraud and abuse in Medicaid is difficult because bad actors conceal their actions. Likewise, measuring waste is difficult because it often occurs due to unseen errors. Currently, there are no data sources that capture the full extent of FWA in Medicaid, making it difficult to determine FWA's impact on program spending.

In addition to the effect on spending, Medicaid FWA can also harm beneficiaries. For example, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) found that Medicaid personal care service attendants who committed fraud also harmed the beneficiaries under their care. Cases of fraud-linked harm included an attendant splitting payment with a beneficiary's family member in return for some of the beneficiary's pain medication (leaving them without needed pain relief) and leaving a beneficiary in unsanitary conditions while billing for services the attendant did not deliver (OIG 2016a). In another case, a substance abuse treatment provider defrauded multiple states by billing for ineligible services and excessive stays and failing to discharge patients. The provider's facilities were insufficiently staffed and supervised, resulting in harm to beneficiaries, including assaults and suicides (Michigan Department of Attorney General 2025).

Program integrity refers to the activities undertaken to prevent FWA and ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. Though program integrity was not an original feature of the Medicaid program, legislation has added safeguards to protect the program from FWA. These include the 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142), which established MFCUs, the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), which created the Health Care Fraud and Abuse Control (HCFAC) Program, and the Deficit Reduction Act of 2005 (P.L. 109-171), which established the Medicaid Integrity Program (MIP). These additions have given the federal government, states, and health plans many program integrity roles and responsibilities, including provider screening, investigating and prosecuting fraud and abuse, and recovering overpayments.

The federal government invests significant resources into Medicaid program integrity. In FY 2024, CMS obligated a total of \$250.4 million exclusively for Medicaid program integrity operations conducted by the agency (CMS 2025a). Additionally, in FY 2023, HHS OIG received \$345.1 million to combat fraud and abuse in federal health care programs, including Medicaid (HHS and DOJ 2024). The federal government also provides matching funds for states' program integrity activities and provides grants for states to operate MFCUs (totaling \$395.8 million in 2024) (OIG 2025a).



MACPAC reviewed statutes, regulations, subregulatory guidance, gray literature, and peer-reviewed literature to identify concepts, policies, and issues related to Medicaid program integrity. MACPAC analyzed data from CMS and HHS OIG to identify known instances of FWA. MACPAC also analyzed reports from CMS, HHS OIG, and the Government Accountability Office (GAO) to identify issues impacting the integrity of the Medicaid program. This brief will define fraud, waste, and abuse, and discuss measures of Medicaid FWA. It will also provide an overview of program integrity responsibilities carried out by the federal government, states, and health plans. Finally, it will identify key issues impacting the integrity of the Medicaid program.

Medicaid FWA

FWA are distinct, but linked concepts in health care. Fraud and abuse occur when an individual or entity exploits a health care system through deception or bending the rules. Waste is any act that results in unnecessary costs to the program, but is unintentional and not exploitative. FWA is inherently difficult to measure, and there are limited data on the amount of FWA in Medicaid. No data capture the total amount of FWA in Medicaid; however, known instances of FWA account for a small portion of program spending. This section will define and provide examples of Medicaid FWA, and discuss related measures.

Fraud and abuse

Fraud and abuse occur when an individual or entity exploits the Medicaid program for personal (typically financial) benefit. Federal regulations define what constitutes fraud and abuse in Medicaid (Box 1). Fraud occurs when a party makes false or misleading statements to benefit themselves or someone else. For example, a health care provider knowingly billing Medicaid for services that they never delivered is committing fraud. Abuse occurs when a party engages in practices that are not medically or fiscally sound and result in unnecessary costs to the Medicaid program. For example, a healthcare provider billing Medicaid for unnecessary services that were delivered is abusing the program. The line between fraud and abuse is not always clear-cut. A practice may be considered fraud in one circumstance and abuse in another, depending on specific facts, circumstances, intent, and knowledge (CMS 2022). For example, upcoding (billing services at a higher level of complexity to receive increased compensation) can be considered either fraud or abuse depending on the perpetrator's intent and knowledge (CMS 2021).

A minority of health care providers are responsible for the majority of health care fraud and abuse; most health care providers do not commit fraud and abuse (NHCAA n.d.).

Provider fraud and abuse typically occurs when a provider bills an insurer such as Medicaid for services that were not delivered as described, were unnecessary, or not delivered at all (Savino and Turvey 2018). Fraudulent and abusive providers can exploit the Medicaid program through a variety of schemes, including self-referring patients, paying kickbacks to patients or other providers, manipulating billing codes, or billing for services that were never delivered (CMS 2016a). For example, a behavioral health company billed a state's Medicaid program for over 30,000 hours of home care services that were never delivered to beneficiaries. The company regularly billed the program for over 100 hours of services delivered by one doctor in a single day (NCDOJ 2025).

BOX 1: Federal Definitions of Fraud and Abuse in Medicaid

“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.” (42 CFR 455.2)

“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.” (42 CFR 455.2)



Health plans can also engage in fraud and abuse, though known instances of health plan fraud and abuse are less common. Health plans can exploit Medicaid by misrepresenting the number of beneficiaries enrolled in their plans, overreporting costs, discouraging beneficiary utilization, and maintaining inadequate provider networks (HCFA 2002). For example, a large Medicaid managed care organization (MCO) entered into settlements with over 20 states totaling more than \$1 billion over allegations that the plan charged state Medicaid programs the full price for prescription drugs the plan purchased at a discount (Miller 2025). There are generally fewer known cases of health plan fraud than provider fraud, but these cases can result in a disproportionate cost to the program due to the size of some MCOs. In 2023, 7 civil settlements with health plans accounted for 50 percent of MFCU fraud recoveries (MACPAC 2026d).

Beneficiaries can commit fraud and abuse, but known instances are rare. Beneficiaries may misrepresent their income to gain eligibility, share benefits cards with non-beneficiaries, and resell prescriptions or medical equipment received through the program. Beneficiaries can also take part in provider fraud schemes by accepting bribes or kickbacks to vouch for false claims (CMS 2016a). Data on beneficiary fraud and abuse are limited compared to provider fraud, and no available data indicate that beneficiary fraud and abuse are common in Medicaid.

Waste

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). Health care waste can result from either clinical failure, such as overtreatment; poor care coordination; and poorly delivered care, or from administrative inefficiencies, errors, and oversights (Becker and Hackbarth 2012). Government health care programs such as Medicaid are vulnerable to unique forms of administrative waste, including payments for ineligible beneficiaries, payments for services covered by other forms of insurance, payments for deceased beneficiaries, and duplicate payments for beneficiaries. For example, HHS OIG found that nearly all states made duplicate capitation payments for beneficiaries enrolled in multiple Medicaid managed care plans. OIG's report estimates that duplicate capitation payments cost the Medicaid program \$72.9 million in August 2019 and \$117.1 million in August 2020 (OIG 2022a). Waste can also occur when states erroneously claim federal matching payments. For example, four states claimed over \$90 million in federal matching payments for home-and community-based services using payment rates that included unallowable room-and-board costs (OIG 2016b).

Measuring FWA

Known instances of FWA account for a small portion of program spending. Between 2019 and 2024, CMS reported that its program integrity activities prevented or recovered \$11.1 billion of FWA in the federal share of Medicaid spending, or 0.34 percent of federal Medicaid spending (Table 1). Halted or recovered federal matching funds for unallowable state Medicaid expenditures accounted for the majority (\$7.6 billion) of FWA prevented or recovered during this period (MACPAC 2026c). Over this same period, MFCUs recovered \$8.3 billion of state and federal Medicaid funds from criminal and civil investigations of Medicaid fraud perpetrated by health care providers. This number accounts for 0.18 percent of state and federal spending between 2019 and 2024 (MACPAC 2026d). 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.



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

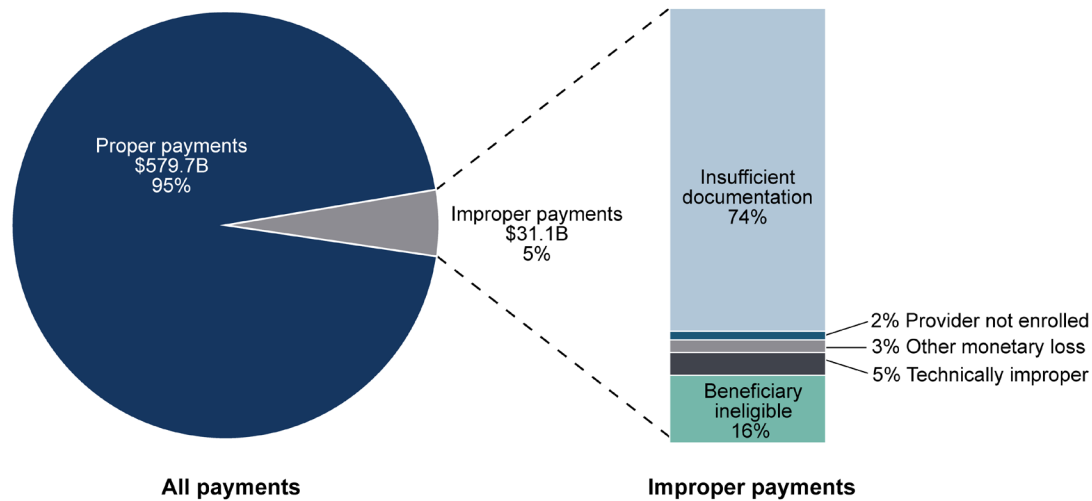
Notes: FWA is fraud, waste, and abuse. MFCUs are Medicaid Fraud Control Units. CMS is the Centers for Medicare & Medicaid Services.

Source: HHS OIG Annual Reports on MFCUs 2019 - 2024, MACStats 2020 - 2026, CMS Annual Reports to Congress on Medicare and Medicaid Program Integrity 2019 - 2024, CBO Historical Budget Data February 2024.

Payment Error Rate Measurement (PERM)

PERM measures improper payments, which 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 Payment Information Act (IPIA) of 2002, P.L. 107-300). A Medicaid payment can be considered improper for many reasons, including the beneficiary being ineligible for the program, a service being ineligible for payment, or a provider not being enrolled in the program. The PERM program is sometimes cited as a measure of FWA in Medicaid. However, PERM does not identify fraud and abuse and its ability to identify waste is limited. These payments may be the result of fraud and abuse, but they may also be the result of unintentional errors. PERM reviewers do not conduct fraud and abuse investigations and do not collect the information necessary to distinguish between fraud and abuse and unintentional errors (CMS 2020).

Improper payments can be the result of waste, but PERM cannot always detect when an improper payment is wasteful. Medicaid payments can be considered improper if they are missing necessary documentation, such as documentation of a service's medical necessity or documentation that the state verified a beneficiary's income. In these examples, documentation may be missing because of problems with the payment (e.g., the service is unnecessary or the beneficiary is ineligible) in which case the payment is wasteful. Documentation could also be missing due to administrative errors, in which case the payment is improper, but not wasteful. PERM does not collect enough information to distinguish between improper and wasteful payments (CMS 2020).

FIGURE 1: 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.

Source: Department of Health and Human Services (HHS). 2024. Fiscal Year 2024 Agency Financial Report. <https://www.hhs.gov/sites/default/files/fy-2024-hhs-agency-financialreport.pdf>

In 2024, CMS estimated that \$31.1 billion out of \$610.8 billion (or 5.1 percent) of Medicaid payments were improper (Figure 1). Of this amount, 74 percent (or \$23 billion) was deemed improper due to missing documentation (HHS 2024). An additional 5 percent of improper payments were determined technically improper, meaning payments were made to the correct party and in the correct amount, but an administrative step was skipped (HHS 2024). In 2024, 16 percent (or \$5 billion) of improper payments were made to ineligible beneficiaries or unenrolled providers (HHS 2024). These payments should not have been made, but PERM does not provide the information needed to determine if these improper payments were the result of fraud or abuse (CMS 2020).

Federal Program Integrity Roles and Responsibilities

The majority of federal Medicaid program integrity responsibilities fall under HHS, which works through CMS and HHS OIG to fulfill its statutory responsibilities, including implementing the Medicaid Integrity Program, the HCFAAC program, and the PERM program (§ 1936 of the Social Security Act (the Act), § 1128C of the Act, IPIA P.L. 107–300). HHS program integrity responsibilities include providing training and technical assistance to states, conducting investigations and audits, and conducting oversight of federal matching funds and states' program integrity activities (CMS 2024a). Outside of HHS, the Department of Justice (DOJ) investigates and prosecutes health care fraud, including Medicaid fraud, and coordinates with HHS OIG on combating Medicaid fraud (Figure 2).

FIGURE 2: Federal Government Program Integrity Responsibilities



to the NCCI codebook and provides technical assistance to states on NCCI coding methodology and edits (CMS 2025d).

Additionally, CMS shares Medicare and Social Security data and facilitates the exchange of Medicaid data to assist states with provider enrollment and screening. The CMS Data Exchange gives states access to a list of terminated Medicaid and Medicare providers and the Social Security Death Master File (DMF) (a list of all deceased individuals), and allows states to share terminated Medicaid provider information with CMS and other states. CMS also operates a data compare service that allows states to use provider screening results from Medicare or other state Medicaid agencies in place of conducting their own screenings (CMS 2024a).

Investigations and audits

Contractors known as Unified Program Integrity Contractors (UPICs) conduct the investigations and audits required by the MIP. CMS contracts with five UPICs, each assigned to a geographic region, which investigate FWA in the Medicare and Medicaid programs (OIG 2022b). UPICs conduct data analysis, site visits, interviews with beneficiaries and providers, and medical reviews to identify FWA. When UPICs detect fraud, they first report the case to CMS, which determines if the case should be referred to law enforcement. HHS OIG also reviews the case to determine if a referral is warranted. If CMS refers the case to law enforcement, the UPIC, CMS, HHS OIG, and the state's MFCU and law enforcement bodies conduct an investigation and take administrative or legal actions against the perpetrator (CMS 2024c).

Oversight

CMS conducts program integrity oversight by reviewing state claims for federal matching funds, conducting reviews of state program integrity functions, reviewing state single audit findings, and administering the PERM program. CMCS FMG conducts financial oversight of state Medicaid spending, identifying state expenditures that are unallowable for federal financial participation (FFP) (CMS 2025a). Claims for federal matching funds can be unallowable for reasons both related and unrelated to fraud (§ 1903(i) of the Act). CMS has the authority to disallow the claim, in which case the state reimburses the federal government for the unallowable amount, or defer the claim, in which case the federal government excludes the unallowable amount from future FFP (42 CFR 430.42, 42 CFR 430.40). CMS has the authority to withhold FFP if states are noncompliant with Section 1902 of the Act, which sets requirements for the administration of state Medicaid programs. However, CMS has not typically used withholding to address FWA (42 CFR 430.35, Mathers et al. 2026).

In addition to financial management, the agency reviews state program integrity functions and FWA risk areas. CPI conducts focused reviews which consist of interviews (either virtual or in-person) and reviews of state policies, procedures, contracts, and FWA case documentation. States must submit corrective action plans (CAPs) that address any deficiencies identified in focused review. CPI reviews state CAPs, monitors progress toward CAP goals, and provides training and technical assistance to address deficiencies (CMS 2024a). CPI also conducts more frequent, off-site desk reviews to monitor states' compliance with CAPs, assess specific service areas, and identify promising state practices (GAO 2017).

CMS also reviews state Medicaid single audits. The Single Audit Act (SAA) of 1984 (P.L. 98-502) requires states to annually audit programs that receive a significant amount of federal funds. The Office of Management and Budget (OMB) releases an annual supplement that identifies which program elements must be audited each year for all applicable programs. CMS helps OMB identify the features in Medicaid most likely to cause improper payments or FWA. After states complete their audits, CMS reviews all audit findings and issues management decisions that direct states to address deficiencies identified in their audits. The agency monitors individual states' progress towards addressing deficiencies and monitors national audit trends (GAO 2023a, CMS 2024a).

CMS oversees the PERM program, which produces annual estimates of improper payments in Medicaid and the State Children's Health Insurance Program (CHIP).² Federal agencies must annually review any programs they administer that OMB considers at high-risk for improper payments, including Medicaid and CHIP.³ CMS hires PERM contractors to analyze payment and claims data to estimate the rate of improper payments in Medicaid



annually, and coordinates with states to ensure that contractors have access to all necessary data and systems. CMS also develops and oversees CAPs created by states in response to deficiencies identified during PERM review (CMS 2020). States develop CAPs in response to deficiencies identified in the PERM process, and CMS monitors state progress toward CAP goals (CMS 2024a).

HHS OIG

The HHS OIG conducts oversight of state Medicaid agencies, MFCUs, and CMS; investigates fraud and abuse; and issues guidance and fraud alerts to states and the public. The majority of HHS OIG's Medicaid program integrity responsibilities are carried out under the Health Care Fraud and Abuse Control program, a joint HHS-DOJ program to combat fraud and abuse in private and public health plans.⁴ HCFAC directs OIG and DOJ to coordinate state; federal; and local law enforcement agencies, conduct investigations; audits; and evaluations, and facilitate the enforcement of laws related to health care fraud and abuse (§ 1128C of the Act).

Oversight

OIG conducts audits and evaluations to identify Medicaid FWA risks and deficiencies in state and federal agencies' program integrity functions. The Office of Audit Services (OAS) audits states, providers, and federal agencies to identify methods to improve the economy, efficiency, and effectiveness of HHS programs, including Medicaid. OAS's Medicaid audits examine specific compliance issues or FWA risks in state Medicaid programs, provider types, or CMS practices. OAS issues recommendations to audit subjects to resolve compliance issues and reduce FWA (OIG 2018a). The Office of Evaluations and Inspections (OEI) conducts issue-level evaluations of HHS programs to identify vulnerabilities and promote efficiency and effectiveness in HHS programs. OEI's Medicaid evaluations examine program integrity issues that span multiple states, programs, or levels of government. OEI evaluations may result in recommendations for operational, regulatory, or legislative action (OIG 2018a).

OIG also oversees states' MFCUs, conducting annual reviews of their performance, administering their federal grant awards, and approving data mining applications. OEI conducts annual evaluations of MFCUs to ensure they comply with regulations in 42 CFR 1007 and OIG policy transmittals, performance standards listed in 89 FR 76431, and to evaluate the units' effectiveness in investigating and prosecuting cases of fraud and patient abuse and neglect (42 CFR 1007.17).⁵ OEI administers grants to MFCUs and receives and publishes data on investigations, prosecutions, and recoveries from all 53 MFCUs (OIG 2018a). OIG also reviews and approves MFCU applications for data mining waivers, which waive restrictions on MFCUs' data-mining activities and allow them to analyze Medicaid payment data to identify potential fraud (42 CFR 1007.20).

Investigations

The OIG Office of Investigations (OI) conducts civil, criminal, and administrative investigations into fraud and abuse in Medicare and Medicaid and imposes sanctions on perpetrators. These sanctions include exclusion from federal health care programs, civil monetary penalties, and referrals to the DOJ for criminal prosecution (OIG 2018a). OI must bar providers from participating in federal health care programs if they have been convicted of health care fraud, patient abuse, illegal distribution of controlled substances, or any crimes related to the Medicare or Medicaid programs. OIG has the discretion, but is not required, to exclude providers who have been convicted of other crimes related to financial misconduct or who have been subject to professional sanctions such as loss of licenses and credentials (§§ 1156 and 1128 of the Act). OIG manages the List of Excluded Individuals and Entities (LEIE), which lists all providers excluded from federal health care programs. States must use the LEIE to screen potential Medicaid providers (OIG, 2025b). OIG also operates a hotline for HHS employees and members of the public to report suspected fraud and abuse in federal health care programs (OIG 2025c).



Guidance and alerts

OIG advises health care providers, plans, and beneficiaries on practices to avoid and prevent fraud and abuse. OIG's Office of Counsel (OC) publishes advisory opinions to the health care industry on what practices will trigger legal or administrative sanctions and establishes safe harbors for certain practices. Additionally, OC publishes special fraud alerts on practices that are suspect or of particular concern to the Medicaid program (OIG 2018a). OIG also publishes fraud and abuse guidance and training documents for health care providers and educates vulnerable communities (such as seniors and immigrants) on how to protect themselves from health care fraud and abuse. OIG operates the online Compliance Resource Portal, which posts special fraud alerts, documents, and videos aimed at the health care industry (HHS and DOJ 2024).

Other HHS agencies

Other HHS agencies share data with state and federal agencies to assist their program integrity functions. The Administration for Children and Families maintains the Public Assistance Reporting Information System (PARIS), a data matching service that identifies individuals receiving duplicate benefits from multiple states' public assistance programs (ACF 2023). States must check PARIS to ensure applicants are not already receiving Medicaid benefits in another state (42 CFR 435.945(d)). Similarly, the Health Resources and Services Administration coordinates with OIG to integrate Medicaid provider exclusions from LEIE into the National Practitioner Databank, which collects information on medical malpractice, convictions, and judgments made against health care providers (HRSA 2024).

DOJ

DOJ pursues major Medicaid fraud cases and coordinates federal, state, and local law enforcement efforts with HHS OIG. DOJ receives fraud case referrals from HHS OIG and will seek civil settlements and judgments with perpetrators or pursue criminal prosecution when federal laws have been violated (HHS and DOJ 2024). DOJ and OIG also operate joint health care fraud strike forces that coordinate with state and local law enforcement to pursue cases of health care fraud, including Medicaid fraud, across the U.S. Sixteen strike force teams operate across the country, including a national rapid response strike force that pursues cross-jurisdictional cases and emerging fraud risks (HHS and DOJ 2024). OIG and DOJ also operate the Health Care Fraud Prevention and Enforcement Team (HEAT), which develops enforcement initiatives, designates areas for oversight, and identifies opportunities for data and intelligence sharing. HEAT also publishes educational resources for providers and beneficiaries and issues special fraud alerts to the health care industry (HHS and DOJ 2024).

State Roles and Responsibilities

Statutes and regulations require states to carry out the majority of day-to-day Medicaid program integrity functions. Responsibilities are split between two bodies: state Medicaid agencies and MFCUs. State Medicaid agencies are responsible for preventing; detecting; and conducting preliminary investigations of FWA, and overseeing MCOs, while MFCUs focus primarily on investigations and prosecutions of suspected fraud and patient abuse cases (Figure 3). Both bodies recover FWA overpayments.



FIGURE 3: State Government Program Integrity Responsibilities

State government program integrity responsibilities

State Medicaid agencies:

- Screen providers and beneficiaries
- Identify FWA and conduct preliminary investigations, refer cases to MFCUs
- Hire RACs to identify FWA
- Conduct MCO oversight
- Submit data for PERM, implement MEQC pilots

Medicaid fraud control units:

Investigate and prosecute Medicaid fraud and patient abuse

- Recovers overpayments
- May conduct data mining to detect fraud

Note: FWA is fraud, waste, and abuse. MCOs are managed care organizations. MFCUs are Medicaid Fraud Control Units. RACs are recovery audit contractors. PERM is the Payment Error Rate Measurement program. MEQC is the Medicaid eligibility quality control program.

State Medicaid agencies

State Medicaid agencies' program integrity activities focus primarily on detecting FWA, conducting preliminary investigations, and recovering overpayments from FWA. State agencies also conduct provider and beneficiary enrollment and education activities to prevent FWA. In addition to these responsibilities, state agencies conduct oversight of their MCOs' program integrity activities.

Prevention

Statutes and regulations require state agencies to screen providers to ensure individuals and entities posing a high risk of fraud and abuse do not participate in the Medicaid program. These activities include criminal background checks, fingerprinting, and site visits, depending on a provider's risk level (42 CFR 455.450).⁶ State agencies must also check the DMF, the National Plan and Provider Enumeration System, the LEIE, and the Excluded Parties List System (EPLS) to confirm the provider's identity and verify that no federal agency has excluded them from receiving payment. Following enrollment, state agencies must check the LEIE and EPLS every month, revalidate provider enrollment once every five years, and report any provider terminations to CMS (42 CFR 455.414, 42 CFR 455.436).

Statutes and regulations also require states to collect and verify information to prevent ineligible applicants from enrolling in the program. State agencies must have an eligibility determination process that verifies applicants' reported income, citizenship, immigration status, and social security number (42 CFR 435.956, 42 CFR 435.948). State agencies must also determine if applicants are covered by other forms of insurance or are enrolled in another state's Medicaid program to ensure that program dollars are not wasted paying for services covered by another state or form of insurance (42 CFR 435.945(d), 42 CFR 433.138).⁷ State agencies must redetermine beneficiaries' eligibility once every 12 months following enrollment (42 CFR 435.916). Beginning on December 31, 2026, states must redetermine eligibility once every six months (P.L. 119-21, an Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14).

State Medicaid agencies educate providers and beneficiaries about fraud and abuse. They disseminate materials and hold trainings to educate providers on fraud and abuse, the consequences of committing fraud and abuse, and how to avoid committing fraud and abuse. State agencies also distribute educational materials to



beneficiaries on similar topics, including how to protect oneself from fraud and abuse and how to report suspected fraud and abuse (NAMD 2025).

Detection, preliminary investigations, and recoveries

State Medicaid agencies must implement systems to identify FWA and recover overpayments. The majority of state agencies centralize these functions under a single Program Integrity Unit, though some disperse program integrity responsibilities throughout the agency (CMS 2014). States must implement a post-payment review system known as a statewide surveillance utilization review subsystem (SURS) to detect potential FWA (42 CFR 456.3). SURS uses state data to identify overutilization, inappropriate care, suspicious billing patterns, and inappropriate claims (CMS 2016b, NAMD 2025). When state agencies discover evidence of fraud, either through SURS, tips from the public, or other monitoring mechanisms, they must conduct a preliminary investigation into the alleged perpetrator. If the state agency determines that an allegation of fraud against a provider is substantive, it must refer the provider to the state's MFCU for a full investigation and suspend payments to the provider (42 CFR 455.23). If the state agency believes a beneficiary has defrauded the program, the agency must refer the case to law enforcement for investigation. State agencies must conduct their own investigations into beneficiaries suspected of abusing the program (42 CFR 455.14, 42 CFR 455.15). The state agency must also recover defrauded payments identified by MFCUs or local law enforcement; however, MFCUs may also carry out recoveries (42 CFR 433.316). The state agency must refund federal share of any recoveries to CMS (42 CFR 433.312).

In addition to implementing their own fraud detection and recovery mechanisms, states must contract with entities known as recovery audit contractors (RACs) to identify and recover overpayments and underpayments made to providers by the state's fee-for-service Medicaid program (§ 1902(a)(42)(B) of the Act, 42 CFR 455.506). States pay RACs a percentage of the overpayments they identify once those payments have been recovered (42 CFR 455.510(a)). States can seek exemptions to the RAC requirement due to challenges in procuring a RAC contractor, high managed care penetration, or operating programs that serve a similar purpose. As of 2021, CMS has exempted 35 states from the RAC requirements (GAO 2023b). Given the difficulty in securing a RAC and the number of states with exemptions, MACPAC has previously recommended that Congress pass legislation to make the RAC program optional for states (MACPAC 2019).

Oversight

State Medicaid agencies conduct oversight of MCOs to ensure they comply with contractual program integrity requirements and report accurate financial and encounter data. Federal regulations require state agencies to monitor MCOs' compliance with federal program integrity requirements, such as referring suspected fraud to the state (42 CFR 438.602(a)). Some state agencies use accountability measures, such as CAPs and financial penalties, to ensure MCO compliance (NAMD 2025). State agencies must also audit each MCO's financial and encounter data for truthfulness and accuracy at least once every three years (42 CFR 438.602(a)). Additionally, state agencies must screen MCO owners, managers, and contractors in a similar manner to providers by checking databases such as the LEIE (42 CFR 438.602(d)).

MFCUs

MFCUs investigate cases of provider fraud and patient abuse involving Medicaid beneficiaries. Section 1902(a)(61) of the Act requires all states to operate MFCUs as a condition of receiving federal matching funds.⁸ As of 2024, all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands (USVI) operate MFCUs (OIG 2025a). MFCUs must operate separately from the state Medicaid agency and either work directly under or have a formal working relationship with the state attorney general or another state entity with the authority to prosecute criminal cases of fraud and patient abuse (42 CFR 1007.7(a)). MFCUs must have the capability to investigate and prosecute (or refer for prosecution) cases of fraud, and employ a staff that includes at least one attorney, one auditor, and one investigator (42 CFR 1007.13).



Typical MFCU investigations begin with a referral from a state Medicaid agency, MCO, or another state or federal agency. Some MFCUs also generate leads from data-mining operations. After receiving and assessing the referral, MFCUs conduct formal investigations and, when appropriate, pursue civil or criminal cases against the individual or entity suspected of fraud. Successful MFCU investigations can result in either civil settlements or criminal convictions, exclusion of the perpetrator from federal health care programs, and the recovery of defrauded funds (OIG 2025e). In 2023, the majority of successful investigations resulted in criminal convictions, which accounted for the majority of overpayments recovered by MFCUs (MACPAC 2026d). MFCUs may recover fraudulent overpayments themselves or refer overpayments for recovery by state Medicaid agencies (42 CFR 1007.11(c)).

States receive enhanced matching funds to operate their MFCUs. MFCUs receive 90 percent matching funds for their first 12 quarters of operation, followed by 75 percent matching for all quarters thereafter (42 CFR 1007.19(a)(2)). MFCUs may only use matching funds to investigate fraud and beneficiary abuse and neglect committed by providers. MFCUs cannot use matching funds to investigate program abuse, provider compliance with laws and regulations, or fraud committed by Medicaid beneficiaries unless these beneficiaries aided a provider committing fraud (42 CFR 1007.19). Furthermore, MFCUs may not use matching funds for data mining activities unless granted a waiver by HHS OIG (42 CFR 1007.19(e)(2), 42 CFR 1007.20). Currently, only 24 MFCUs have received waivers (OIG 2025e). All MFCUs must annually recertify with HHS OIG to continue receiving matching funds, and must submit annual reports on their staffing levels, caseload, case outcomes, collections, and sources of case referrals (42 CFR 1007.17).

Other state roles and responsibilities

States must conduct annual single audits of their Medicaid programs in compliance with the SAA. The SAA and subsequent HHS rulemaking require any non-federal entity spending more than \$750,000 per year in federal awards to conduct an annual single audit or program audit (45 CFR 75.501). Generally, state auditors (i.e., state comptrollers, state controllers, state examiners) audit their state's Medicaid programs, though some states contract accounting firms to conduct all or part of the single audit (GAO 2023a). States conduct their audits according to the annual audit supplement created by OMB with assistance from CMS. States must report audit findings to the Federal Audit Clearinghouse, and state Medicaid agencies must take corrective action in response to any deficiencies identified in the audit. In addition to single audits, some state legislatures require audits of specific elements of the Medicaid program, such as beneficiary eligibility or payments to providers (GAO 2023a).

States must also participate in the PERM program and conduct Medicaid Eligibility Quality Control (MEQC) pilots. States participate in PERM once every three years, with 17 states participating each year. During a state's PERM year, the state must submit payment and claims data to the PERM contractor and grant the contractor access to relevant state data systems. The state must also designate a state PERM point of contact and maintain communication with state Medicaid agency staff, CMS, and the contractor to ensure the completion of the PERM process (CMS 2020). States must also submit a corrective action plan to CMS and address any deficiencies identified during the PERM review (42 CFR 431.970). Between PERM years, states must conduct one 12-month MEQC pilot to evaluate the accuracy of beneficiary eligibility determinations (42 CFR 431.806). An MEQC review body separate from the state Medicaid agency must review 800 total Medicaid and CHIP eligibility determinations to confirm that applicants were correctly granted or denied benefits (42 CFR 431.812). The state Medicaid agency must correct any errors or deficiencies found in sampled cases and submit a report to CMS that identifies root causes and corrective actions (42 CFR 431.820).

Program Integrity in the U.S. Territories

The U.S. territories, which consist of Guam, Puerto Rico, the USVI, American Samoa, and the Commonwealth of the Northern Mariana Islands (CNMI), must comply with most state program integrity requirements. Requirements in 42 CFR 455, including detecting and investigating fraud, referring fraud to law enforcement, and screening and enrolling providers, apply to all five territories. Additionally, all territories must designate a program integrity lead



within their Medicaid agency (§ 1108(g)(7) of the Act). Federal regulations exempt Guam, the USVI, American Samoa, and the CNMI from the PERM and MEQC programs (42 CFR 431.954, 42 CFR 431.800). Puerto Rico is subject to additional requirements. The territory must develop a contracting reform plan to combat FWA in its Medicaid program and, as of 2023, must participate in both the PERM and MEQC programs (§ 1108(g)(7) of the Act). While territories have not historically had MFCUs, Puerto Rico established one in 2018, and the USVI followed suit in 2019. American Samoa, CNMI, and Guam were required to take reasonable steps towards establishing MFCUs by October 2021. There is no available information on what steps these territories have taken towards this goal; as of 2025, none have established a MFCU (MACPAC 2021, OIG 2025f). As of 2025, all territories have state plan amendments (SPAs) exempting them from operating a RAC program (CMS 2011a, 2011b, 2011c, 2011d, 2011e).

Health Plan Roles and Responsibilities

States' managed care contracts dictate MCOs' program integrity functions, and federal regulations require all contracts to contain certain provisions. At a minimum, contracts must require MCOs to detect FWA in their provider networks, identify and report overpayments, report financial and encounter data to states, and implement internal compliance structures (Figure 4). States have flexibility in choosing which program integrity requirements they include in their managed care contracts, leading to variation in MCO program integrity activities across states.

FIGURE 4: Health Plan Program Integrity Responsibilities



Health plan program integrity responsibilities

Managed care organizations:

- Identify FWA
- Refer fraud cases to states
- Identify and recover overpayments to MCO providers
- Implement internal compliance structures

Note: FWA is fraud, waste, and abuse. MCO is managed care organization.

Prevention, detection, and investigation

Contracts must require MCOs to identify and promptly report any suspected fraud to the state (42 CFR 438.608). States vary in how they implement these requirements in their managed care contracts. For example, some state contracts may require MCOs to operate Special Investigation Units (SIUs) dedicated to identifying FWA in their provider networks. These units consist of MCO staff with investigative backgrounds who review suspected instances of fraud before referring cases to the SMA or MFCU for further investigation (CMS 2023a). States can also define how promptly MCOs must report suspected fraud, and whether fraud must be reported to the state Medicaid agency, the MFCU, or to both agencies (CMS 2023a).⁹ Contracts must also require MCOs to have a method for verifying that beneficiaries received services billed by providers, which MCOs can use to identify potential FWA (42 CFR 438.608). Additionally, contracts must require MCOs to ensure their network providers have been screened and enrolled in Medicaid, report any provider terminations to the state, and immediately cease payment to providers suspected of fraud (42 CFR 438.608).



Overpayment reporting and recovery

Contracts must require MCOs to have mechanisms for identifying, reporting, and returning overpayments to the state. MCOs must have processes for reporting identified and recovered overpayments to the state within 30 days and must submit an annual report of all identified and recovered overpayments, regardless of whether they were due to fraud, abuse, or unintentional errors. (42 CFR 438.608, 42 CFR 433.312). Additionally, all MCOs must have a mechanism for network providers to report and return any overpayments to the MCO (42 CFR 438.608(d)(2)). Contracts must specify how overpayments are returned and retained; however, states set their own overpayment retention policies (42 CFR 438.608 (d)). Some states allow MCOs to retain all recovered overpayments, while others require MCOs to return overpayments to the state. Other states have a “finder’s keepers” agreement that allows the party that first identifies the overpayment to retain the recovered funds, incentivizing MCOs to pursue overpayments (CMS 2023b). Regardless of the arrangement, states must refund the federal share of any overpayment returned by MCOs to the state (42 CFR 433.312).

Internal oversight and reporting

Beyond requirements to combat FWA in their provider networks, contracts must require MCOs to implement internal controls to prevent fraudulent and abusive behavior within their own organizations. These include policies to ensure compliance with applicable laws and regulations, a dedicated compliance officer and committee, and routine internal monitoring of compliance risks (42 CFR 438.608(a)(1)). MCOs must also report financial and encounter data, data to certify the actuarial soundness of capitation rates, and data to determine the MCO’s medical loss ratio (42 CFR 438.604). Individuals who have been excluded from participating in government procurement activities may not hold key leadership positions or hold more than 5 percent equity in the MCO (42 CFR 438.608). Some states impose additional oversight and requirements, such as annual audits and operational reviews to ensure MCO compliance and improve performance (NAMC 2025).

Key Issues in Program Integrity

Federal agencies have documented opportunities for improving program integrity functions, including in federal investigations, assistance, and oversight and in managed care operations and oversight. Oversight bodies such as HHS OIG and GAO have found flaws in the federal government’s assistance to states’ program integrity functions, oversight of states, and investigations of FWA (OIG 2022b, GAO 2017, GAO 2023a, GAO 2023b). Additionally, multiple agencies, including HHS OIG, GAO, and CMS, have identified shortcomings in both MCOs’ program integrity functions as well as state and federal oversight of managed care (GAO 2018a, MACPAC 2025, OIG 2018b, OIG 2025g).

Federal investigations, assistance, and oversight

Federal contractors tasked with investigating FWA in Medicaid and Medicare conduct limited Medicaid investigations. An HHS OIG evaluation found that UPICs, which operate under the direction of CMS, engaged in limited Medicaid program integrity activities. CMS contracts UPICs to conduct program integrity investigations, data analysis, and evaluations for both Medicaid and Medicare; however, UPICs conducted nearly four times more Medicare investigations than Medicaid Investigations (OIG 2022b). OIG found that states’ reluctance to share data, send leads to UPICs, and sign joint operating agreements, in addition to poor data quality, hindered UPICs’ ability to conduct Medicaid investigations. Furthermore, only 11 percent of UPIC investigations involved Medicaid managed care, despite managed care covering the majority of beneficiaries (OIG 2022b). OIG found that data quality and access, as well as restrictions in states’ contracts with MCOs, limited UPICs’ ability to investigate FWA in managed care, (OIG 2022b).

A 2017 report from GAO found that CMS did not effectively collect and communicate promising practices from states during focused program integrity reviews. Of the five states surveyed for the report, only one reported that CMS asked questions about promising practices (GAO 2017). MACPAC analysis of focused program integrity



reviews similarly found no mentions of promising practices (MACPAC 2025b). Furthermore, GAO found that CMS lacks a centralized method for communicating promising state practices, limiting states' ability to learn from each other's program integrity successes (GAO 2017). CMS has taken some steps to share promising practices, such as distributing a promising practices template to states and sharing submissions via email (GAO 2017). The report also found that the MII, while useful to states, was unable to meet all states' training needs due to limited staffing and classroom capacity (GAO 2017). MII began offering virtual training in 2011; however, states have found this training to be less effective than in-person training (GAO 2017). Since 2020, all MII training has been delivered virtually (CMS 2024b).

CMS's reviews of state single audits have had limited effect in improving state program integrity operations. A 2023 report by GAO identified several issues with this oversight process. Sixty percent of auditor findings were repeated in the same states multiple years in a row. For example, in 2019, 2020, and 2021, auditors found deficiencies in coding and documentation that resulted in costs to North Carolina's Medicaid program (GAO 2023a). Repeated findings suggest that CMS corrective action plans are not resolving program integrity deficiencies. GAO also found that CMS makes limited use of national trends identified across state single audits. While CMS uses audit findings to inform its approach to individual states or groups of states, the agency does not use audit trends to inform its national oversight and technical assistance strategies. Furthermore, GAO found that CMS does not share national audit trends with states, limiting their ability to proactively address risks and potential deficiencies in their programs. CMS has taken some steps to track audit findings across states; however, it is not clear if CMS uses these trends to inform program integrity strategy (GAO 2023a).

Managed care

State and federal agencies have limited insight into the prevalence of FWA occurring within Medicaid managed care networks, despite managed care covering the majority of Medicaid beneficiaries. Medicaid MCOs operate in 42 states, the District of Columbia, and Puerto Rico, and cover 75 percent of all Medicaid beneficiaries (MACPAC 2026e). Furthermore, spending on managed care accounts for over 50 percent of Medicaid spending (MACPAC 2026f). However, many investigation and oversight mechanisms do not have visibility into managed care. For example, the managed care element of PERM only determines whether states properly paid capitation payments to MCOs; it does not determine whether MCO payments to providers were proper (CMS 2020). A GAO review of 27 state and federal audits found that PERM did not capture \$68 million in overpayments to MCO network providers and unallowable MCO costs. This figure does not capture the full extent of overpayments and unallowable costs, because it only examined a minority of MCOs (GAO 2018b). GAO found similar issues in the RAC program. Federal regulations do not require state RAC programs to review payments made by managed care organizations. Furthermore, the majority of the 34 states exempted from the RAC program cited managed care penetration as a reason for not contracting RACs. However, states that have contracted RACs to review managed care payments have successfully recovered hundreds of millions of dollars in overpayments made by MCOs (GAO 2023b). CMS has taken some steps to increase oversight of managed care. For example, the agency has conducted 22 program integrity audits of managed care plans in 5 states and has planned to expand audits to 42 states over 2024-2028 (CMS 2024a).

MACPAC analyzed 23 focused reviews of program integrity in states' managed care plans conducted between 2019 and 2025. In 19 of 23 states, MCOs referred an inadequate number of fraud cases to states or submitted low-quality referrals that lacked important investigative information. Additionally, MCOs in 17 of 23 states identified and recovered an inadequate number of overpayments (MACPAC 2025). CMS considers overpayment recovery or fraud referral frequency inadequate if the number of referrals or recoveries is low relative to the MCOs' beneficiary population or revenue; however, the agency does not explicitly define the threshold for inadequate. Many state contracts were missing key provisions, including internal compliance structures, mechanisms for providers to report overpayments, and overpayment retention policies (MACPAC 2025). The reviews also found deficiencies in MCO resources and activities: 11 states had at least one MCO that did not sufficiently verify that beneficiaries received services from providers, 8 states had at least one MCO with SIU staffing issues (such as staff being located out of state, or employing a small number of staff relative to the plan



size), 8 states had at least one MCO that conducted limited or no site visits, and 10 states had at least one MCO that terminated few or no providers suspected of fraud.¹⁰

Reports from HHS OIG and GAO found issues in Medicaid managed care and identified incentives and barriers that limit MCOs' program integrity activities. A 2018 HHS OIG evaluation of 38 MCOs found issues with FWA identification, referrals, and provider terminations. OIG found that 18 percent of MCOs identified fewer than 30 cases of fraud that year, and that one-third of MCOs referred fewer than 10 fraud cases to the state (OIG 2018b). The report noted that MCOs with smaller SIUs generally referred fewer cases of fraud to states. The evaluation also found that MCOs did not always inform states when they took actions, ranging from payment reviews to contract termination, against providers suspected of FWA (OIG 2018b). A 2025 OIG evaluation shared similar findings. Ten percent of MCOs surveyed by OIG did not make a single fraud referral in 2022, and more than half made 2 or fewer referrals per 10,000 enrollees. OIG found that MCOs with dedicated Medicaid staff and MCOs with staff who received fraud referral training referred more fraud to states. However, the majority of MCOs neither received training nor had dedicated Medicaid staff (OIG 2025g). A 2018 GAO performance audit identified incentives that may discourage MCOs from pursuing FWA in their provider networks. Stakeholders from states and MCOs stated that plans may be reluctant to pursue FWA because investigations and corrective actions hurt provider network retention. Additionally, state stakeholders stated that MCOs may not refer fraud to the state if their contract does not allow the plan to retain any portion of recovered overpayments. One state stakeholder claimed that MCOs may not pursue FWA because overpayments increase their capitation rates (GAO 2018b).

Conclusion

Fraud, waste, and abuse create unnecessary costs to the Medicaid program and can expose beneficiaries to harmful practices. Known instances of FWA account for a small portion of Medicaid spending though the availability of FWA data are limited and the total amount of FWA may be larger. The federal government, states, and health plans play a role in protecting the integrity of the Medicaid program and engage in a wide range of activities to prevent, detect, and investigate FWA. Opportunities to ensure Medicaid program integrity include improved federal assistance to states; oversight; and investigations, and oversight of managed care and MCO program integrity activities.

Endnotes

¹ MFCU recoveries include the federal share of funds recovered from fraud convictions and civil settlements. FWA prevented or recovered also includes the federal share from MFCU recoveries. These two amounts overlap and should not be combined to produce a count of total prevented or recovered FWA.

² CMS created the PERM program to comply with the Improper Payments Information Act of 2002 (IPIA) (P.L. 107–300), and the later Improper Payments Elimination and Recovery Act of 2010 (IPERA) (P.L. 111–204) and Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) (P.L. 107–300).

³ The OMB defines “significant risk” as improper payments exceeding \$10 million or 2.5 percent of program spending.

⁴ The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) authorizes the Health Care Fraud and Abuse Control Program.

⁵ MFCUs use the term ‘abuse’ to refer to patient abuse and neglect, defined in 42 CFR 1007.1 as “any act that constitutes abuse of a patient or resident of a health care facility or board and care facility under applicable State law. Such conduct may include the infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical or financial harm, pain, or mental anguish.”



⁶ Provider risk is determined by provider type (e.g. physician, home health aide, etc.) and is based on risk levels defined by Medicare.

⁷ Individuals with other forms of insurance, including health insurance, can still receive Medicaid benefits.

⁸ States may seek an exemption to this requirement per § 1902(a)(61) of the Act, if they can demonstrate that the operation of a MFCU would not be cost-effective. States must demonstrate that minimal fraud exists and that beneficiaries can be protected from patient abuse and neglect in the absence of a MFCU.

⁹ CMS recommends that contracts require MCOs to report fraud within 2 days to both the state Medicaid agency and the Medicaid Fraud Control Unit.

¹⁰ CMS stopped assessing MCO provider terminations after 2019.

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