

From Policy to Practice: Medicaid Health Plans Are Taking Action Against Fraud, Waste & Abuse in Medicaid

Preventing, detecting and correcting fraud, waste, and abuse (FWA) are central to program integrity efforts across many government programs. These activities generally include policies, controls, and other actions to ensure a program runs properly and lawfully while also promoting transparency and accountability.

by preventing, identifying, and remediating fraud, waste, and abuse. Medicaid MCO efforts are wide-ranging and comprehensive, covering services such as provider verifications and claim adjudication, the implementation of formal compliance programs, provider screenings, FWA detection, investigations, and reporting.

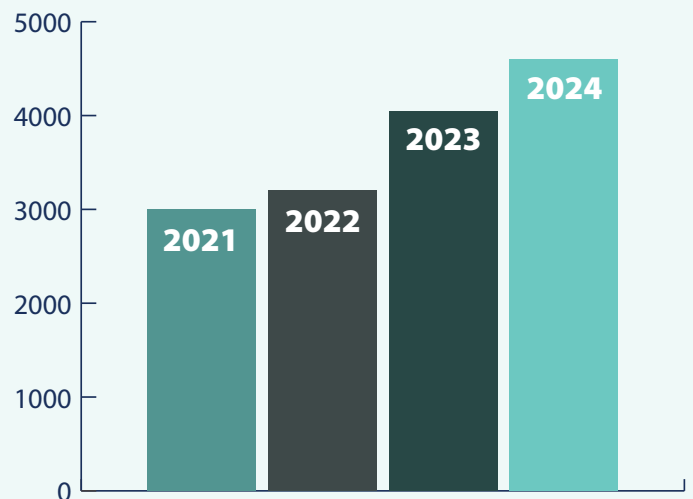
Fraud, waste, and abuse differ mainly by intent and standards:

- » **Fraud** is intentional deception to obtain an unauthorized payment (e.g., billing for services never provided) and is a criminal act.
- » **Waste** is the unintentional overuse or misuse of resources that drives unnecessary costs (e.g., duplicative tests, inefficient processes).
- » **Abuse** is conduct outside accepted medical or business standards that cause unnecessary cost or payment that may or may not be intentional (e.g., medically unnecessary services, upcoding).

Fraud referrals to Medicaid Fraud Control Units (MFCUs) are an important pathway for Medicaid MCOs working to keep their state and federal partners informed and aligned about suspected and actual FWA activity. MFCUs are state-level law enforcement agencies, certified and funded by the federal government, that investigate and prosecute Medicaid fraud. A recent Office of Inspector General (OIG) report found that Medicaid MCOs have steadily increased their fraud referrals each year, rising from just under 3,000 fraud referrals in 2021 to more than 4,600 in 2024.

As joint funders of Medicaid, both the federal government and the states are instrumental in ensuring Medicaid program integrity. As Medicaid's predominant delivery model, Medicaid managed care organizations (MCOs) play a key role implementing Medicaid program integrity that supports and supplements federal and state program integrity efforts. Notably, states partner with Medicaid MCOs for multiple reasons, but one key part is the demonstrated capacity of MCOs to support Medicaid program integrity

Increase in Medicaid MCO Fraud Referrals (2021-2024)



Formal Compliance Program

With capitated managed care as the predominant delivery model for Medicaid services in most states, federal law requires contracted state Medicaid agencies to ensure that Medicaid MCOs implement and maintain robust compliance and program integrity systems. States are also required to contract with External Quality Review Organizations (EQROs) to perform annual independent reviews of MCO performance. At the federal level, CMS reviews and approves state contracts with Medicaid MCOs and monitors state oversight systems and the OIG has jurisdiction to audit and investigate Medicaid MCOs, state agencies, and contractors.

How MCOs are detecting and combating Fraud, Waste, & Abuse

- » **Formal compliance programs** with written policies, procedures, and standards of conduct (42 CFR § 438.608).
- » **Designated compliance teams** including a dedicated compliance officer and compliance committee.
- » **Training** comprised of regular instruction for senior leaders and staff on federal and state standards.
- » **Enforcement** with clear disciplinary guidelines to support consistent compliance.
- » **Monitoring & Auditing** includes ongoing systems to detect, assess, and respond to risks.
- » **Investigation & Remediation** processes to investigate potential issues and implement corrective actions.
- » **Data analyses** incorporated as part of routine reviews and analyses of claims and encounter data.



Provider Screening & Verifications

In compliance with federal policies, Medicaid MCOs screen potential and current network providers and employees to verify they are not excluded from the Medicaid program by HHS/OIG or debarred by federal officials from participating in federal contracts (42 CFR § 438.610). Screening methods include license verification and database checks for criminal history and/or other disqualifying information. In practice, most Medicaid MCO provider screenings and verifications are more robust than the federal requirements including more frequent reviews of provider licensure requirements. In addition, identified discrepancies are often flagged for immediate outreach or temporary suspension from the network pending resolution of the issue.

Robust Data Monitoring & Analysis

Robust data monitoring and advanced data analytics systems enable Medicaid MCOs to identify and prevent payment for extreme quantities of services provided on the same day, medically impossible or unlikely services, and services improperly combined or separated for payment purposes. When anomalies are detected, Medicaid MCOs refer potential FWA to the state Medicaid agency and/or MFCUs while initiating rapid review, provider outreach, and/or a pre-payment hold.

Reporting Requirements & Auditing Protocols

Medicaid MCOs are federally required to have robust auditing protocols in place to monitor, investigate, and report cases of suspected FWA to the state Medicaid agency, the MFCU, or another designated agency (42 CFR § 438.608). Under 42 CFR § 438.602, Medicaid MCOs also participate in state audits of their encounter and financial data for accuracy and completeness at least once every three years. Federal auditors, such as those from the Medicaid Integrity Program (MIP), may also conduct audits of managed care entities.

Some Medicaid MCOs maintain fully staffed Special Investigations Units that conduct proactive data mining, independent investigations, and targeted provider audits. These units may also report suspected fraud directly to law enforcement. Other MCOs deploy investigative teams that conduct multi-visit chart reviews, assess billing system logic, and interview provider office staff when billing patterns raise concerns.

What is an “improper payment”?

The term “**improper payment**” is distinct from, though often discussed in conjunction with, issues of FWA. The Payment Integrity Information Act defines “improper payments” as any payment that should not have been made or that was made in an incorrect amount regardless of whether there is evidence of fraud or intent to deceive. Examples of errors that could lead to improper payments include payments for ineligible services or that had insufficient documentation. Within Medicaid, improper payments are measured and reported through the Payment Error Rate Measurement (PERM) program. Unlike program integrity activities focused on detecting and addressing FWA, improper payment measurement is a statistical assessment of payment accuracy based on a sampling of claims data rather than an investigation of intent or misconduct. Medicaid MCOs consistently demonstrate stronger performance than fee-for-service models in identifying improper payments.



Medicaid MCOs play a critical role as partners in detecting and mitigating FWA in the Medicaid program. Building on federal requirements and working with their state partners, the compliance infrastructure and ongoing monitoring efforts of Medicaid MCOs help safeguard program integrity while protecting enrollees and the fiscal sustainability of the Medicaid program.

