

# Medicaid Program Integrity: Preventing and Addressing Waste, Fraud and Abuse

Medicaid operates under a dual federal-state regulatory structure that prevents, detects and prosecutes fraud.

However, claims of widespread fraud within the program are now being used to [justify](#) policy and regulatory actions that could harm the millions of Americans who rely on Medicaid. The evidence tells a different story: the robust strategies that states and managed care plans use to prevent and detect fraud are limiting the scope of fraud in Medicaid. **While policymakers should explore targeted approaches that can bring further improvements, they must reject proposals that would only hinder fraud-fighting efforts and ensure the program continues to offer access to coverage and essential health care services for the patients and communities who rely on the program.**

## Medicaid's multi-layered approach to program integrity

Medicaid program integrity is a [continuous, multi-layered system](#). Federal agencies set standards, audit compliance and provide oversight, while states implement and enforce federal standards and any additional state standards they wish to put in place. Managed care plans and providers carry out day-to-day integrity work. Independent government entities, such as attorneys general, inspectors general and appeals boards, add further accountability. Each layer reinforces the others.



**Eligibility & Enrollment:** Federal rules require periodic redetermination of every enrollee. States verify citizenship, residency, income and household composition. Since 2009, states have also been required to cross-check enrollment through the federal [Public Assistance Reporting Information System](#) (PARIS), which flags people enrolled in more than one state program.



**Patient & Provider Screening:** States, managed care plans and provider organizations screen and credential every enrolled provider. Managed care organizations, which cover roughly [80% of beneficiaries](#), operate their own program integrity units, investigate suspected fraud and report findings to states.



**Service Verification:** Before claims are paid, services are subject to prior authorization, utilization management or diagnostic criteria to flag non-compliant claims.



**Payment Review & Audits:** Independent recovery audit contractors and post-payment reviews identify overpayments and require providers to return them. Managed care contracts include [Medical Loss Ratios](#) (MLR; minimum spending requirements), and states have the authority to issue financial penalties and terminate non-compliant plans.



**Investigation & Enforcement:** Every state operates a [Medicaid Fraud Control Unit](#) that investigates and prosecutes fraud and works closely with federal partners. State attorneys general, the Department of Health and Human Services (HHS) Office of Inspector General, state inspectors general and fraud hotlines layer additional enforcement.



**Oversight:** The CMS [Medicaid Integrity Program](#) reports annually to Congress and reviews state program integrity. The [Medicaid Integrity Institute](#) trains state program integrity staff.

## Medicaid's program integrity initiatives are working



There were 1,151 convictions and \$1.4 billion in recoveries by state Medicaid Fraud Control Units in FY 2024.



Medicaid's 6.6% spending growth in 2024 was lower than Medicare (7.8%).



There were 300+ state-level convictions and \$80 million in judgments and restitution reported by a single state attorney general's office in recent years.



The HHS Office of Inspector General found that beneficiary fraud was negligible in 2023.



States are modernizing program integrity tools, shifting from reactive claims review to proactive, data-driven fraud detection and prevention.

## Further funding reductions would undermine Medicaid program integrity, not strengthen it

If fraud prevention is the goal, policies that divert resources away from inspector general offices, audit capacity and state integrity staff — and increase administrative burden elsewhere — will undermine the very oversight apparatus that catches wrongdoing.

Policymakers should not invoke waste, fraud and abuse as justification for additional funding reductions, coverage restrictions or administrative barriers in Medicaid. The policy changes and funding reductions advanced by the One Big Beautiful Bill Act (OBBBA) are already negatively impacting vulnerable populations who rely on Medicaid as well as jeopardizing state and community health care systems. Additional cuts justified by claims of rampant waste, fraud and abuse must be opposed.

### Related Resources:

- ✓ **National Association of Medicaid Directors:** State and Territory Medicaid Programs Share the Federal Government's Interest and Urgency around Medicaid Program Integrity
- ✓ **Health Affairs:** Unfounded Fraud Allegations Threaten Vital Medicaid Home And Community-Based Services
- ✓ **KFF:** 5 Key Facts About Medicaid Program Integrity
- ✓ **National Association of Medicaid Directors & Advancing States:** Medicaid HCBS: Support at Home, Life in Community
- ✓ **ANCOR:** Admin Rhetoric On HCBS Services Deeply Concerning