

Medicaid Managed Care: Combatting Fraud, Waste and Abuse



Introduction and Summary

Preventing and rooting out fraud, waste, and abuse (FWA) in health care are core to the mission of health plans, including Medicaid managed care organizations (MCOs) serving more than 2/3 of the nation's Medicaid beneficiaries. FWA diverts critical resources away from the vulnerable populations Medicaid is designed to serve, drives up healthcare costs, undermines taxpayer trust, and threatens the long-term sustainability of one of the nation's most essential public health programs.

Federal and state Medicaid laws and regulations hold Medicaid MCOs accountable to implement compliance programs designed to prevent and detect FWA. However, for MCOs, program integrity is more than a regulatory obligation—it is a core operational feature and embedded in the fabric of managed care.

MCOs serve as critical partners to states in the detection and prevention of FWA. They have robust infrastructure, sophisticated data capabilities, and frontline operational expertise that significantly extend the reach of state program integrity efforts. Through dedicated Special Investigative Units, advanced data analytics, rigorous provider credentialing and screening, and comprehensive compliance programs, MCOs amplify the capacity of state Medicaid agencies by enabling earlier detection, more targeted investigations, and faster referrals to enforcement authorities than state resources alone could achieve. These processes give MCOs a unique vantage point to identify irregular billing patterns, improper payments, and other indicators of FWA while demonstrating measurable value to states. Moreover, unlike many government fee for service systems (FFS), MCOs are well-positioned to adopt new technologies and adapt quickly to emerging trends to target fraud waste and abuse.

In addition to the significant efforts MCOs are already undertaking to combat FWA, the industry is well positioned to continue partnering with CMS, state Medicaid agencies, law enforcement, and others to strengthen these efforts.

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What is FWA? The Centers for Medicare & Medicaid Services (CMS) defines the terms fraud, waste, and abuse as follows:¹

Fraud is when someone knowingly deceives, conceals, or misrepresents themselves to obtain money or property from the Medicaid program. Examples can include providers billing for services that were never actually performed or drugs that were not dispensed, misrepresenting procedures that were performed, or soliciting kickbacks for patient referrals to generate unnecessary costs.

Waste is overusing services or other practices that directly or indirectly result in unnecessary costs to any health care benefit program. This could include conducting excessive office visits, ordering more lab tests than are needed, or prescribing more medications than are medically necessary.

Abuse is when health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program. This could include a provider overcharging for medical services or using billing codes incorrectly to increase the amount of the reimbursement paid by Medicaid.

Types of Medicaid Fraud, Waste and Abuse:

**Billing for Unnecessary
Items or Services**

**Billing for Services
or Items Not Furnished**

Kickbacks

**Medical Identity
Theft**

Medicaid Managed Care Is Aggressively Combating FWA

Requirements on MCOs to Limit FWA

Medicaid MCOs must adhere to a comprehensive set of federal standards designed to combat FWA.^{2,3} Failure to comply with regulatory or contractual requirements may result in significant penalties, loss of contracts, and reputational damage.

For example:

- MCOs are required to have a compliance program guided by written policies, procedures, and codes of conduct that include certain elements. MCOs must have a designated compliance officer and a dedicated committee at both the Board and senior management levels that oversee FWA compliance efforts. MCOs must provide ongoing organization program integrity training to staff and enforce disciplinary guidelines for violations. They are required to implement a system that includes regular internal monitoring and auditing of compliance risks, and prompt responses including investigation and correction of identified issues.
- CMS mandates that MCOs notify states of any potentially fraudulent overpayments and refer other suspected cases of FWA, as appropriate.
- MCOs must have mechanisms in place to verify that billed services have been delivered to enrollees, reinforcing transparency and accountability throughout the process.
- MCOs must participate in state audits of their encounter and financial data for accuracy and completeness at least once every three years.

MCOs are also subject to state rules and oversight.⁴ CMS regulations require state monitoring of MCO compliance with a variety of federal rules. Moreover, individual states can impose additional anti-FWA contractual requirements on MCOs. See, as examples, requirements imposed by New York,⁵ Pennsylvania,⁶ and Texas.⁷

Other Incentives for MCOs to Limit FWA

Given MCOs are compensated through capitated payments, they are inherently incentivized by states to ensure efficient oversight of health care services. When MCOs limit FWA, it brings direct value to beneficiaries and state Medicaid programs by:

- **Improving Quality of Care:** Limiting FWA ensures more resources are available to invest in member health, including preventive services, chronic disease management, and programs that improve health outcomes.
- **Safeguarding Public Trust:** By actively combating FWA and maintaining program integrity, MCOs reinforce trust with members, providers, and government partners. This is vital for long-term success and for fulfilling the mission to serve Medicaid populations.
- **Enabling Reinvestment:** Dollars saved through FWA prevention can be redirected to address priority health needs, expand access to care, and enhance member services, creating a positive cycle of improvement within the Medicaid program.
- **Differentiation in Competitive Markets:** MCOs that demonstrate especially strong controls against FWA and responsible stewards of public funds provide an area of differentiation that may be viewed favorably by states during contract renewals or competitive bidding processes.

MCO Strategies to Prevent and Detect FWA

MCOs employ a variety of methods to prevent FWA from occurring and to detect FWA when it does occur.

Special Investigative Units (SIUs). SIUs play a critical role in MCOs' safeguarding of public funds, ensuring program integrity, and maintaining compliance with federal and state Medicaid requirements. SIUs are dedicated teams responsible for detecting, investigating, preventing, and referring cases of FWA related to Medicaid-covered services with the principal mission of protecting the integrity of the Medicaid program by identifying inappropriate or unlawful activities by providers, members, vendors, or employees.

The SIUs use a variety of methods to prevent and detect FWA, including random and targeted claims audits; data analytics and machine learning to flag high-risk claims for additional review before being paid; education to health care practices on proper billing procedures; and hotlines for beneficiaries and others to report suspected FWA.

Audits. MCOs perform a variety of audits to monitor compliance and assist with identifying potential program violations or overpayment to providers. Audits may involve data matching services billed for reasonableness using available sources (including CMS), in-depth data analysis of inappropriate submission of claims, and evaluating claims data reports to analyze provider utilization and identify unusual trends in weekly, monthly, and yearly patterns.⁸

Data Validation. MCOs systematically review claims, encounter data, and enrollment records to ensure accuracy, completeness, and consistency with covered services. MCOs can identify anomalies such as duplicate billing, services billed for ineligible members, or claims submitted by excluded providers by cross-referencing submitted claims against member eligibility files, provider credentials, and service authorization records which may be indicators of fraudulent activity.⁹ In addition, MCOs use tools such as prior authorization, diagnostic requirements, limits on service types or frequency, and other measures to ensure Medicaid covers only services that are appropriate and aligned with established medical standards.

Routine Provider Screenings. MCOs regularly screen their network providers and provider employees for federal exclusions and debarments. As part of their internal compliance efforts, MCOs review the U.S. Department of Health and Human Services' Office of Inspector General's (HHS OIG) List of Excluded Individuals and Entities (LEIE) as well as the federal System for Award Management (SAM) to protect against excluded or debarred individuals being involved in providing or overseeing Medicaid services. This screening occurs both when providers join the network and on an ongoing basis, helping prevent prohibited individuals from receiving Medicaid payments and safeguarding the MCO against improper payments, penalties, and compliance issues.¹⁰

Provider Training. Provider training is an important tool MCOs use to enhance program integrity. Typical provider education programs include education about core federal statutes that apply to providers, billing and documentation requirements, screening and reporting requirements, and penalties for providers with compliance violations.¹¹

Anti-Fraud Hotlines. Anti-fraud hotlines are regularly used by MCOs as another layer of protecting Medicaid program integrity. These hotlines are available to members, providers and the public as a confidential and anonymous outlet to report suspected FWA activities.

Public-Private Collaborations. Industry-wide, AHIP members participate in public-private collaborations like the Healthcare Fraud Prevention Partnership (HFPP), which brings together federal and state agencies, law enforcement, and other stakeholders to share data and support program integrity efforts.¹²

Responding to FWA

When an MCO identifies potential FWA, it can trigger a range of actions depending on the significance and frequency of the issue. Examples can include targeted re-education or training to help prevent future occurrences, implementation of formal corrective action plans, suspension or denial of payment for affected claims, recoupment of funds through claw-backs, and/or termination of the provider's contract with the plan.¹³

MCOs are required to refer cases involving suspected criminal or civil fraud to the State Medicaid Fraud Control Unit (MFCU) or other appropriate law enforcement agencies. In fiscal year 2025, MFCUs received nearly 30 percent more fraud referrals from MCOs compared to fiscal year 2024 and the number of cases initiated by MFCUs based on MCO referrals increased by five percent.¹⁴ In certain situations, the MCO may also report issues to federal agencies, such as CMS or HHS OIG, especially if the FWA involves broader systemic concerns or cross-state actors. MCOs also maintain detailed documentation of their investigations and actions taken to comply with regulatory requirements and support transparency and accountability.

Collaboration With State and Federal FWA Efforts

MCOs share information with state and federal agencies, participate in audits, and contribute to industry-wide initiatives aimed at improving program integrity and reducing FWA in Medicaid.

For example:

- MCOs receive educational resources and technical assistance from CMS through initiatives like the Medicaid Integrity Program (MIP).¹⁵

- The HHS OIG and the Department of Justice (DOJ) work in partnership with states and MCOs to utilize a variety of actions that identify and eliminate FWA in the Medicaid program.
- In 2024, 144 private payers participated in the HFPP, a statutorily-authorized public-private partnership that includes MCOs, federal agencies, law enforcement, state Medicaid agencies, and other stakeholders.¹⁶ HFPP is designed to help partners move from a reactive to preventive approach to fraud by leveraging a cross-payer dataset that spans the full spectrum of payers and anti-fraud organizations. HFPP data and information-sharing can help prevent FWA, examine emerging trends, and develop key recommendations and strategies.¹⁷

MCOs are active stewards of a Medicaid program that tens of millions of Americans depend on for their health and well-being.

The industry's investments in SIU capacity, compliance infrastructure, data analytics, and law enforcement partnerships reflect a genuine and sustained commitment to ensuring that Medicaid resources reach the patients they are meant to serve.

As states continue to rely on Medicaid managed care delivery systems, MCOs will continue to play a key role in identifying and reducing FWA because of their connection to the day-to-day flow of claims, encounters, and provider network activity. This will include strategies to strengthen "front-end" controls such as credentialing and revalidation, prepayment review, prior authorization guardrails, and provider education and payment integrity audits. In addition, with growing access to near-real-time encounter data, stronger predictive analytics (including machine-learning-enabled outlier detection), and increasingly integrated care-management and pharmacy data, plans will be even better positioned to identify abnormal billing patterns, medically unlikely utilization, and emerging schemes before improper spending becomes widespread.

AHIP and its Medicaid managed care members welcome engagement with CMS, state Medicaid agencies, legislative staff, MFCUs, and stakeholder organizations to advance program integrity solutions that are effective, proportionate, and built on the shared goal of a Medicaid program that works—for beneficiaries, for providers, and for taxpayers.



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Endnotes

- 1 Centers for Medicare & Medicaid Services. "Health Care Fraud and Program Integrity: An Overview for Providers." Citing the Medicaid regulatory definitions at 42 C.F.R. § 455.2. July 2016. <https://www.cms.gov/files/document/overviewfwaprovidersbooklet072616pdf>
- 2 Electronic Code of Federal Regulations. 42 C.F.R. § 438.608. Program integrity requirements under the contract. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-H/section-438.608>
- 3 Electronic Code of Federal Regulations. 42 C.F.R. § 438.602. State responsibilities. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-H/section-438.602>
- 4 NAMD Staff. "Why Did They Do It That Way? Program Integrity." National Association of Medicaid Directors, June 30, 2025. <https://medicaiddirectors.org/resource/why-did-they-do-it-that-way-program-integrity/>
- 5 New York State Office of the Medicaid Inspector General. "Medicaid Managed Care Fraud, Waste, and Abuse Prevention Programs." January 2023. <https://omig.ny.gov/information-resources/medicaid-managed-care-fraud-waste-and-abuse-prevention-programs-guidance-and>
- 6 Pennsylvania Department of Human Services. HC BH Program Standards and Requirements – Appendices. Commonwealth of Pennsylvania, Jan. 1, 2025. <https://www.pa.gov/content/dam/copapwp-pagov/en/dhs/documents/healthchoices/documents/2025-01-01-hc-bh-psr-appendices.pdf>
- 7 Texas Health and Human Services Office of Inspector General. "Special Investigative Units Help Prevent Fraud, Waste and Abuse." Aug. 18, 2022. <https://oig.hhs.texas.gov/about-us/news/special-investigative-units-help-prevent-fraud-waste-and-abuse>
- 8 Medicaid and CHIP Payment and Access Commission (MACPAC). Managed Care Program Integrity. January 2021. <https://www.macpac.gov/subtopic/managed-care-program-integrity/>
- 9 Medicaid and CHIP Payment and Access Commission (MACPAC). Managed Care Program Integrity. January 2021. <https://www.macpac.gov/subtopic/managed-care-program-integrity/>
- 10 Centers for Medicare & Medicaid Services. "The Medicaid Managed Care Plan's Role in Preventing, Detecting, and Reporting Fraud, Waste, and Abuse." U.S. Department of Health and Human Services, January 2016. <https://www.cms.gov/files/document/mcpfactsheet011416pdf>
- 11 Najjar, A. V., Alizamani, L., Zarqi, M., & Hooshmand, E. (2025). A global scoping review on the patterns of medical fraud and abuse: integrating data-driven detection, prevention, and legal responses. Archives of public health. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11831774/>
- 12 Centers for Medicare & Medicaid Services. Calendar Years 2023–2024 Healthcare Fraud Prevention Partnership Biennial Report to Congress. U.S. Department of Health and Human Services, January 2026. <https://www.cms.gov/files/document/cy23-24-biennial-hfpp-report-congress.pdf>
- 13 Centers for Medicare & Medicaid Services. "The Medicaid Managed Care Plan's Role in Preventing, Detecting, and Reporting Fraud, Waste, and Abuse." U.S. Department of Health and Human Services, January 2016. <https://www.cms.gov/files/document/mcpfactsheet011416pdf>
- 14 U.S. Department of Health and Human Services Office of Inspector General. Medicaid Fraud Control Units Annual Report: Fiscal Year 2025. Data Snapshot OEI-09-26-00140. March 2026. <https://oig.hhs.gov/reports/all/2026/medicaid-fraud-control-units-annual-report-fiscal-year-2025/>
- 15 Centers for Medicare & Medicaid Services. "Medicaid Integrity Program." U.S. Department of Health and Human Services. Last modified Nov. 14, 2024. <https://www.cms.gov/medicare/medicaid-coordination/states/medicaid-integrity-program>
- 16 CMS (2026) HFPP Report to Congress
- 17 CMS (2026) HFPP Report to Congress