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Here We Stand

For People. For Care.

For Medicaid.

MEDICAID BRIEF

Supporting the Integrity of Medicaid and the People it Serves

State Fiscal Challenges, Program Integrity, and Waste, Fraud and Abuse

INTRODUCTION

Medicaid covers nearly one in five people in America and accounts for one-fifth of all health care spending. It is a key source of coverage for communities with limited resources. In 2023, Medicaid covered over eight in 10 children living in poverty and of the one in six adults covered, nearly half lived in poverty. Additionally, Medicaid covers a high percentage of persons of color, adults with disabilities, and older adults living in nursing homes. Nearly half of U.S. births are covered by Medicaid. With its outsized healthcare market share and budgetary impact, the Medicaid program attracts policy and regulatory actions designed to improve efficiency, accountability, and outcomes.

State Medicaid programs are currently navigating two significant market and regulatory factors. The first is a heightened focus on program integrity and the second is fiscal pressures. Partnering effectively with Medicaid in this environment demands that social services organizations (SSOs) and community-based organizations (CBOs) understand context, stay current on the administration's oversight actions, and message with intent.

CONTEXT

State Fiscal Climate

Medicaid is jointly financed by the federal government and the states. In this arrangement, states are guaranteed non-capitated federal matching dollars for qualified services provided to eligible enrollees. The federal/state financing partnership was significantly altered during the COVID-19 public health emergency. During the emergency, eligibility requirements were suspended so Americans could benefit from continuous Medicaid coverage. At the same time, the federal government allocated a range of fiscal relief to undergird struggling state economies, including raising the federal Medicaid matching rate.

After several years of budget surplus, states are now experiencing slow revenue growth and rising healthcare costs. The sharp increase in Federal funds flowing to states during FY20–24 has leveled off. The arduous process of redetermining Medicaid eligibility (aka “the Unwinding”) concluded with a higher number of Americans covered by Medicaid than pre-pandemic. With federal aid expiring and enrollment elevated, state Medicaid budgets have grown to upwards of 30% of a state’s expenditure. At the same time, research from the Pew Foundation finds that state “rainy day” funds — a key indicator of fiscal resiliency — have experienced their first decline since the Great Recession of 2009.

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In an already tenuous fiscal climate, H.R.1, the One Big Beautiful Bill Act (OBBBA), adds pressure with new expenses and restrictions on revenue. OBBBA requires Medicaid eligibility be checked every six months rather than annually, doubling staff effort and increasing cost. OBBBA adds new work reporting requirements for adults covered through Medicaid expansion via the Affordable Care Act, which demand states build entirely new systems for oversight and tracking. At the same time, OBBBA restricted two financing levers some states use to fund Medicaid. The law bans new or higher health care provider taxes, and state-directed payments generated via Medicaid managed care plans are now capped at a lower rate. To help soften the negative impact of Medicaid cuts on rural hospitals, H.R.1 established the Rural Health Transformation Program which brings limited funds to all states and a limited number of additional competitively awarded funds.

State Legislative Session

With a tightening fiscal climate, states will legislate to cut costs and address revenue deficits. Lutheran Services in America network leaders should anticipate a high level of state legislative activity related to Medicaid to address new requirements and shortfalls wrought by H.R. 1. Ten state legislative sessions closed at the end of CY2026 quarter one, two states have biannual legislative sessions, and several states have special sessions. Keep abreast of the legislative calendar here via the National Conference of State Legislatures.

Medicaid Program Integrity

Program integrity is a long-established function of the federal/state Medicaid partnership. It is built on a chassis of oversight, data and analysis, and procedural fairness which creates a shared toolbox for prevention, detection, and correction. The known cases of waste, fraud, and abuse are a small proportion of Medicaid spending, and the full scope is not known. For context, the Medicaid and CHIP Payment and Access Commission (MACPAC) estimates that in 2024 waste fraud and abuse accounted for less than 1% spent on the Medicaid program that year.

While Medicaid is currently experiencing a highly publicized and, in some cases, politicized focus on waste, fraud, and abuse, the commitment to program integrity is nothing new. Building an efficient, impactful, and accountable Medicaid program requires differential understanding and attention on waste vs fraud vs abuse. Criminal fraud is different from poor or sloppy program administration and is remediated differently. (See call-out box on definitions.)

Medicaid agencies have an array of program integrity tools in their toolbox which are deployed to either prevent or address criminal fraud and abuse. According to the National Association of Medicaid Directors (NAMD), practices include:

- eligibility process reviews,
- embedding oversight levers in Medicaid managed care contracts,
- rigorous provider credentialing processes,
- establishing utilization management standards to address types and frequency of services,
- standardized documentation and billing for services,
- post-payment reviews and audits, and
- required participation in Public Assistance Reporting Information System (PARIS) cross-state data checks of duplicate benefits or services.

Each state has a Medicaid Fraud Control Unit (MFCU) that works collaboratively with the federal Office of the Inspector General (OIG) and elevates fraud and abuse appropriate for prosecution and penalties. The OIG generates public, Congressional reports detailing convictions and financial recoveries that stem from MFCU/OIG actions.

States use a range of policies and strategies to reduce waste, improve operational performance, and bring down costs in the Medicaid program. Again, according to NAMD strategies include: Medicaid managed care accountability designed to avoid improper payments; value-based payment arrangements that build accountability to care outcomes rather than service volume; strategies to bring down spending on prescription drugs which is the largest driver of Medicaid costs; and embedding automation into eligibility redetermination — a key lesson learned during the Unwinding.

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Definitions

The Code of Federal Regulations describes fraud and abuse as criminal acts as summarized below. Waste is regularly bundled with concerns over fraud and abuse and therefore merits description.

Abuse: Describes *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.

Fraud: Describes 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.

Waste: Describes *inappropriate utilization of services* and misuse of resources. Rising healthcare costs combined with year over year Medicaid program growth drive a focus on eradicating preventable and unnecessary expenditures (e.g. duplicate tests). Waste is not a criminal or intentional act and therefore is not defined in the CFR regulating Medicaid.

ADMINISTRATIVE ACTIONS

The Fraud Narrative

H.R.1, the budget reconciliation bill known as the One Big Beautiful Bill Act (OBBBA) which was passed in July 2025, included seismic changes to the Medicaid program. OBBBA enacted an 11% cut in Medicaid spending — the largest reduction in the program's history — and the largest share of spending cuts in the bill overall. Alongside restrictions in eligibility, OBBBA included provisions to address program integrity that when taken together projected a claimed savings of over $1 trillion across a decade. A significant and misleading argument deployed to garner Congressional support for vast Medicaid cuts was the existence of rampant waste, fraud, and abuse within the program. So began a fraud narrative that has continued to be both highly publicized and the anchor for regulatory action by the Centers for Medicare and Medicaid Services (CMS).

The “War on Fraud”

In the State of the Union address on February 24, 2026, President Trump announced a “war on fraud” conducted by the Task Force to Eliminate Fraud chaired by Vice President Vance. Trump suggested that recouping fraud losses would counterbalance the federal budget deficit — currently just under $2 trillion. Both CMS and the House of Representatives have since taken action in the “war on fraud” by ramping up oversight of state Medicaid programs.

Officials from the Government Accountability Office (GAO) testified before Congress regarding findings of $100 billion of improper Medicaid and Medicare payments in FY23 and their recommendations to enhance program integrity. Testimony drew from GAO reports dating from 2008–2024; officials highlighted steps CMS has taken to address program integrity and recommended actions not yet taken. The House Energy and Commerce Committee has sent program integrity inquiries to a first wave of 10 Democrat-led states. CMS has launched the Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative. A recent CRUSH RFI provided a 30-day window for public comment about potential anti-fraud rulemaking and other initiatives across Medicare, Medicaid, CHIP, and the ACA Marketplace.

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In the first quarter of 2026, CMS exercised its program integrity enforcement authority in two different ways:

1. Deferral: CMS enacts a temporary pause on federal payment of prior state claims while conducting a review of those claims. The deferral may/may not be converted into a formal disallowance based on findings.

2. Withholding: In cases where CMS finds a state substantially out of compliance, they withhold future federal Medicaid matching payments until the state comes into compliance. In both the retrospective and prospective enforcement, states have the opportunity to appeal and readjudicate findings.

Tracking Administrative Actions

Lutheran Services in America has a pulse on federal actions taken against state Medicaid programs to combat purported waste, fraud, and abuse. Members can stay abreast of program integrity topics in the biweekly Capitol Communications newsletters and monthly Capitol Conversations webinars. Missing any of these resources? Sign up for Lutheran Services in America communications.

Medicaid Services Under Scrutiny

Through its recent oversight actions, CMS has consistently sought to scrutinize certain areas:

- behavioral health,
- home- and community-based services (HCBS), and
- autism-related services.

The use of these services is on the rise nationwide, making them a target for federal scrutiny. As discussed below, increased utilization among underserved populations or as a byproduct of redirected services does not constitute fraud.

In the case of HCBS, there has long been a concerted bipartisan effort at "rebalancing" long-term services and supports for people with disabilities and older adults away from institutional settings and toward home- and community-based settings. In the case of autism services and housing services for people with mental health conditions and/or substance use disorders, states have spent the last decade attempting to fill a known gap for these historically underserved populations. The result has been exponential growth and increased spending in services like Applied Behavior Analysis (ABA) therapy designed to help people with autism improve communication and daily living skills via positive reinforcement. ABA's rapid spread may have outpaced guardrails for quality and utilization and led to a co-occurring need to better monitor quality and outcomes.

In this context, increased utilization alone should not be considered evidence of criminal fraud. CMS has also focused scrutiny on non-emergency medical transport. The service is notoriously difficult for state Medicaid agencies to provide and is largely sourced from small, decentralized providers adding to oversight challenges. Use our ***Here We Stand*** Messaging and Action Guide to address these challenges.

Championing HCBS

Lutheran Services in America strongly supports home- and community-based services for its economical and bipartisan approach. HCBS allow seniors and people with disabilities to live safely at home. HCBS growth reflects decades of bipartisan federal and state efforts to shift funding from expensive institutional care to more cost-efficient community-based care. Defunding HCBS isn't a solution, it's a cost shift; it pushes the financial burden onto family caregivers and communities.

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