STATES SHOULD SUSPEND PAYMENTS



TO FRAUDULENT MEDICAID PROVIDERS

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Key Findings

1. Medicaid is plagued by improper payments and fraud, with improper payment rates **EXCEEDING 20 PERCENT.**

2. Federal regulations require state agencies to suspend all payments to providers upon credible allegations of fraud, **BUT STATES OFTEN ALLOW THEM TO CONTINUE BILLING.**

3. The Trump administration has overseen a crackdown on Medicaid fraud, **BRINGING CHARGES AGAINST HUNDREDS OF DEFENDANTS.**

4. Medicaid Fraud Control Units (MFCUs) are supposed to investigate fraud, bring charges, and recover lost funds, **BUT THEY HAVE FAILED IN THEIR MISSION.**

5. States should require Medicaid agencies to suspend payments to providers credibly accused of fraud, prohibit managed care organizations from paying providers that would be suspended in fee-for-service, and require Medicaid agencies to report all credible allegations of fraud to the MFCU for investigation.

The Bottom Line

States should enforce Medicaid fraud suspensions.

Overview

For decades, Medicaid enrollment and costs have grown at an unsustainable rate.[1] In 2024, total Medicaid spending was $964 billion, up from just $206 billion in 2000.[2] As costs have grown, so have improper payments and fraud. Since 2003, Medicaid has been on the Government Accountability Office's list of high-risk programs, with at least $37 billion in improper payments in 2025, more than any program except for Medicare.[3]

However, this estimate of improper payments is just the tip of the iceberg. Each state reports its Medicaid improper payments only once every three years, and from 2020 to 2023, normal eligibility reviews and improper payment tracking were suspended due to the pandemic.[4] Additionally, improper payments and fraud related to managed care plans at the provider level are not included in the calculation at all.[5]

The true improper payment rate is likely much higher, at an estimated 20 to 25 percent of payments.[6]

Estimates of fraud specifically are difficult to establish.[7] Massive fraud operations that have been allowed to continue unchecked for years do not show up in accounts of improper payments, and typically fraud can only be accounted for after it is uncovered and investigated.[8] A recent government-wide estimate found that fraud costs the government as much as $521 billion annually, equal to seven percent of all federal spending.[9]

In Medicaid, federal regulations require states to stop payments to providers that are credibly accused of fraud, but this is rarely enforced.[10] States are responsible for fielding reports of potential fraud and determining the correct course of action, and often allow providers to continue billing even when fraud is suspected.[11] There are similar provisions for managed care organizations, which receive a monthly payment from the state agency per Medicaid enrollee and use those fees to pay providers for services.[12] States and the federal government have even less visibility over fraud by providers in managed care plan networks since the managed care organization has the responsibility to detect and report fraud.[13]

States can crack down on fraud by requiring Medicaid agencies to suspend payments to providers immediately when there is an allegation of fraud and to refer all credible allegations of fraud to the MFCU for further investigation.

Fraud by Medicaid providers is widespread

Medicaid provider fraud occurs when providers bill for services that are not necessary, bill for services not actually provided to patients, use stolen patient identities to file claims for services provided to other people, or provide kickbacks or bribes to enrollees for requesting services that are not needed.[14]

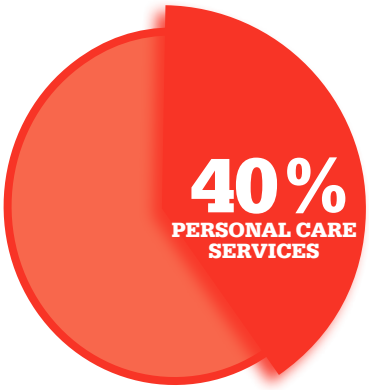
The Medicaid program has all of the elements that provide a ripe environment for fraud and has been a high-risk program for decades.[15] These factors include rapid program growth, state agency administration of federal funding, and lax eligibility verification.[16] Within Medicaid,

personal care services carry the highest risk of fraud, with 38 percent of fraud convictions in 2025 stemming from this type of provider.[17]

In recent years, state and federal investigations have uncovered countless cases of Medicaid fraud.

- In New York, there was a $38 million fraud scheme involving billing for social adult day care services that were medically unnecessary and never provided.[18]
- A review of autism support services funded by Medicaid in Maine found $45.6 million in improper payments.[19]
- A program in Minnesota that used Medicaid dollars to fund housing for enrollees racked up more than $100 million in charges in just one year, most of which were suspected to be fraudulent.[20]
- In Colorado, an audit found that 100 percent of sampled payments related to autism services were flagged as improper or likely improper, at a cost of $285 million.[21]
- A $49 million fraud scheme in Virginia bribed homeless individuals by offering them hotel stays in exchange for using their information to bill Medicaid for crisis stabilization services that they never received.[22]
- In Ohio, fraudulent billing for personal care services has cost Medicaid an estimated $1.2 billion.[23]

NEARLY FOUR IN 10 FRAUD CONVICTIONS INVOLVE PERSONAL CARE SERVICES



Source: U.S. Department of Health and Human Services

Managed care plans have long been a blind spot for improper payment and fraud reviews.[24] Routine improper payment reviews related to managed care only capture payments made by the state to managed care plans, not payments to service providers for enrollees.[25] For example, improper payment reviews related to managed care plans verify whether the payment was made in the correct amount based on the demographic information of the enrollee.[26] However, these reviews will not uncover instances of managed care plans paying providers for services never rendered.[27]

Despite serving 75 percent of Medicaid enrollees and accounting for more than half of Medicaid spending, managed care plans make fewer referrals of provider fraud than the fee-for-service program.[28] Most state contracts with managed care plans require suspected fraud to be reported, but there is little training and few resources devoted to uncovering provider fraud within managed care networks, and scant oversight by the state to ensure the referral requirement is being implemented.[29]

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States routinely allow providers suspected of fraud to continue to bill Medicaid

Federal regulations require states to suspend payments to providers suspected of fraud.[30] An allegation of fraud is considered to be credible if the state agency has examined the facts and determined that the allegation is believable—evidentiary proof of wrongdoing is not required.[31] The allegation can come from any source, such as a fraud hotline, a suspicious pattern spotted by data analytics, lawsuits, audits, or law enforcement actions.[32]

Despite these requirements, suspicious providers routinely slip through the cracks. **A review by the Office of Inspector General for the Department of Health and Human Services found that 41 of 56 state Medicaid agencies imposed 10 or fewer provider suspensions due to allegations of fraud within one year.**[33]

Recently, 3,000 providers were suspended in Minnesota due to suspected fraud.[34] However, the state is allowing the providers to continue billing Medicaid while the providers appeal.[35] An audit in Florida found that the state Medicaid agency did not suspend payments to providers in 54 out of 95 credible allegations of fraud while they were under active investigation.[36] In the last five years, California has imposed only 97 payment suspensions for credible allegations of fraud, and issued 339 good-cause exceptions to the requirement to suspend providers in the same period.[37]



Source: California Department of Health Care Services

In Maine, there were multiple audits that found one provider to be overbilling Medicaid dating back to 2015.[38] Despite multiple investigations and audits demonstrating clear patterns of overbilling, the state Medicaid agency did not suspend the provider until December 2025, allowing more than $1.7 million in improper payments to occur.[39]

The Trump administration has made progress in fighting Medicaid fraud

The Trump administration has led a historic crackdown on fraud across all federal programs, including Medicaid.[40] In June 2026, the National Health Care Fraud Takedown, a multi-agency coordinated effort, led to charges against nearly 300 defendants involved in cases that totaled more than $518 million in false claims in the Medicaid program alone.[41] The Centers for Medicare & Medicaid Services (CMS) suspended more than 1,000 providers as part of the same crackdown.[42]

As part of the government-wide anti-fraud efforts, CMS undertook an initiative to crush fraud in Medicare and Medicaid, prioritizing stopping fraud in its tracks rather than chasing down

fraudulent payments years later.[43] In 2025 alone, this initiative yielded more than $4.1 billion in savings in Medicaid and the Children's Health Insurance Program.[44]

Investigations into Medicaid fraud in Minnesota led to the suspension of more than $550 million in Medicaid payments related to suspected fraud.[45] Additionally, CMS has withheld more than $2 billion from California over suspected fraudulent charges against Medicaid.[46]

The administration has also used data analytics to identify suspicious patterns and stop fraud before it happens, saving taxpayer dollars up front instead of chasing them down later.[47] These efforts uncovered a $67 million Medicaid scam in Illinois, in which a provider submitted claims for more than 500 hours of therapy services per day, which was well above the capacity of the provider even if all staff were working 24 hours per day.[48]

The federal efforts to prevent fraud are an important first step. But more must be done to stem the tide of taxpayer dollars flowing to criminals.

Medicaid Fraud Control Units have the power to investigate and stop fraud but have been ineffective

MFCUs operate in all 50 states, the District of Columbia, and two territories and are supposed to be the frontline force fighting provider fraud in Medicaid.[49] These units are jointly funded by states and the federal government, and their performance is monitored by the Office of Inspector General for the Department of Health and Human Services.[50] However, across the country, MFCUs have been failing in their mission.[51]

From 2019 to 2025, Medicaid spending skyrocketed, rising by 68 percent.[52] Over the same time period, funding for MFCUs rose by 40 percent.[53] However, despite the increase in funding, fraud recoveries fell when adjusted for inflation, and the numbers of open investigations, indictments, and convictions all plummeted.[54] More than one-third of MFCUs recover fewer funds than they receive in grants, and for every $1 billion in Medicaid spending, only 15 investigations occur.[55]

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In New York, the MFCU reported zero open investigations for more than half of provider types—including high-risk providers such as hospice.[56] For every $1 billion in Medicaid spending in the state, the MFCU achieved 0.1 indictments.[57] Due to these failures, the federal government recently suspended funding for the New York MFCU.[58]

In California, 98 percent of enrollees receive Medicaid through a managed care organization.[59] However, just three percent of referrals to the MFCU came from managed care, and only five of the 26 managed care organizations operating in the state made any referrals at all.[60]

To successfully crack down on provider fraud, states need functioning MFCUs to promptly investigate credible accusations of fraud, bring charges, and recover lost funds. A crucial step in fixing the broken Medicaid fraud enforcement process is ensuring that states refer providers for investigation.

States should immediately suspend payments to providers suspected of fraud

State Medicaid agencies and managed care plans have a responsibility to take prompt action when a health service provider is credibly suspected of fraud. Upon receiving an accusation of fraud by a provider, state agencies should immediately suspend payments to the provider while the case is being investigated.

To hold all providers in the system accountable, states should mandate that managed care plans suspend payments to providers that meet the criteria for suspension under fee-for-service and require managed care plans to refer providers suspected of fraud for investigation.

States should require Medicaid agencies to refer providers credibly suspected of fraud to MFCUs for investigation, and states and the federal government should hold MFCUs accountable for actually investigating and bringing charges.

The Bottom Line:

States should enforce Medicaid fraud suspensions.

The Trump administration is leading an unprecedented crackdown on fraud across all federal programs, including Medicaid. However, states are the first line of defense against Medicaid fraud, as they are responsible for administering the program. It is vital that states suspend providers suspected of fraud and ensure that allegations are promptly investigated and that charges are brought when appropriate.

Every Medicaid dollar that is wasted on fraudulent schemes is a dollar not spent on the truly needy. When providers are allowed to bilk the system for years, collecting millions of taxpayer dollars for personal gain, the truly needy who are left waiting for services are the ones who pay the price.

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