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Medicaid Fraud and Its Systemic Impact on U.S. Healthcare Access and Cost

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Abstract

Within the United States, Medicaid fraud is a white-collar crime that involves providing false information to obtain Medicaid benefits or payment for services that are illegitimate or unnecessary. This criminal act is not a victimless crime. Around 80 million Americans, an estimated one in five people, rely on Medicaid to cover a range of services that include but are not limited to preventive care, hospital stays, and prescription drugs (FamiliesUSA, 2025). The costs associated with Medicaid fraud are passed on to the greater population that utilizes the program in the form of increased health insurance premiums, exposure to counterproductive medical procedures, and can increase taxes (FBI, 2016). In order to ensure the long-term integrity of the Medicaid program, administrators must continuously update their respective detective strategies. This article, through the investigation of healthcare fraud detection systems and methods, explores the best sustainable intervention methods for combating fraud along with the most effective avenue for healthcare administrators to take regarding implementation. In examining the pre-existing research on detection strategies, the current state of data analytics, compliance, prevention partnerships will be summarized. From these findings, potential recurring gaps in the effectiveness of solutions will be identified to outline the current needs of implemented practices. The article will conclude with evidence-based recommendations and strategies for healthcare systems to follow regarding collaboration, technological solutions, and transparent reporting.

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An Introduction to the Issue

Established through Title XIX of the Social Security Act of 1965, Medicaid's intended purpose is to provide health coverage for low-income individuals and families. Originally, it began as a federal-state program where states received federal funds to aid in the medical coverage of their eligible residents. As the years have passed, the program has expanded with eligibility and benefits playing an important role in the U.S. healthcare system as a whole. For example, in states that have expanded Medicaid to reach more households, the uninsured rate dropped from 35% to 15% between 2013 and 2022 for low-income non-elderly adults (Harker & Sharer, 2024). Prior to Medicaid programs, the U.S. healthcare system mostly consisted of a combination of private insurance, charity care, and fee-for-service (Mosely, 2008). Today, Medicaid is instrumental in improving health outcomes, financial stability, and access to care for eligible individuals nationwide. However, despite Medicaid's intended mission, fraud threatens its sustainability and public trust.

Medicaid fraud is defined as knowingly submitting false information to the Medicaid program for the purpose of receiving unauthorized payments or benefits. There are several types of Medicaid fraud which can be split into provider examples and beneficiary examples. Types that solely concern the provider include billing for unnecessary services, billing for multiple procedures when only one is required (unbundling), and billing for services at a higher level of complexity than provided (upcoding) (Centers for Medicare & Medicaid Services, 2016). Types that can involve both beneficiaries and providers include collaborating to file false reimbursement claims (collusion), altering a drug prescription to obtain for illegal use (drug diversion), duplicating Medicaid ID cards, and knowingly providing or collecting incorrect eligibility information. Among these types, provider fraud is the most common with the subcategory of billing for services not provided being the most common scheme (Brown, 2025).

These immoral acts have greater consequences on everyone in the United States who receives some form of healthcare, regardless of if they directly benefit from Medicaid programs or not. For instance, fraud can lead to higher premiums and out-of-pocket for both insurance companies and policy holders as a result of inflated claims. Medicaid fraud artificially increases the overall cost of care when providers bill for more expensive services than provided (upcoding), double-bill for the same service, or bill for services not rendered (phantom billing). This causes insurers, both private and government funded, to unnecessarily pay for more for claims. In the long run, in order to offset inflated claim payments and maintain profitability, insurance companies transfer the incurred increased costs onto policy holders in the form of increased premiums. For example, Centene Corporation, one of the leading providers for government-sponsored healthcare, received $620 million in duplicate Medicaid payments with the total amount across all insurers

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reaching $4.3 billion (Wilson, 2025). In response, Centene had to repay states about $2 billion. To account for the loss in revenue, Centene adjusted its pricing strategies and raised premiums on plans in multiple states, resulting in a higher cost of healthcare.

In addition to affected premiums, taxes can be altered as well. Due to the fact that Medicaid is funded by taxpayers, increased costs due to fraud means that more tax revenue is required to support the program. For example, in 2012, the state of Illinois enacted a $1 per pack cigarette tax in part to address the state's Medicaid funding crisis (The Civic Federation, 2012). Impacting the care experience of Medicaid beneficiaries', changes in taxpayer funding can lead to longer wait times, fewer available providers, and can reduce who qualifies for the program in the first place (American Hospital Association, 2025). Additionally, to aid in the coverage of fraud-related losses, the government may sometimes be forced to cut services in other areas. These services include but are not limited to treatment for chronic conditions, home-based care for senior citizens, and support for people with disabilities (Miller, 2025). Essentially, Medicaid fraud upends the healthcare system and leads to consequences for both taxpayers and those who pay insurance premiums.

Application of Solutions

Data Analytics

Although the issue of Medicaid fraud continues to remain within our country, there are several solutions and strategies for interventions that healthcare administrators can adopt to sustainably combat fraud. Current Medicaid fraud detection strategies employ a combination of both traditional and modern approaches in order to protect a program's financial wellbeing and reliability. Key strategies include data analytics with predictive modeling, internal compliance, and data sharing collaboration (Waiver Consulting Group, n.d.). For the first mentioned approach, healthcare organizations can analyze data related to billing and claims in order to identify unusual patterns that are indicators of fraud. This technique can help to identify anomalies that deviate from typical internal patterns, predict where future fraud may occur, enable prompt investigation as anomalies occur in real time, and aid in the automation of fraud detection. For example, through the use of data analytics the Department of Justice's (DOJ) Healthcare Fraud Detection Unit uncovered a slew of doctors who gave patients an abnormally large amount of back pain injections (Wong, 2024). In total, 16 people in Michigan and Ohio (including 12 physicians) were sentenced in 2022 for their roles in submitting more than $250 million in false claims and illegally distributing more than 6.6 million opioid pills (Wong, 2024). Without the use of analytics, it would have taken investigators a longer period of time to catch the perpetrators.

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Compliance

In regard to the internal control and compliance strategy, organizations involved in Medicaid billing have implemented safeguards to help deter and detect fraud within an organization. This can look like and is not limited to educating staff on Medicaid billing regulations, regularly auditing billing processes, and establishing concise policies that emphasize ethical billing practices. The Centers for Medicaid and Medicare Services, through the Medicaid Alliance for Program Safeguards, has compiled these ethical principles into a guideline. This guideline explains the essential elements of a compliance program consisting of a high level of oversight, clear lines of communication, corrective actions, and employee training that is continuous (Centers for Medicare & Medicaid Services, 2002). Within the past decade, there have been several Medicaid organizations that have put the strategies described above into practice. For instance, Kaiser Permanente utilizes a Segregation of Duties (SoD) policy that requires that no single employee shall control all aspects of a critical process (Kaiser Permanente, 2024). In short, someone who authorizes a Medicaid bill cannot also process payments or reconcile accounts. Another organization, the Optum division of UnitedHealth Group, provides mandatory Fraud, Waste, and Abuse (FWA) training to ensure that its employees are equipped with the tools to properly detect fraud (OptumRx, 2025). The effectiveness of the policies and training provided can be seen in the Minnesota Department of Human Services internal fraud training program which has saved them $800,000 annually (Legislative Audit Commission, n.d.).

Collaboration

Lastly, in reference to data sharing collaboration, strengthened partnerships between federal and state agencies for the purpose of coordinating investigations have also been employed. Several states have made use of Medicaid Fraud Control Units (MFCUs) wherein states prosecute Medicaid provider fraud and patient abuse with the help of federal funding and oversight. As a result of this partnership and its implementation in all 50 states, in 2023 MFCUs across the country recovered $1.4 billion in revenue with 1,151 convictions and 1,042 exclusions from federally funded health programs (U.S. Department of Health & Human Services, 2024). Other interagency collaborations, such as those that take place between private insurers and federal investigators, have also been a staple when it comes to combating fraud. For instance, 2019's operation Double Helix saw the National Health Care Anti-Fraud Association (NHCAA), a group of private insurers, partner with federal investigators in order to take down fraudulent entities. In the end, 35 individuals were charged for over $2.1 billion in losses (U.S. Department of Justice, 2019). By fostering opportunities for insurers and government entities to work together, detection and enforcement can more easily be made large-scale.

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Recurring Barriers & Limitations

As stated in the previous section, fraud detection strategies can take many forms which include but are not limited to data analytics with predictive modeling, internal compliance, and data sharing collaboration. While the implementation of these measures have been instrumental in ensuring that Medicaid resources are used properly, there is still room for improvement. A 2018 study conducted by the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG) on weaknesses in Medicaid managed care organizations (MCOs) found that recurring limitations in identifying fraud include few referral of fraud cases, a lack of reporting on corrective actions, an inadequate recovery of overpayments, and weak coordination between state entities (U.S. Department of Health and Human Services, 2018). Additionally, MCOs who take actions against those who are suspected of fraud do not always inform the State. This lack of information sharing may limit the States' ability to effectively address trends in Medicaid abuse as they are unable to monitor the providers in question across the state's Medicaid programs. As stated by HHS, "coordination, collaboration, and communication" can assist Americans in receiving "more efficient, high quality health programs", underscoring the importance of state-federal coordination (OIG-HHS, 2022). Furthermore, inconsistent provider screening is also a hindrance as some states do not conduct comprehensive background checks prior to enrolling providers into Medicaid. A 2016 audit by the Office of the Inspector General found that 22 states did not verify all of the required exclusion databases (U.S. Department of Health and Human Services, 2018). This is crucial because a lack of attention allows for previously banned individuals to gain access to Medicaid funds, putting both billions of dollars and honest patients at risk.

Conclusion

In order for healthcare administrators and organizations to effectively reduce Medicaid fraud, they must strengthen their external partnerships through continued solution sharing. By improving communication and collaboration between agencies, both the awareness and availability of best practices for safeguarding Medicaid could be more widespread. Organizations may also learn helpful tips from one another due to each entity presumably possessing years of experience within the field of Medicaid. Without the adequate sharing of information, newly recognized solutions to fraud will not reach their potential impact within the healthcare industry. Furthermore, increased use of real-time data analytics can prove to be beneficial as fraud schemes continue to evolve. The benefits of utilizing a system like such can be seen in the Pennsylvania Department of Human Services' use of AI-focused fraud detection. Implementing the Fraud Capture system in 2023, they were able to identify outlier billing patterns which lead to the termination of 325 providers and $33.7 million in savings (Commonwealth of Pennsylvania,

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2025). This example highlights the importance of utilizing advanced analytics to its fullest degree. Lastly, transparent reporting on Medicaid fraud metrics by both MFCUs and MCOs alike can help administrators identify the practices that are and are not working to their fullest potential. Key performance indicators of fraud detection systems can include the total number of dollars recovered, the amount of time taken for fraud to be detected, the amount of false positive/negative rates (Anny, n.d.). With the suggested recommendations on improving detection interventions, the widespread practice of Medicaid fraud in the United States will face strengthened opposition. However, without proper management, the negative effects of fraud will continue to exist in the form of increased healthcare costs, waste of taxpayer dollars, and a pervasive culture of corruption. Given the harmful societal implications at play, it is crucial for healthcare administrators and policymakers alike to continue to update prevention strategies in a manner that is both effective and sustainable.

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