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Crackdown on Medicaid and Medicare fraud means health systems need to prepare for heightened compliance scrutiny

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<https://www.chartis.com/insights/crackdown-medicaid-and-medicare-fraud-means-health-systems-need-prepare-heightened>

The Buzz This Week

This week a fifth state has come under scrutiny as the Trump Administration broadens its crackdown on healthcare fraud, waste, and abuse.

Florida must now submit information about how it identifies, prevents, and addresses fraud in the Medicaid program. Federal investigations are also underway for California, New York, Maine, and Minnesota, which is facing an unprecedented deferral of \$259.5 million in Medicaid payments.

The sweeping initiative to reduce misuse of federal healthcare resources allows the Centers for Medicare & Medicaid Services (CMS) to prospectively defer or withhold payments when it suspects fraud. The burden of proof falls on the states and healthcare organizations.

Recent actions include:

- **The White House announced a national task force** this week to investigate fraud allegations in federally funded public benefit programs, including ones that provide medical care, housing, food, and cash assistance. The task force covers both Medicare and Medicaid, though early enforcement actions appear more heavily focused on Medicaid program integrity.
- **The House Energy and Commerce (E&C) Committee earlier this month launched a congressional investigation in 10 states**, alleging Medicaid fraud. A previous committee hearing had called out specific services, including applied behavior analysis, non-emergency medical transportation, laboratory

services, and home and community-based services, citing billing complexity and limited real-time oversight.

- **CMS announced in February a broader crackdown on Medicaid and Medicare fraud**, shifting toward more proactive prevention. This effort includes real-time detection tools, enhanced program-integrity actions, and a request for stakeholder input on tackling fraud prevention.
- **The recent federal investigation into Minnesota Medicaid program fraud** has led to freezing provider enrollment and potential withholding of up to \$515 million in quarterly funding until the state submits an acceptable corrective action plan. Minnesota has filed a lawsuit to release the funds while legislators advance a state-level anti-fraud package.

While past administrations have targeted fraud, the US Department of Justice (DOJ) filed a record number of fraud lawsuits against healthcare companies in 2025. The growing use of AI and advanced technologies is also strengthening enforcement, leading to more investigations and subpoenas that require providers to explain billing and coding patterns and other potential data outliers.

Why It Matters

This more aggressive enforcement environment is leading to heightened compliance requirements across the healthcare industry.

The federal government is moving toward a broader strategy of pre-payment controls, enrollment restrictions, audits, and False Claims Act (FCA) enforcement. As a result, health systems and hospitals will face higher expectations around documentation, coding accuracy, vendor and provider screening, and oversight capabilities.

Even when federal action is aimed at states, providers are likely to feel the impact through tighter state-level oversight. This could come through more aggressive managed care and agency audits, increased controls on participating providers, and new administrative requirements.

As regulators and payers shift toward more front-end prevention, hospitals and health systems are likely to see more upfront documentation and data requests, as well as prospective payment delays tied to program reviews.

These requests are especially likely in high-cost services for which spending has risen in recent years, such as home health, autism services, behavioral health, durable medical equipment, laboratory testing, and some post-acute services. Both CMS and the DOJ have signaled continued focus in these service lines, citing elevated fraud risk due to spending growth, complex documentation requirements, and the widespread use of outside agencies and contractors.

Because fraud reviews often hinge on diagnosis capture and utilization trends, health systems should expect heightened scrutiny of employed and affiliated physician behavior, especially related to physician documentation, referral relationships, and variation across providers. This may be particularly relevant for

health systems that rely on large multi-specialty groups or contracted physician organizations.

For many hospitals and health systems, meeting these heightened expectations will require increased investment in compliance infrastructure. This includes expanded internal audit capacity, enhanced coding reviews, provider education, stronger credentialing controls, and advanced analytics tools.

Providers should consider actions to strengthen program integrity and proactive prevention capabilities, including:

- Enhance documentation and coding accuracy
- Expand internal auditing, claims monitoring, and rapid remediation capabilities
- Deploy analytics tools to detect anomalies
- Strengthen provider credentialing and oversight processes
- Increase provider education and training
- Improve oversight of third-party vendors and billing partners
- Monitor regulatory updates to align policies and procedures

As federal and state scrutiny of healthcare spending intensifies, program integrity and compliance capabilities will become an increasingly important operational priority.

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