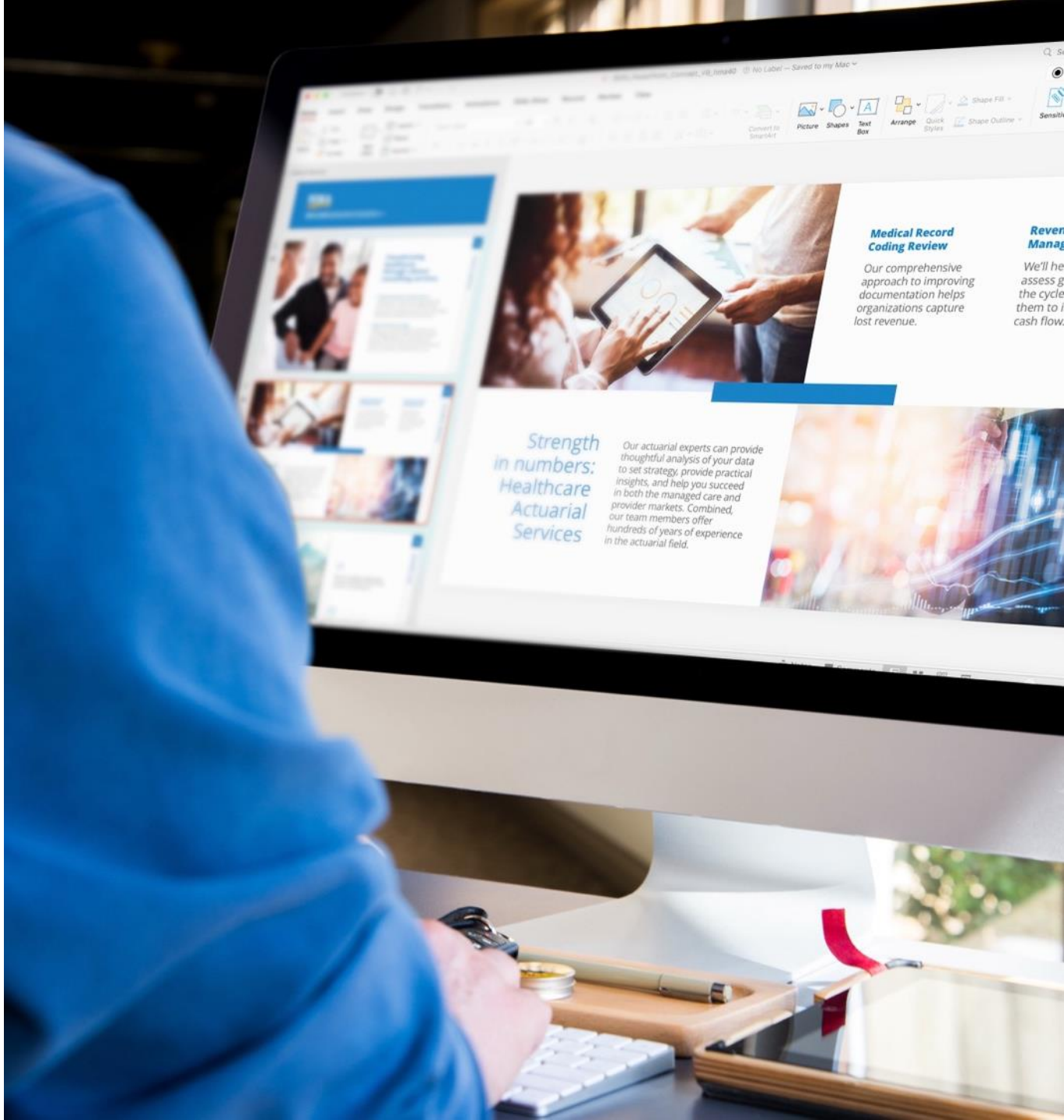
HMA

Summer Webinar Series:

How New Program Integrity Expectations Affect Medicaid Payments

August 2026



Summer Webinar Series

- The Future of Medicaid State Directed Payments
- Understanding Work and Community Engagement Requirements and New Section 1115 Guidance
- How New Program Integrity Expectations Affect Medicaid Payments

Access all three webinars here:

Federal legal and regulatory changes are driving seismic changes across healthcare, with significant implications for Medicaid

The combination of statutory changes enacted through OBBBA and subsequent federal guidance is reshaping Medicaid financing, eligibility, oversight, and waiver policy, creating simultaneous strategic, operational, and financial implications across the healthcare system.

KEY DRIVERS OF CHANGE

Eligibility & Coverage

- Community engagement
- Redeterminations and retention
- Eligibility operations

Medicaid Financing & Reimbursement

- State directed payments
- Provider financing
- Managed care payment policy

Program Integrity & Oversight

- Fraud, waste, and abuse requirements
- Compliance and reporting expectations
- Federal oversight

Waiver Policy & Innovation

- Section 1115 guidance
- Budget neutrality expectations
- Demonstration strategy

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Program Integrity Is Entering a New Era

Federal agencies' expectations for oversight, payment accuracy, provider accountability, and audit readiness are requiring health plans, states, and providers to rethink how program integrity is designed, managed, and measured.

Strategic Shift in Expectations

From Compliance to Enterprise Accountability

- Program integrity is no longer the accountability of a single department. Success requires coordinated governance across operations, finance, compliance, provider management, analytics, and clinical functions.

From Retrospective Reviews to Real-Time Risk Management

- Organizations are increasingly expected to identify vulnerabilities before they become audit findings, recoveries, or public concerns. Data-driven oversight is becoming a core management capability.

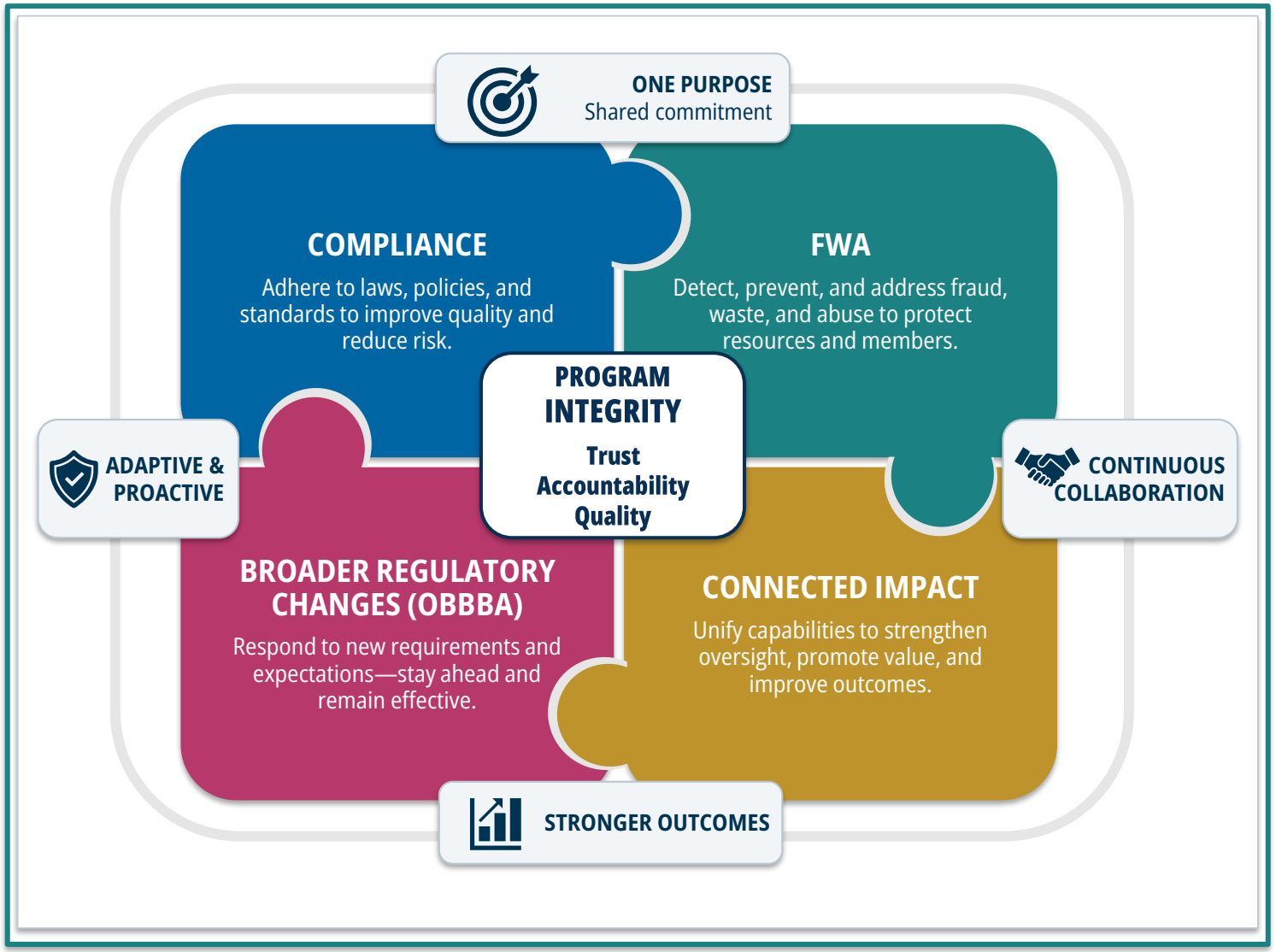
From Program Protection to Enterprise Performance

- Effective program integrity protects more than payments. It strengthens provider oversight, improves operational efficiency, maintains regulatory confidence, and safeguards resources that support member care.

Challenge:
Building a program integrity capability that can withstand heightened oversight while protecting financial and operational performance.

Success:
Treating program integrity as a strategic capability, not a compliance requirement.

Program Integrity Requires Connected Capabilities



As expectations evolve, organizations can no longer manage compliance, provider oversight, payment integrity, analytics, investigations, and operations as independent activities.

The strongest programs connect these capabilities through shared governance, integrated data, and coordinated decision-making.

Federal FWA Scrutiny is Accelerating

Five major **federal developments point to a sharper program integrity environment**, with growing emphasis on provider oversight, data-driven detection, payment recovery and state and plan accountability.

CY 2027 Home Health Prospective Payment System

Expands CMS authority to recover improper payments and revoke noncompliant providers.

Federal Actions Target State Medicaid Programs

CMS, HHS OIG, and/or Congress have initiated action towards 13 state Medicaid programs (WA, OR, CA, CO, NE, MN, FL, PA, HI, NY, MA, VT, and ME)

Provider Revalidation Directive

CMS directed states to rapidly revalidate providers identified as high risk for fraud, waste, abuse, and corruption and submit enhanced oversight strategies within 30 days

Nationwide Medicare Enrollment Moratorium

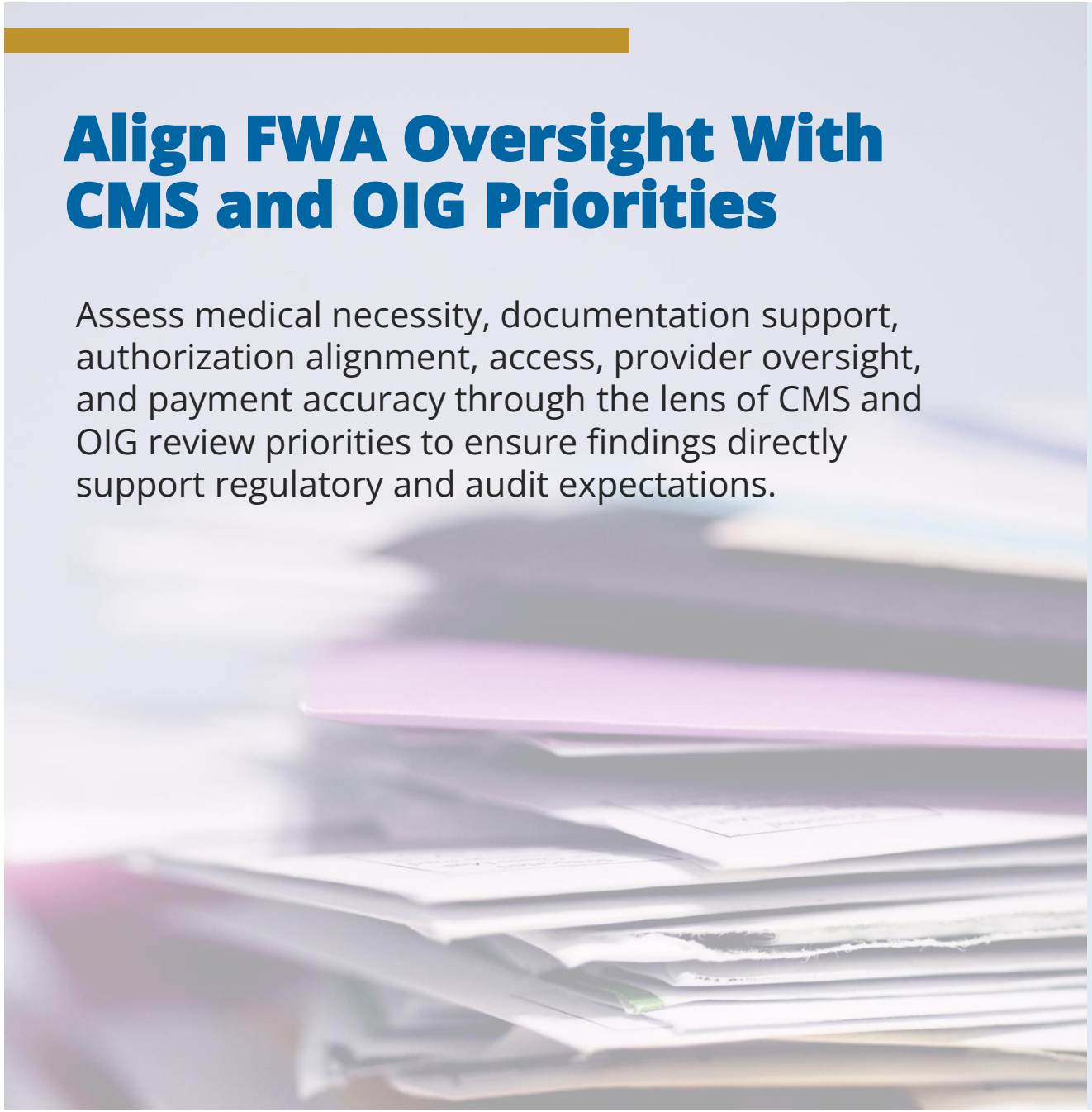
CMS is pausing new enrollments and certain ownership changes for select provider types while expanding investigations, analytics, and enforcement activities targeting suspected fraud

FY 2027 Hospice Wage Index and Payment Rate Update Proposed Rule

Creates a public Hospice Service and Spending Variation Index (SSVI), to identify hospice providers with potentially atypical utilization and spending patterns

Align FWA Oversight With CMS and OIG Priorities

Assess medical necessity, documentation support, authorization alignment, access, provider oversight, and payment accuracy through the lens of CMS and OIG review priorities to ensure findings directly support regulatory and audit expectations.



NEMT

Review trip eligibility, medical necessity, provider billing, and payment-rule alignment; validate trips against member access needs and service records.

DME

Test medical necessity, prior authorization, supplier patterns, and rental-versus-purchase billing for documentation support and payment accuracy.

Laboratory

Focus on ordering patterns, medical necessity, code selection, and claim edits to identify unsupported testing, duplicate billing, and payment inaccuracies.

Pharmacy

Review NDC, prescriber, pharmacy, and PBM data for formulary, utilization, contract, and payment-accuracy issues.

HCBS

Match EVV, authorization, plan-of-care, and claims data to confirm services were delivered, documented, and billed within CMS program-integrity expectations.

Behavioral Health & ABA

Review treatment-plan support, service intensity, provider credentials, and episode patterns for medical necessity, documentation, and access safeguards.

High Dollar Claims

Validate outlier claims against records, authorization, coverage, coordination of benefits, and itemized billing before recovery or corrective action.

Program Integrity Requires Advanced Compliance Capabilities

Established FWA and compliance programs have been built, but enhanced regulatory focus on FWA introduces new complexities that will require states, plans, and providers to go beyond traditional methodologies.

Capabilities Have Already Built

- Compliance program infrastructure (CMS, state requirements)
- Risk adjustment and coding programs
- Special Investigations Units (SIU)
- Audit response and reporting processes
- Vendor oversight frameworks

New Complexities Across Programs

- Cross-program compliance (Medicare Advantage, Medicaid, DSNP, ACA, SNP)
- Increasing audit frequency and depth (RADV, OIG, state audits)
- Advanced analytics required for FWA detection and prevention
- Integrated data across claims, encounters, and clinical sources
- Real-time monitoring and proactive compliance management

Mitigation to Remediation

Payment integrity generally relies on three core pillars: **mitigating** errors before payment, **monitoring** discrepancies using data, and **remediating** improper disbursements after the fact.

Mitigate

- **Mitigation** is the most cost-effective layer, aimed at stopping improper payments before claims are paid (pre-payment).

Monitor

- **Monitoring** uses advanced data analytics to identify complex FWA patterns that bypass initial automated claims systems, analyzing data both real-time and retrospectively.

Remediate

- **Remediation** focuses on recovering overpayments, completing provider education or corrective action plans. In addition, root causes should determine next steps such as system edits, policies, or additional governance.

Mitigation to Remediation

Mitigation

- Pre-service Reviews
- Automated Edits
- Provider Support

Monitor

- Data Analytics
- Real-time Monitoring
- Retrospective Reviews

Remediate

- Post-payment Recovery
- Feedback Mechanisms
- Payment Suspensions (Health Plans)

Healthcare organizations can use these steps to mitigate fraud, waste, and abuse while avoiding costly recovery efforts.

Strengthening the operational front line of program integrity, FWA, and compliance requirements

Healthcare organizations operating Medicare, Medicaid, and Marketplace programs face increasing pressure to strengthen FWA oversight while navigating evolving regulatory requirements and growing financial risk.

Core Readiness Focus Areas

Pillar	What Plans Need to Do	Why It Matters
Risk Identification and Stratification	**Identify high-risk providers,** members, claims patterns, and program vulnerabilities	Assessments translate data into actionable insights that help plans focus resources on the highest-value opportunities while balancing financial impact, compliance risk, member and provider experience.
Compliance and Governance	**Strengthen policies, oversight structures**, and delegated entity management	Defining governance, accountability, escalation pathways, and performance metrics move payment integrity from fragmented activities to a coordinated enterprise capability.
Data and Systems Integration	**Align claims, encounter, clinical, and vendor data** for accurate reporting and monitoring	Aligned systems and analytics ensure that operationalized workflows, case queues, and decision support tools enable payment integrity, FWA, billing, and SIU teams to act efficiently and consistently.
FWA Detection and Investigation	**Enhance analytics,** SIU workflows, and case management capabilities	Ensure investigations and enforcement actions are defensible, efficient, and compliant.
Monitoring and Reporting	**Track audit outcomes,** compliance KPIs, and financial impacts	Ongoing tracking enables plans to identify operational risks early and support proactive management and continuous improvement.

End-to-End Program Integrity, Compliance, and FWA Lifecycle

Flexible, modular solutions aligned to the program integrity lifecycle, enabling states, plans, and providers to focus investment where risk and opportunity are greatest.

Assess	Plan	Implement	Monitor
Program Integrity Risk Assessment, Financial Exposure Analysis, and Audit Readiness Evaluation	Program Integrity Strategy and Operating Model Design	Program Integrity and SIU Operational Transformation	Continuous FWA Monitoring and Risk Scoring
Organizational Capability and Governance Assessment	Governance, Policy, and Compliance Framework Development	Advanced Analytics and Payment Integrity Implementation	Audit Support, Recovery Tracking, and Performance Monitoring
Data, Analytics, and Reporting Capability Assessment	Prioritized Roadmap and Audit Readiness Strategy	Provider Oversight, Enrollment, and Compliance Enhancement	Compliance Reporting, Dashboards, and Continuous Improvement

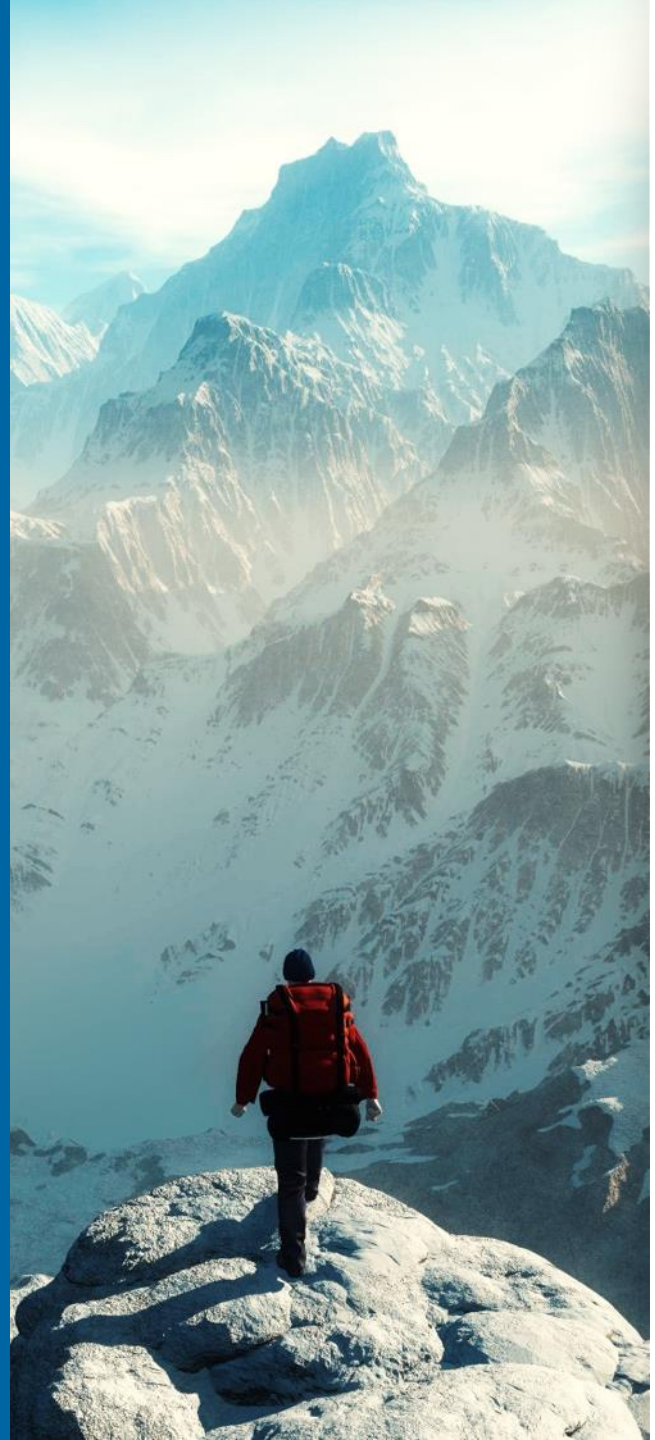
Transforming Program Integrity through Medicaid Enterprise Modernization

Opportunities to create predictive, data-driven models

Current State		Future State
Fee-for-Service (FFS): EDI and MMIS claim editing Encounters: EDI Editing	→	FFS: EDI, Pre-Pay, MMIS claim editing Encounters: EDI Editing
FFS: Manual pre-payment review process	→	FFS: Pre-payment review improved through automation and enhanced functionality
FFS: Slow legacy system update lifecycle	→	FFS: Timely claim edit updates through post-pay to pre-pay informed edits
FFS/Encounter: Post payment review process of submitted claims and encounters	→	FFS/Encounter: Post Payment review process enhanced by AI and advanced models

All states are having issues with fraud.

The key to stronger Program Integrity is a proactive approach, increasing transparency, and improving provider accountability.



01

Post-pay detection allows fraud to **continue for months**, often with high recoupment failure rates

02

Investigations are **manual**, **slow**, and **reactive**, resulting in high fraud cost and low deterrent effect

03

Traditional pre-pay edits fall short of program outcomes — focused primarily on billing errors instead of fraud, and often dependent on an elongated claims engine enhancement process.

Program Integrity Approach

Multiple Points of Identification
Data and System Modernization
Comprehensive Approach

Assess	Plan	Implement	Monitor
Current-state Assessment, MES Modernization Program Evolution, and Mainframe/MMIS Limitations	Business Process Changes and Technology Improvement and Modernization	Data Flow Architecture and Modeling, Recommendation to Include Multiple Approaches and Techniques	Pre- and Post-payment Review Process – Transition from Manual to Automated, Tool-driven Approach
Traditional Fraud Detection Gaps, Provider Moratorium	Future-state Operating Model and Limitations on Providers Established	Data-driven Pre-Pay Fraud Detection and Modernized Adjudication Process, Emphasis on Proactive Identification	Operational Performance Monitoring and Business Process Modifications to Existing Procedures
Business Drivers and Technology Drivers, Short Term vs. Long Term Strategy	Communication and Stakeholder Alignment and Mitigating Provider Abrasion	Implementation Scope and Solution Deployment – Program Integrity Modules (Pre- and Post-Payment, Provider Enrollment Fraud Detection, Core System Improvements including EDI)	Improvement of Service Delivery from Department and Feedback Loop for Ongoing Optimization

Assessment and Advisory Support: Establishing a Clear, Enterprise-Wide View of Program Integrity Risk

Context for Leaders: Public programs face growing scrutiny—requiring strong governance, defensible controls, and proactive oversight.

Value Proposition: Delivering an objective assessment of program integrity, payment integrity, compliance, and investigative capabilities across public program through a prioritized, actionable roadmap that strengthens compliance, reduces improper payments, and enhances audit readiness

1	2	3	4	5
Governance	**Operations**	**Analytics**	**Regulatory**	**Integration**
Structure and oversight	Provider, payment, and investigations	Detection, scoring, and monitoring	Federal and state alignment	Claims, compliance, and vendors

Implementation Support: Translating Strategy Into Measurable Compliance, Operational, and Financial Impact

Context for Leaders: Assessment alone does not reduce risk. Organizations must operationalize improvements across governance, workflows, systems, and analytics.

Implementation Approach: A phased, practical model that accelerates readiness while minimizing operational disruption

Phase 1: Compliance and Governance Stabilization

- Strengthen governance, policies, and oversight controls
- Establish performance metrics and accountability structures
- Prioritize "quick-win" initiatives to reduce immediate risk exposure

Phase 2: Operational and Technology Enablement

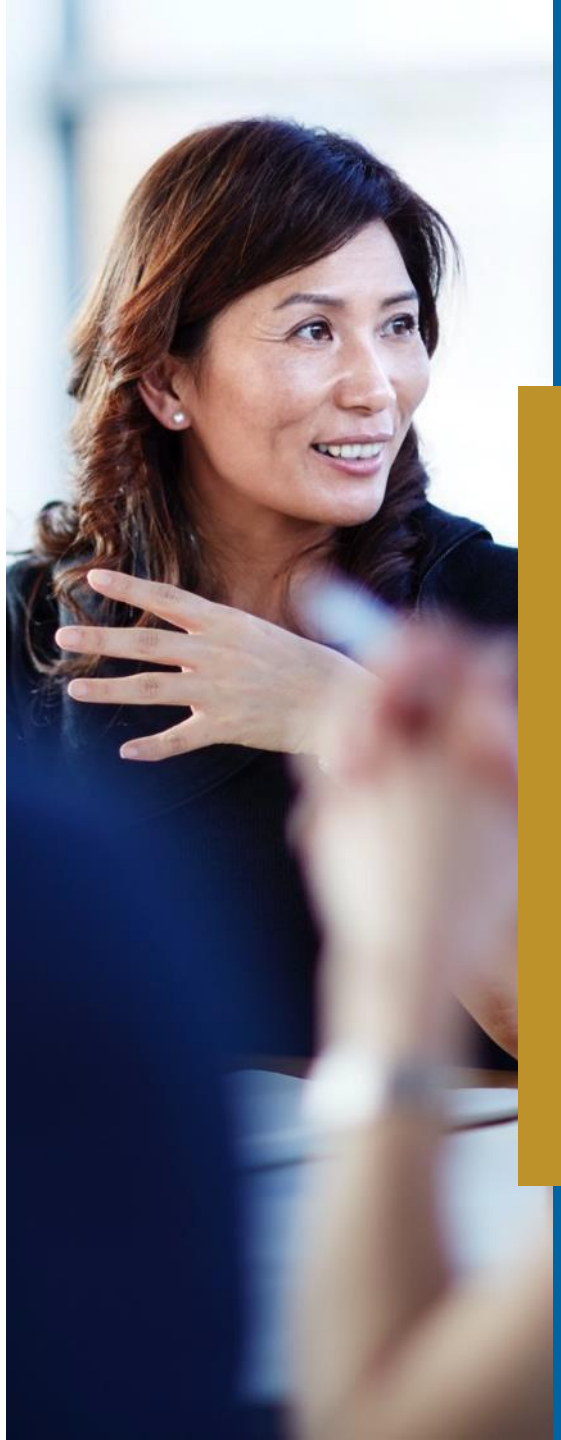
- Redesign PIU/SIU workflows, provider monitoring, and payment integrity processes
- Implement enhanced analytics, reporting, and risk-scoring methodologies
- Improve pre- and post-payment review processes and case management

Phase 3: Sustainability and Continuous Improvement

- Organizational change management and staff training
- Ongoing maturity assessments and compliance readiness reviews
- Continuous improvement framework to adapt to emerging fraud schemes

Drive faster readiness while helping protect financial and operational performance.

States, plans, and providers can protect revenue, maintain compliance, and strengthen operational performance across public programs.



Reduce audit exposure by improving payment accuracy, coding, and reporting

Enhanced FWA detection and prevention effectiveness

Strengthen compliance across programs and products

Accelerate enterprise-wide program integrity maturity

Questions?

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