MEDICAID PROGRAM INTEGRITY

CRUSH Medicaid Fraud

A Call to Action Informed by State and Federal Leaders

Booz Allen x 4L

CMS has made prevention the cornerstone of Medicaid fraud oversight. Leveraging their CRUSH fraud initiative, CMS is moving program integrity from pay-and-chase to stop-and-caught.

Booz Allen Hamilton and 4L Data have spent the past few months in conversation with state and federal program integrity leaders. This brief summarizes themes from those discussions and presents approaches for consideration across revalidation, detection, and investigation. Individual contributions are not attributed.

$41.9B
MEDICARE

$4.1B
MEDICAID & CHIP

FY2025 program integrity savings reported by CMS — the highest return on record, and the case that prevention works at scale. [1]

Dynamic Fraud. Continuous Prevention.

No single approach stops fraud. Stopping it takes continuous insight into every NPI's behaviors, relationships and patterns — NPIs are easy to obtain, and fraud actors may bill under dozens of numbers and aliases. Here's what we heard will make the most impact.

01 Accelerate Provider Revalidation

> States are tasked with developing two-year revalidation strategies, prioritizing high-risk providers — including those without an NPI — and moving toward continuous verification of provider legitimacy.

THE BARRIER

Cadence cannot outrun bad data. More frequent review depends on reliable data. Licensure, ownership, affiliations, and sanctions can change between cycles. CMS's Data Exchange System already supports sharing Medicaid terminations and Medicare revocations. States still need to reconcile those records with other sources and provider identities. The implementation question is how to make relevant changes visible and actionable within existing enrollment workflows.

WHAT WORKS

Verify provider information against authoritative and independent sources, rather than relying solely on provider self-reporting. Monitor for changes as source updates become available, record their provenance and effective dates, and prioritize issues for review. Risk stratification can help direct resources toward providers requiring closer examination, while provider intelligence adds context to claim-level oversight.

02 Leverage Advanced Data and Technology

> States are being asked to leverage AI, machine learning, and predictive analytics to shift from reactive recovery to pre-payment prevention, with provider data monitored daily and status changes flagged in real time.

THE BARRIER

When analytics rely on delayed data, opportunities for pre-payment intervention narrow. Some schemes become clearer through relationships among ownership, addresses, referrals, and billing patterns. Reviewing those signals together can reveal risks that isolated claim checks miss. Shared attributes can also have legitimate explanations, so findings require context and validation.

WHAT WORKS

Combine rules, anomaly detection, and relationship analysis to surface patterns for review, including patterns not anticipated by existing rules. Before payment action, evaluate evidence and risk scores through defined review procedures. Use documentation requests where appropriate, alongside existing adjudication. Measure false positives, review turnaround, and payment delays to protect legitimate providers and beneficiary access.

03 Strengthen Investigative Handoffs and Collaboration

> States are encouraged to conduct rigorous handoff reviews, establish performance metrics, and improve coordination among managed care organizations, state agencies, and law enforcement.

THE BARRIER

Detection creates value only when teams can assess and act on referrals. More alerts can increase backlogs when review capacity is limited. Incomplete evidence and fragmented case information can require investigators to repeat work. Coordination also depends on knowing when related matters are already under review, within applicable information-sharing limits.

WHAT WORKS

Technology should assemble the evidence, map the relationships and tee up the decision, so a handoff is a change of hands rather than a rebuild. A shared analytic environment across program integrity and fraud control units makes referral quality measurable and duplication visible. Automate what is mechanical; keep human judgment where consequences require it, and use technology designed to increase first-line investigative throughput to case decisions by 20X or more — fast enough to investigate at the speed fraudsters are using technology to build new schemes.

THE COMMON THREAD

Continuous, Not Periodic

State and federal program integrity leaders agree that monitoring needs to be continuous and actionable. Claims do not commit fraud; providers do. The provider is the one actor present in every program, every claim type and every scheme — and provider information changes continuously while oversight today is largely static, capturing change only at discrete points in time.

> **Verifying data more often is not enough. The requirement is to revalidate continuously, analyze continuously, and audit continuously.**

Commercial payers already act in seconds. Public programs work inside timelines that do not compress, so speed alone isn't the answer. The operative word is not faster. It is continuous.

Booz Allen Hamilton and 4L Data are working with state and federal program leaders on practical paths to immediate and continuous compliance — from provider monitoring and pre-payment detection to shared analytic environments for fraud control units.

TO LEARN MORE

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[1] CMS, Center for Program Integrity, *CMS Reports Highest Program Integrity ROI Ever Recorded*, May 2026. FY2025 Medicare program integrity savings of $41.9B (up 59% from $26.3B in FY2024, a $22.3-to-1 return) and FY2025 Medicaid and CHIP savings of $4.1B. cms.gov/fraud

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