Elevance Health | Public Policy Institute

Executing Payment Integrity through Medicaid Managed Care

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Contents

Key Takeaways

- Through a combination of front-end payment controls, provider engagement, analytics, and targeted investigations, managed care organizations (MCOs) equip Medicaid programs with a comprehensive payment integrity infrastructure to support fraud, waste, and abuse (FWA) priorities.
- MCOs can shift payment integrity upstream from retrospective recovery to prevention, with Elevance Health-affiliated Medicaid plans achieving approximately $75 per member per year (PMPY) in cost avoidance from front-end controls in 2025.
- By integrating analytics, claims and medical record review, provider interviews, and coding expertise, the majority of FWA investigations across Elevance Health-affiliated Medicaid plans originate through internal detection capabilities, with plans partnering with government partners when further investigation is warranted.

Overview

Safeguards that assure Medicaid payments are accurate, timely, and compliant with federal and state rules are often referred to as payment integrity and are part of broader program integrity strategies to combat fraud, waste, and abuse (FWA).

Although each state approaches payment integrity somewhat differently, all share the same goal: ensuring that Medicaid funds are used to support the health-related needs of the 70 million beneficiaries enrolled in the program.[1]

Medicaid managed care organizations (MCOs) have adopted a proactive and analytics-driven approach to payment integrity where the framework prevents, detects, and recovers improper spending of Medicaid funds. This paper provides an overview of Elevance Health's comprehensive payment integrity efforts and offers additional considerations for further standardization and collaboration between state Medicaid agencies, federal regulators, and MCOs.

Background

Payment integrity ensures that Medicaid funds are paid in the correct amounts to the right care providers and beneficiaries for appropriate services that are covered by the program.[2]

Payment integrity requires preventing and correcting all types of improper payments, including over- or underpayments arising from simple administrative errors as well as cases of FWA (Figure 1).

Figure 1
Defining Fraud, Waste, and Abuse

Fraud		"An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit… It includes any act that constitutes fraud under applicable Federal or State law"[3]
Waste		Practices that, directly or indirectly, result in unnecessary costs to the Medicaid program such as overusing services. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.[4]
Abuse		"Practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care."[5]

Between 2019 and 2024, prevented and recovered FWA payments made up 0.18 percent of state Medicaid spending and 0.34 percent of federal Medicaid spending. Although a small share of total spending, these savings are significant, totaling $1.38 billion in state spending and $1.54 billion in federal spending in 2024 alone.[6]

Most of these improper payments arose from administrative, technical, or clerical errors. Insufficient documentation, specifically, was the cause of 74 percent of all Medicaid payment errors.[7] For these reasons, among others, federal and state policymakers have prioritized Medicaid payment integrity, emphasizing the need to prevent FWA and improper payments while preserving access to and quality of care for Medicaid beneficiaries.[8]

MCOs play an important role in payment integrity. By federal law, contracts between MCOs and state Medicaid programs must outline requirements for how MCOs will detect, report, and address recoveries of improper payments, including referring cases to Medicaid Fraud Control Units (MFCUs) as necessary.[9] States must also audit MCO financial data, encounter data, and compliance with larger program integrity requirements. Likewise, states and MCOs must screen care providers seeking network participation and provide them with the proper supports to submit their claims accurately.[10] MCOs also have the flexibility to invest in additional payment integrity resources, such as staffing and technology, to advance these efforts.

Elevance Health's Approach

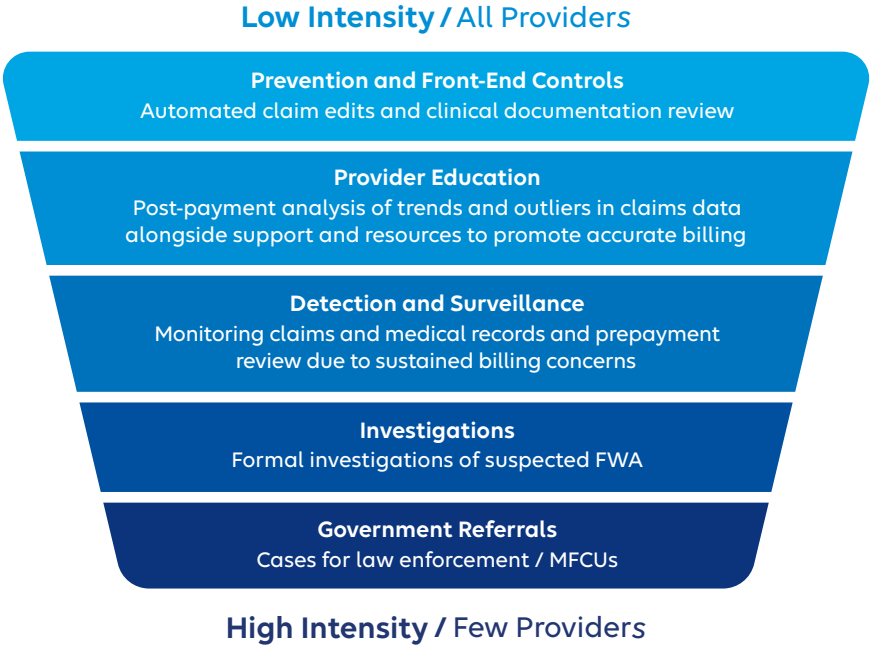
The greatest opportunity to protect Medicaid resources lies in preventing inaccurate or inappropriate payments before claims are paid—rather than recovering improper payments after they occur.

Effective programs achieve appropriate payments while maintaining timely access to care for members and minimizing unnecessary administrative burden for care providers. Medicaid MCOs are well positioned to accomplish these aims through efforts that integrate clinical review, provider engagement, and investigative capabilities across the entire claims lifecycle.

Elevance Health has developed a comprehensive payment integrity framework that successfully prevents, detects, and recovers inappropriate spending by emphasizing front-end controls for prevention and provider engagement along with detection, surveillance, and investigation of FWA (Figure 2). Rather than relying primarily on retrospective recovery efforts, this approach applies multiple layers of clinical expertise, advanced analytics, automation, and provider engagement to identify potential issues as early as possible.

Figure 2

Payment Integrity Framework



Note. FWA = Fraud, Waste, and Abuse. MFCUs = Medicaid Fraud Control Units.

Prevention and Front-End Controls

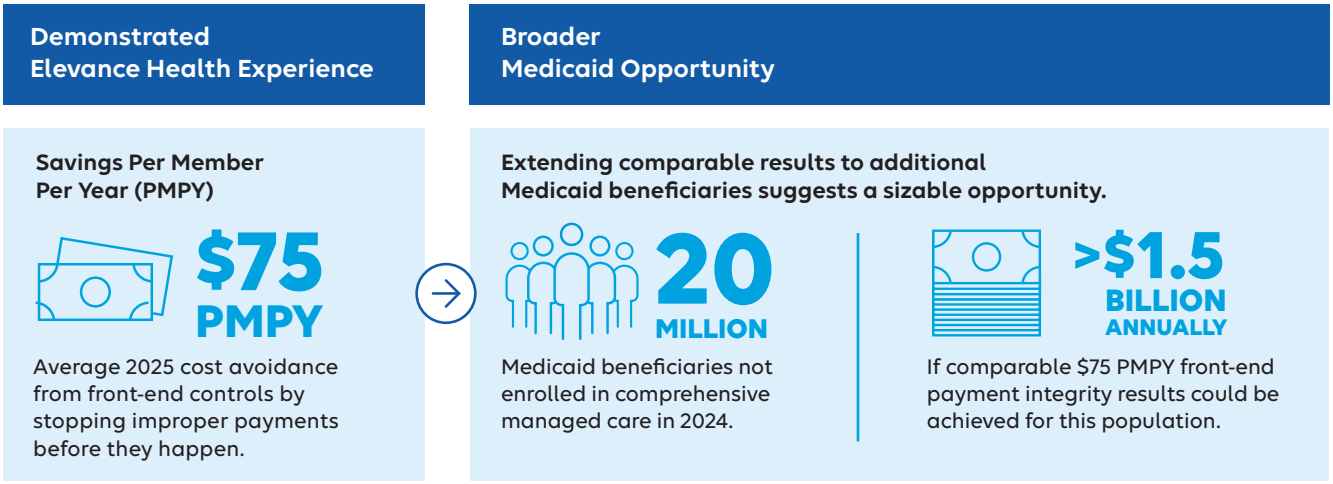
The first layer of Elevance Health's payment integrity framework focuses on preventing improper payments before claims are paid. By resolving straightforward billing and coding issues upstream, more resource-intensive payment integrity activities can be focused on higher-risk care providers and more complex cases involving potential FWA. Prepayment controls improve payment accuracy, reduce provider abrasion associated with post-payment recoveries, and allow payment integrity resources to concentrate on the relatively small number of claims that require clinical review or investigation.

Coordination of benefits (COB). Federal COB policy reflects Medicaid's role as payer of last resort, requiring programs to identify liable third parties before Medicaid funds are expended. Therefore, a foundational component of Medicaid payment integrity is management of COB, which ensures claims are paid by the appropriate responsible party (including Medicare, commercial insurers, and other liable third parties). Through a combination of data-driven identification, automation, and expertise among COB staff, other insurance coverage is identified and validated to determine the primary payer responsible before Medicaid funds are expended.

Claim edits. Claims are subjected to a comprehensive series of automated edits designed to identify billing inaccuracies and apply payment policies at the point of submission. These edits address correct coding requirements, contract provisions, claims administration rules, clinical and reimbursement policies, nationally recognized coding standards, and customized business rules developed to address emerging FWA risks. The scale of these front-end controls is substantial: In 2025, Elevance Health-affiliated plans saved an average of approximately $75 per member per year (PMPY) by preventing improper payments before they occurred. Applying the observed $75 PMPY cost avoidance to the approximately 20 million Medicaid beneficiaries not enrolled in comprehensive managed care suggests a sizable opportunity. If comparable front-end payment integrity results could be achieved for this population, the resulting cost avoidance could exceed $1.5 billion annually (Figure 3).[11]

Figure 3

Savings Through Preventing Improper Payments



Medical review. When warranted, medical records are reviewed to verify that services were appropriately documented, coded accurately, medically necessary, and consistent with accepted clinical standards and state Medicaid policies. When providers do not include any required supporting clinical documentation with a claim, Elevance Health's internal data systems automatically retrieve available medical records, reducing manual provider outreach and eliminating unnecessary delays associated with requesting documentation after claim submission. MCO's automated processes can accelerate claim adjudications while reducing administrative burden for both care providers and health plan staff.

Prepay audits. Claims that require further clinical evaluation undergo prepayment audit and coding review by certified coding specialists and clinical professionals. Elevance Health reviews over 500 of these audits per month on average, reducing financial risk while improving payment accuracy, regulatory compliance, and operational efficiency.

Finally, advanced data analytics complements these front-end controls by continuously evaluating claims for emerging billing patterns and potential overpayment risks. Analytical models assess compliance with provider contracts, organizational policies, and applicable federal and state requirements while identifying trends that warrant additional review. MCOs are particularly well positioned to leverage these capabilities because they maintain integrated claims, clinical, provider, and care management data across different states and lines of business, allowing them to identify longitudinal billing patterns that would be more difficult to detect through traditional fee-for-service claims review alone.

Provider Education

Many payment inaccuracies result from evolving coding requirements, documentation gaps, or misunderstanding of reimbursement policies. To complement front-end controls, MCOs address these challenges through ongoing provider relationships that emphasize collaboration, education, and continuous improvement rather than relying exclusively on retrospective payment recovery.

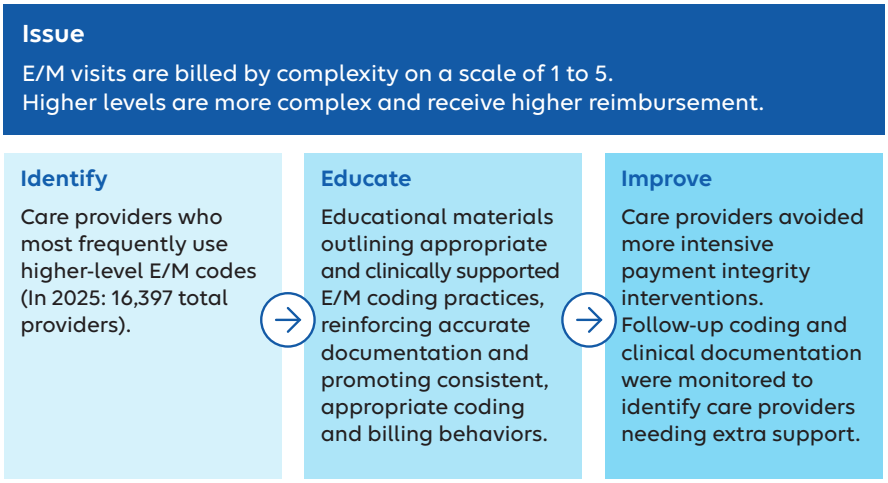
Elevance Health prioritizes provider education when opportunities for improvement are identified through analytics, prepay review, or other front-end controls. This education-first approach helps care providers strengthen documentation practices, improve coding accuracy, and maintain compliance with federal, state, and payer requirements while reducing unnecessary administrative burden associated with repeated audits and payment corrections. The organization's provider engagement model follows a continuous improvement framework built on three core steps:

1. **Identify.** Advanced analytics and payment integrity reviews identify provider-specific billing trends, coding variation, and documentation opportunities that may indicate education is warranted before more intensive intervention is necessary.
2. **Educate.** Certified coding specialists provide individualized education and outreach tailored to each provider's practice patterns. Education is grounded in current CMS requirements, American Medical Association coding guidance, official coding guidelines, documentation requirements, and applicable payer and reimbursement policies. The education focuses on accurate coding and documentation to support appropriate billing for services performed, providing practical, actionable guidance that providers can incorporate into their daily practice.
3. **Improve.** Follow-up analytics measure changes in coding behavior and documentation quality over time, allowing Elevance Health to evaluate the effectiveness of educational interventions and identify providers who may benefit from additional support or, when necessary, further payment integrity review.

Evaluation and management (E/M) coding trend analytics provide one illustration of Elevance Health's provider engagement model in practice (Figure 4).

Figure 4

Elevance Health Provider Engagement Model for Coding Trends



Note. E/M = Evaluation and Management.

Finally, as an additional offering, Elevance Health offers care providers access to the Provider e-Learning Resource Center (PeRC), a centralized on-demand educational platform that allows care providers to complete self-paced training, stay current with evolving coding guidance, and access practical documentation resources as needed. By making education continuously available rather than limited to audit findings, the organization promotes sustained improvements in billing accuracy and compliance.

Detection, Surveillance, and Investigations

While prevention and provider education address many payment accuracy issues before they result in improper payments, effective payment integrity also requires continuous surveillance to identify emerging risks that may only become apparent through longitudinal analysis.

Special Investigations Unit. Elevance Health's surveillance activities are supported by a dedicated, internal Special Investigations Unit (SIU) that works alongside payment integrity teams to investigate potential FWA. Rather than functioning as a stand- alone enforcement entity, the SIU represents a specialized component within the broader payment integrity strategy, receiving information from numerous sources including advanced analytics, payment integrity reviews, provider outreach, compliance reporting, member complaints, and external partners. Potential cases are assessed and handled in accordance with applicable Medicaid state requirements, which vary in their expectations for reporting, case identification, and investigation. Within those requirements, available information is evaluated to determine the appropriate level of investigative response.

Claims monitoring. Clinical coding specialists and payment integrity teams continuously monitor claims and medical records to validate coding accuracy, documentation sufficiency, and consistency between billed services and care delivered. These reviews identify overpayments while also revealing broader billing patterns that may require provider education, corrective action, or referral to the SIU for further investigation.

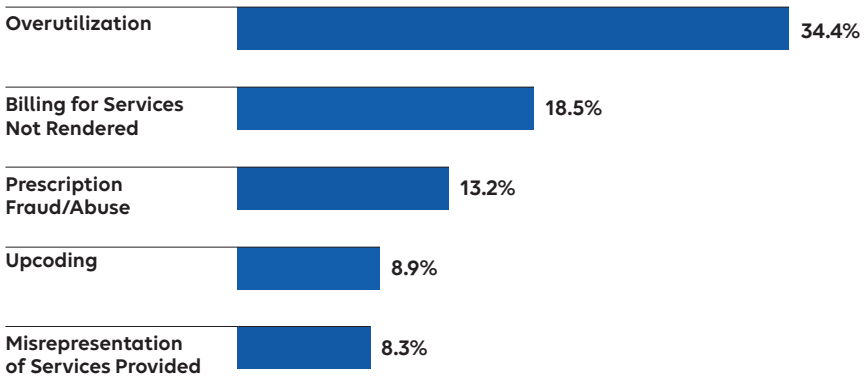
Advanced analytics further strengthen this surveillance capability by evaluating provider billing behavior over time to identify significant outlier patterns, unexpected shifts in utilization, coding anomalies, and other indicators of possible FWA. Rather than relying on isolated claims, these analyses incorporate longitudinal provider behavior and peer comparisons to prioritize resources where they are likely to have the greatest impact.

Investigations. These combine claims analysis, medical record review, provider interviews, coding expertise, and clinical assessment to determine whether questionable billing reflects documentation deficiencies, billing errors, or potentially fraudulent conduct. The nature and scope of investigative activities vary across Medicaid markets based on factors including state-specific contractual and regulatory requirements, identified risks, investigative priorities, membership characteristics, and other program considerations. Across Elevance Health's Medicaid markets, the majority of investigative matters originate internally through analytics and other enterprise detection capabilities rather than external complaints or government referrals.

The allegations identified through investigations reflect the wide range of fraud risks present across Medicaid programs. As shown in Figure 5, the five most common allegation types in 2025 were overutilization (34.4%), billing for services not rendered (18.5%), prescription fraud or abuse (13.2%), upcoding (8.9%), and misrepresentation of services provided (8.3%).

Figure 5

Most Common FWA Investigation Allegation Types, 2025



The type of allegations varies across care provider specialties, reinforcing the importance of evaluating billing behavior against the appropriate clinical, coding, peer, and operational factors. In 2025, the top three provider types subject to allegations—behavioral health providers, adult care providers, and pharmacies—accounted for 38.1 percent of all provider investigations. The primary allegation differed substantially across these provider types. Overutilization represented more than half (50.4%) of behavioral health investigations, billing for services not rendered accounted for 41.2 percent of adult care investigations, and nearly all (94.4%) investigations of pharmacies were due to suspected prescription fraud or abuse. Thus, effective surveillance must account for specialty-specific billing patterns rather than relying on uniform detection rules.

Findings from investigations inform a graduated set of interventions based on the level of identified risk. Many cases are resolved through provider education, corrective action plans, or recovery of overpayments through voluntary repayment, settlement, or administrative offset. Where permitted under applicable state requirements, care providers demonstrating sustained billing concerns may be placed on prepayment review, where certified coders and clinicians manually review claims before payment to prevent additional improper payments while corrective actions are underway.

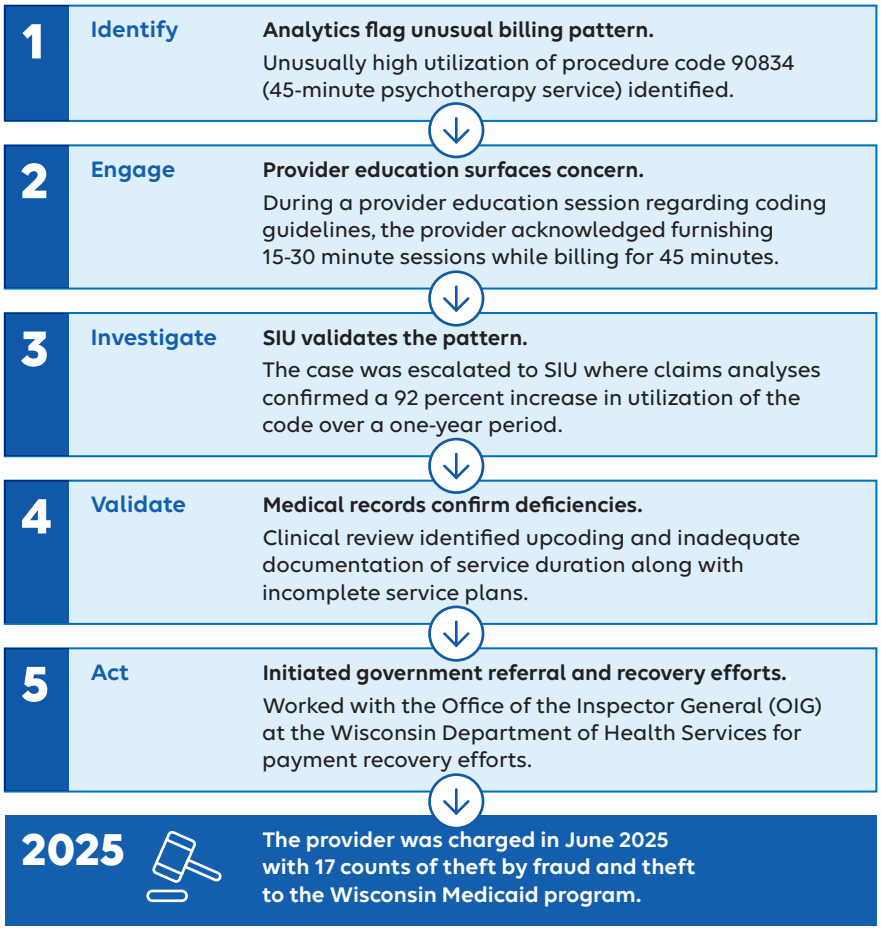
Government Referrals

While MCOs actively investigate suspected fraud, requirements for referring potential fraud to government partners vary across state Medicaid programs. Based on applicable state contractual and regulatory requirements and investigative findings, Elevance Health coordinates with state Medicaid agencies, MFCUs, Attorneys General, licensing boards, law enforcement, and other authorized entities to support further investigation or enforcement, including civil or criminal action when warranted. Among cases referred in 2025, approximately two-thirds were for overutilization and billing for services not rendered, illustrating the types of billing concerns that may require coordination with government partners.

As one example, a Wisconsin behavioral health investigation demonstrates how managed care's payment integrity efforts can complement state oversight. An Elevance Health-affiliated Medicaid plan was among multiple MCOs that identified concerning billing practices associated with a care provider and shared information with the state. Elevance Health's review began with provider outreach regarding an outlier billing pattern and, as additional concerns emerged based on additional findings, escalated ultimately to an internal SIU investigation (Figure 6). This case demonstrates how Elevance Health connects provider engagement, data analytics, clinical review, and the SIU to identify and address upcoding while working with state partners during the process.

Figure 6

Wisconsin's Elevance Health-Affliliated Medicaid Plan Case Study



Note. State of Wisconsin No. 25-CF.[12]

Policy Considerations

Effective Medicaid payment integrity extends beyond recovering improper payments. By integrating front-end controls, provider engagement, advanced analytics, and targeted investigations, MCOs can address payment accuracy throughout the claims lifecycle while reserving the most intensive resources for the highest-risk cases. To build on successes in promoting payment integrity, policymakers and state Medicaid programs can consider the following:

Standardize Medicaid payment integrity practices across states.

Variation in state payment integrity requirements creates administrative complexity for MCOs operating across multiple states and CMS for oversight purposes while limiting opportunities to identify cross-state fraud and abuse. Greater consistency in payment integrity expectations, including standardizing reporting requirements, data definitions, and recovery metrics, would improve oversight, reduce burden, and support more effective detection of emerging risks.

Promote the use of data sharing.

Expanding data sharing across Medicaid, Medicare, and other coverage sources can improve coordination of benefits and identification of high-risk billing patterns as they occur while reducing reliance on retrospective recovery efforts.

Prioritize risk-based payment integrity activities.

Payment integrity programs are most effective when oversight is proportionate to provider risk. States should reduce reliance on lower-value activities that provide limited payment integrity benefit in favor of analytic approaches that more systematically target emerging trends in FWA that emphasize prevention and early intervention.

Strengthen collaboration across the Medicaid program integrity ecosystem.

Effective payment integrity depends on coordinated action among MCOs, care providers, state agencies, MFCUs, and law enforcement. Ensuring partners have sufficient resources to investigate increasingly sophisticated fraud schemes and strengthening these partnerships can improve early identification of improper payments, promote provider compliance, and ensure investigative resources are focused on the highest-risk cases.

Conclusion

As Medicaid programs increase their focus on payment integrity, their strategies should prioritize prevention, data-driven oversight, provider partnerships, and coordinated enforcement. MCOs can complement state oversight by applying a layered, risk-based approach that prevents improper payments, improves provider compliance, and strengthens coordination across Medicaid payment integrity activities. By shifting the focus from recovering improper payments to preventing them, Medicaid programs and their MCO partners can improve payment accuracy, reduce administrative burden, and better safeguard taxpayer resources.

Endnotes

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[3] *42 CFR § 433.304.*

[4] Office of the Inspector General. Fraud, Waste, and Abuse for Health Care Providers. (n.d.). U.S. Department of Health and Human Services. Retrieved August 14, 2026, from https://oig.hhs.gov/reports-and-publications/featured-topics/ihs/training/fraud-waste-and-abuse-for-health-care-providers/content/#/lessons/Q_LqlRct1c1EKs6p7TnS8VmuIdHlizi6.

[5] *42 CFR § 433.304.*

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[7] Ibid.

[8] Centers for Medicare & Medicaid Services. (2026, February 27). Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH), 91 FR 9803. U.S. Department of Health and Human Services. Retrieved August 14, 2026, from https://www.federalregister.gov/documents/2026/02/27/2026-03968/request-for-information-rfi-related-to-comprehensive-regulations-to-uncover-suspicious-healthcare.

[9] *42 CFR § 438.608.*

[10] Medicaid and CHIP Payment and Access Commission. (2026, April).

[11] Centers for Medicare & Medicaid Services. (2026, February 12). Managed Care Enrollment by Program and Population (All) [Data Set]. Retrieved August 14, 2026, from https://data.medicaid.gov/dataset/e2ce0d2f-07c5-5213-947a-31e19bc649f6?conditions%5b0%5d%5bproperty%5d=year&conditions%5b0%5d%5bvalue%5d=2024&conditions%5b0%5d%5boperator%5d=%3D.

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