Medicaid Program-Integrity Bill Package: Summaries and Provider Impact

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Republicans on a House health committee rolled out a package of bills Tuesday to combat fraud in Medicaid, a central issue to the GOP heading into the midterms.

"While states are on the front lines of confronting this fraud, we must take commonsense steps to ensure that they are able to recoup their costs and incentivize the vital work that is needed to ensure the program can continue to work for the Americans it was designed to serve," Rep. Brett Guthrie (R-Ky.), chair of the House Energy and Commerce Committee, said in a statement Tuesday.

The package consists of 14 bills to expand the data available to fight fraud, allow states to retain more funding recovered from fraud cases to invest in audits and investigations, and increase requirements around state oversight of the program. Although Republicans have coalesced around combating fraud in Medicaid, the House is running out of time this year to act on legislation, as they don't return until after the midterm elections. All nine are discussion drafts dated September 23–25, 2026, with no bill numbers yet. Several are written to the same spot in the Social Security Act. Two add §1903(cc), three add §1902(a)(91), and two add §1902(zz). That suggests they are meant to be merged into one package, likely at an Energy & Commerce markup.

Bill-by-Bill Summaries

1. SMART Act (Balderson): Standardized Fraud Analytics

- Within 180 days, HHS must give every state standardized data-analytics tools.
- The tools must work with state claims systems (MMIS) and eligibility systems.
- HHS must build risk scores for providers that bill in more than one state or more than one federal program, using billing, utilization and enrollment data, and send alerts to states.
- HHS must also provide training and an annual report to Congress.
- **Provider impact:** indirect. It creates a federal algorithm that flags providers and triggers state follow-up.

2. Medicaid Integrity Improvement Act (Joyce): Annual MFCU Audits

- Within one year, each state Medicaid Fraud Control Unit (MFCU) must audit a statistically valid sample of "high-risk" providers every year, working with the HHS Inspector General and the state agency.
- "High-risk" includes providers in CMS's high-risk screening category.
- It also includes anyone the MFCU flags for:
  - unusual billing patterns, payment anomalies or prior audits
  - ownership changes or undisclosed ownership interests
  - affiliations with entities that are sanctioned or under investigation
  - credible allegations of fraud
- MFCUs must report the overpayments they find and collect.
- **Provider impact:** direct and recurring audits.

3. Public Access to HHS Health Data Act (Bentz): Open-Data Repository

- HHS must post all publicly available HHS datasets on opendata.hhs.gov.
- The data must be free, machine-readable and downloadable in bulk through APIs.
- **Provider impact:** minimal directly. It does make it easier for outside analysts and potential whistleblower plaintiffs to mine billing data.

4. STOP Medicaid Fraud Act (Evans): Electronic Verification for NEMT and ABA

- States must require electronic verification of non-emergency medical transportation (NEMT) and applied behavior analysis (ABA, an autism therapy) services furnished on or after January 1, 2027.
- This uses the same six data elements as the existing home-health verification system:
  - service type
  - recipient
  - date
  - location
  - who provided it
  - start and end times
- States that miss the deadline get a corrective-action path with roughly a year to comply.
- States that already require verification for these services are exempt.
- **Provider impact:** the only bill that puts a new operational mandate directly on providers.

5. Medicaid Integrity and Fiscal Accountability Act (Pfluger): Single Accountable Official

- Starting January 1, 2028, each state must name one individual responsible for:
  - accurate and timely claims processing
  - payment integrity
  - financial reporting
  - controls over federal compliance
- **Provider impact:** indirect. An accountable official tends to tighten claims edits and prepayment review.

6. Medicaid Fraud Prevention Act (Rulli): Annual State Fraud Risk Assessments

- States must do an annual fraud risk assessment covering fee-for-service, managed care and eligibility systems.
- The assessment must rank vulnerabilities and estimate dollars at risk, using HHS guidelines due January 1, 2027.
- States must then put a corrective action plan in place within 90 days, with measurable targets and deadlines.
- **Provider impact:** indirect. Corrective plans typically turn into new edits, documentation rules and revalidations, and those requirements reach providers through managed care plans.

7. HELP STATES Act (Kean): States Keep More of Fraud Recoveries

- Starting 18 months after enactment, states may keep up to 25% of the federal share of overpayments recovered due to fraud.
- That money must go back into program integrity: audits, investigations, analytics and IT.
- **Provider impact:** indirect. It funds more enforcement.

8. Medicaid Fraud Fighting and Taxpayer Protection Act (Griffith): Bigger State False Claims Act Bonus

- States with a qualifying state False Claims Act currently get a 10-percentage-point reduction in the federal share of their recoveries. This raises it to 25 points, for actions filed after enactment.
- **Provider impact:** strong incentive for states to pass, strengthen and aggressively use False Claims Acts, including whistleblower-initiated lawsuits.

9. Medicaid Whistleblower Protection Act (Miller-Meeks): State Whistleblower Laws

- By January 1, 2028, states must have laws barring retaliation against "covered individuals" who report Medicaid violations, fraud, mismanagement or safety dangers.
- A report counts even if it goes only to a supervisor.
- Remedies include:
  - reinstatement
  - double back pay with interest
  - special damages and attorneys' fees
  - punitive damages
- **Provider impact:** clear exposure for public and county hospitals. It is unclear whether private providers count as state "contractors," which could widen it.

Provisions with the Greatest Compliance-Driven Financial Impact

Ranked by likely cost to hospitals and other providers acting in good faith:

1. Electronic Verification Mandate for NEMT and ABA (Evans): Highest Direct Cost, Narrow Scope

- This is the only provision that forces providers to change daily operations.
- The January 2027 date is unrealistic if enacted late this year, though the corrective-action process softens it.
- Costs include:
  - GPS or mobile verification tools
  - integration with the state's system
  - device costs for drivers and therapists
  - training
  - ongoing claim denials when a visit fails to verify
- The home-health rollout showed that denials and rework during implementation are the biggest hidden cost.
- ABA practices are often small and thinly capitalized, so some may exit, creating access problems.
- Hospitals feel this mainly through hospital-run autism or behavioral programs and through discharge transportation arrangements.
- **New staffing:**
  - an electronic-verification coordinator or exceptions-resolution staff
  - scheduling and billing staff to reconcile visits that fail to verify
  - IT integration support

2. Annual MFCU Audits of High-Risk Providers (Joyce): Highest Recurring Financial Exposure for Hospitals and Systems

- The "high-risk" definition is broad enough to capture ordinary hospital activity:
  - ownership changes, which covers any merger or acquisition
  - affiliations with any entity under investigation, which is common in large systems
  - "abnormal" billing patterns, which can just reflect case mix or a specialty program
- Statistical sampling allows error rates to be extrapolated across the whole claims universe. Routine documentation and coding errors, not fraud, can therefore produce large overpayment demands.
- **New staffing:**
  - an audit-response coordinator
  - coding and clinical documentation specialists to defend sampled claims
  - a compliance analyst to monitor the system's own risk profile
  - outside counsel and statistical experts to challenge sampling methods

3. Raising the State False Claims Act Incentive to 25 Points (Griffith): Largest Legal-Liability Risk

- False Claims Act liability covers "reckless disregard," not just intentional fraud, and carries treble damages plus per-claim penalties.
- States that lack a qualifying statute will be motivated to pass one, and existing statutes will be used more often.
- Combined with the open-data bill, whistleblower plaintiffs gain both the data and the motive.
- **Costs and staffing:**
  - legal defense and settlement reserves
  - a stronger compliance program, including auditing, internal investigations and legal hold processes

4. The Enforcement-Infrastructure Bills (SMART, Rulli, Pfluger, Kean): Cumulative Indirect Burden

- None of these bills regulates providers directly, but together they build the pipeline that generates scrutiny:
  - more prepayment reviews
  - more records requests
  - payment holds triggered by algorithmic alerts
  - stricter managed care plan audits
- Kean's retention provision makes the system partly self-funding: recoveries pay for more audits.
- Multistate systems and providers billing both Medicare and Medicaid are singled out by SMART's cross-program risk scores. False positives still cost staff time to resolve.

5. Whistleblower Protections (Miller-Meeks): Significant for Public Hospitals

- Public and county hospital employees are clearly covered.
- "Adverse action" includes threats and harassment, and a report made only to a supervisor counts.
- With double back pay and punitive damages available, ordinary personnel decisions involving anyone who has raised a concern carry litigation risk.

- **New staffing:**
  - HR and legal investigation capacity
  - non-retaliation training
  - careful documentation of personnel actions

The Bigger Picture

The package works as a loop:

1. Analytics flag a provider (SMART).
2. The state's fraud risk assessment prioritizes that area (Rulli).
3. The MFCU audits a statistical sample (Joyce).
4. Recoveries partly stay with the state (Kean).
5. False Claims Act actions get a bigger bonus (Griffith).
6. Insiders are protected when they report (Miller-Meeks).

For a hospital, the main cost is not any single bill. It is a permanently higher volume of audits, data requests and legal exposure that falls hardest on providers with thin compliance teams, such as rural, safety-net and small behavioral health providers.

This is a policy analysis, not legal advice. Final text may change in markup, especially where the bills collide on statutory numbering.