

Publications

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Federal Scrutiny of State Medicaid Programs and Medicaid Providers Intensifies

Key Takeaways

- CMS and congressional leaders are increasing oversight of state Medicaid programs through off-cycle revalidation demands, fraud investigations and threats to defer federal Medicaid funding. Recent directives from CMS Administrator Dr. Mehmet Oz signal heightened expectations for state enforcement efforts.
- The increased scrutiny creates operational and financial risks for Medicaid providers, particularly those viewed as high risk or operating in targeted service areas.
- Medicaid providers should expect closer scrutiny of enrollment, billing and program participation as CMS and Congress increase pressure on states to strengthen Medicaid oversight. Providers should review revalidation procedures, enrollment records and documentation practices to help avoid payment disruptions or compliance issues.

The federal government is increasing pressure on state Medicaid agencies to address potential fraud, waste and abuse through more aggressive Medicaid oversight, including requirements for off-cycle provider revalidation, demands for enhanced fraud investigations and threats of deferral of federal Medicaid funds. Increased congressional oversight and recent statements by CMS Administrator Dr. Mehmet Oz, as well as his April 23 letters to all governors and state Medicaid directors, all point in the same direction: the feds expect states to more aggressively supervise providers and better document oversight of those viewed as high risk.

Pressure on Program Integrity

The Trump administration appears increasingly willing to use payment suspension, deferrals and corrective-action demands as front-end program-integrity tools, rather than waiting for completed audits and consequential disallowances or overpayment demands.

Minnesota is the clearest example of this new approach. In March 2026, Minnesota's Attorney General and Department of Human Services sued CMS and HHS over an effort to withhold roughly \$243 million in Medicaid payments. On April 6, a federal court denied preliminary relief, concluding the challenge was premature because there had not yet

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been final agency action. Although CMS later approved Minnesota's revised corrective-action plan, Minnesota government reports suggested uncertainty remained over release of the deferred funds.

Off-cycle Provider Revalidation a Central Focus

Dr. Oz's April letters asked states to undertake a "swift revalidation" of Medicaid providers at high risk of fraud, waste, abuse and corruption, and to notify CMS within 10 business days whether they would do so and on what timetable. The letters also directed each state Medicaid agency to submit, within 30 days, a comprehensive two-year provider revalidation strategy signed by the state Medicaid director.

These directives make clear CMS expects more than a restatement of existing enrollment cycles. States are being urged to use off-cycle Medicaid provider revalidation for providers in the "high" categorical risk tier, prioritize providers not screened within the previous 12 months and explain how they will review providers without National Provider Identifiers (NPIs). Notably, CMS does not attempt to define which providers qualify as "high" risk, leaving that distinction to the states. But recent federal materials have highlighted home- and community-based services, non-emergency medical transportation, autism therapy, substance use disorder treatment, laboratory services, home health and hospice as areas likely to remain under the microscope.

Here, "revalidation" refers to provider enrollment screening, not beneficiary eligibility renewals. Provider revalidation confirms enrollment information, credentials, ownership and practice details. It is separate from member re-enrollment, new work requirements or eligibility redeterminations, which are already coming as a result of H.R. 1.

The operational stakes are significant. CMS guidance states that providers who fail to revalidate by the applicable deadline should not receive Medicaid payment between the due date and completion of screening. For providers selected for off-cycle review, revalidation may therefore affect both payment continuity and continued program participation. Enhanced revalidation cycles will also further strain the limited administrative resources at state Medicaid agencies.

Congressional Scrutiny Incoming

Congressional oversight is moving in parallel with CMS activity. On March 5, House Energy and Commerce Committee leadership announced that, as part of an ongoing Medicaid fraud investigation that began with Minnesota, the Committee sent letters to 10 additional states.¹

The Committee's requests covered audits, program-integrity controls, criminal referrals, provider sanctions and disenrollments, screening and revalidation procedures, site visits, risk-level assignments, unusual growth in enrollment or claims, use of data analytics and artificial intelligence, oversight of waiver programs, improper payments and recoveries, payment suspensions and fiscal intermediary oversight. We anticipate further developments as the Committee continues its investigations.

Provider takeaways

Medicaid providers should expect increased scrutiny from all levels of government. Providers of all types are likely to face more frequent payment audits and more frequent revalidation, including requests to confirm licensure, ownership and control information, practice locations and documentation supporting billed services.

To prepare, providers should consider the following proactive measures:

- **Prioritize and update systems for monitoring revalidation notices and enrollment-status updates** by mail, email and Medicaid portal communications. Failure to respond timely could jeopardize enrollment, interrupt reimbursement, or jeopardize provider appeal rights.
- **Update and renew attention to enrollment and claims-filing compliance.** Inaccurate enrollment information (e.g., ownership disclosures, etc.) in the face of enhanced government oversight poses increased risk.
- **Prepare for audits and investigations responses** by training staff to respond to government investigators. Ensure staff know provider policies and procedures and understand how to access and provide documents in response to lawful requests.

Should you have questions regarding the information discussed, please reach out Ryan Thurber, Jennifer Evans, Jeff Fitzgerald, Cody Pyke or your preferred Polsinelli attorney.

[1] The Committee sent letters to California, Colorado, Massachusetts, Maine, Nebraska, New York, Oregon, Pennsylvania, Vermont and Washington.