EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
COMMONWEALTH OF MASSACHUSETTS
OFFICE OF MEDICAID
ONE ASHBURTON PLACE, BOSTON, MA 02108

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

KIAME MAHANIAH, MD, MBA
SECRETARY

MIKE LEVINE
UNDERSECRETARY
FOR MASSHEALTH

March 17, 2026

THIS LETTER SENT VIA EMAIL

Brett Guthrie, Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

John Joyce, M.D., Chairman
Subcommittee on Oversight and Investigations
2125 Rayburn House Office Building
Washington, D.C. 20515

H. Morgan Griffith, Chairman
Subcommittee on Health
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Guthrie, Chairman Joyce, and Chairman Griffith,

Enclosed is Massachusetts's response to the letter we received from the House of Representatives' Committee on Energy and Commerce (Committee) dated March 3, 2026.

Overview

The Massachusetts Executive Office of Health and Human Services (EOHHS) is the Single State Agency responsible for administering the Medicaid and CHIP programs,

collectively known in Massachusetts as the MassHealth program. MassHealth provides comprehensive health care coverage for nearly two million Massachusetts residents, including 40% of our children and 60% of our residents with disabilities.

EOHHS and MassHealth (herein referred to as MassHealth) prioritize program integrity to safeguard state and federal resources. As described in further detail below, provider fraud, waste, and abuse (FWA) are addressed through a comprehensive array of controls that includes:

- Provider audits, claims reviews, and documentation reviews that ensure compliance with state and federal regulations, including clinical requirements.

- Extensive pre-pay controls that utilize claims processing edits (i.e., review logic applied to each claim at the time of submission that flag or deny payments that do not meet program requirements) and pre-pay reviews to prevent inappropriate payments.

- Advanced analytic methods that flag aberrant provider billing for review and possible payment recovery.

- Managed care oversight processes that promote accountability and implement controls for managed care organizations' provider networks.

- Partnerships with law enforcement that result in timely referrals of credible fraud allegations, payment suspensions, investigations, overpayment recoveries, and terminations as appropriate.

- Provider screening, enrollment, and revalidation that ensure providers meet program requirements and that prohibit providers with a history of engaging in FWA from participation.

EOHHS partners closely with the Massachusetts Attorney General's Office Medicaid Fraud Division (MFD), the state's designated Medicaid Fraud Control Unit (MFCU),[1] to

[1] Federal law generally requires states participating in Medicaid to operate a Medicaid Fraud Control Unit responsible for investigating and prosecuting provider fraud and abuse. 42 U.S.C. 1396a(a)(61). Federal regulations implementing this statute require state Medicaid agencies to maintain mechanisms for identifying fraud and abuse and referring cases to the state's certified Medicaid Fraud Control Unit. 42 C.F.R. 455, Subpart A et. seq. In Massachusetts, the Medicaid Fraud Division (MFD) of the Massachusetts Attorney General's Office serves as the State's Medicaid Fraud Control Unit.

combat fraud. For example, MassHealth's own program integrity controls identified the Worcester non-emergency medical transportation (NEMT) fraud case cited in the Committee's letter and referred that provider to MFD, resulting in criminal charges against the provider. As described in greater detail below, MassHealth maintains multiple channels for identifying and referring credible allegations of fraud to the appropriate law enforcement entity and does so as appropriate.

Additionally, Massachusetts is proud of our partnership with the Centers for Medicare & Medicaid Services (CMS) to ensure our Medicaid program maintains effective program integrity controls and operates in compliance with federal requirements. CMS directly engages with MassHealth, conducting regular monitoring and receiving regular reporting from MassHealth on its administration of the Medicaid program.

Building on these comprehensive controls already in place, MassHealth remains committed to proactively assessing program integrity operations, identifying areas for expansion, and investing in new technologies that can improve the effectiveness and efficiency of program integrity functions.

Response to the Committee's Questions

1. **What actions, if any, are being taken to identify, assess fraud risk, and investigate Medicaid fraud schemes that may be occurring in the state?**

   MassHealth deploys a variety of tactics to identify providers engaging in fraud. Since 2016, MassHealth has put in place a pre-pay advanced analytics platform that assesses providers' organizational characteristics and billing patterns to identify providers engaged in FWA. For example, by leveraging a corporate records database, this platform detects shared ownership or affiliations with other providers that have been previously terminated for engaging in fraudulent activities, strengthening proactive identification of fraudulent providers. This can prevent fraudulent providers from being paid in the first place.

In addition, as described in detail in our response to Question 2, MassHealth conducts audits on providers with suspicious billing patterns and/or that are referred by third parties for suspected FWA. MassHealth's audits assess samples of claims and evaluate provider compliance with federal and state requirements. In some cases, these audits identify credible allegations of fraud for referral to MFD for investigation and prosecution.

MassHealth also manages and promotes multiple channels through which stakeholders and the general public can submit fraud referrals, including:

- Member Fraud Hotline through which members and others can share allegations of suspected fraud;

- Close coordination with managed care entities (MCEs) that audit providers within their networks through their internal Special Investigations Units and refer credible allegations of fraud that arise through their reviews; and

- Ongoing dialogue across external partners**,** including providers, members, MCEs and other stakeholders who collaborate with MassHealth to identify FWA occurring within the program.

In addition to referring credible allegations of fraud to MFD for investigation and suspending payments to providers who have been referred for fraud, processes which are explained in greater detail in response to later questions, MassHealth also shares its draft audit findings with MFD. This additional step ensures that audit findings can be reviewed for potential fraud schemes known to MFD, including fraud schemes that have been brought to their attention by federal and other state law enforcement. In calendar year 2025, MassHealth reviewed over 950 audit requests and draft audit findings with MFD as part of routine coordination of efforts across MassHealth, contracted MCEs, and MFD. These referrals and audit findings serve as leads for MFD to investigate and, where fraud is uncovered through their investigation, take civil and criminal enforcement actions.

a. Please provide all audits related to fraud, waste, and abuse in the state's Medicaid programs including audits completed by third-party contract auditors, from January 1, 2021, to present.

The identification and prevention of fraud, waste, and abuse is a key priority for MassHealth and the Commonwealth of Massachusetts. Consistent with this commitment, the MassHealth program is subject to regular audits and oversight. At the federal level, MassHealth is audited by the Federal Office of Inspector General and the Centers for Medicare & Medicaid Services (CMS). At the state level, the program also undergoes frequent audits conducted by the Massachusetts Office of the Inspector General, the Office of the State Auditor, and the Office of the Comptroller. MassHealth values these audits as an important tool for strengthening program integrity and helping to identify and prevent fraud, waste, and abuse.

Please see **Attachment A:** *External Audit List*, which details completed external audits of the MassHealth Medicaid program from January 2021 to present. As noted below, MassHealth also performs hundreds of individual provider audits annually.

b. Are any audits of the Medicaid program ongoing? If so, please detail the type of audits that are ongoing.

Yes. Please see **Attachment A:** *External Audit List*, which details ongoing audits.

2. What program integrity measures are currently in place to prevent FWA in your state's Medicaid programs?

MassHealth protects taxpayer dollars by working to prevent FWA before it happens. We maintain a comprehensive set of program integrity controls across our fee-for-service (FFS) and managed care programs designed to prevent, detect, and address FWA. These controls consist of analytics, both pre-pay review and post-pay provider audits, and close coordination with law enforcement partners. Over the past three years, these FWA prevention activities

have included over 1,200 individual provider audits and claim record reviews as well as 88 algorithmic claim data reviews (rules-based claims data analyses), many of which recur on an annual basis. These proactive measures generate hundreds of millions of dollars in direct savings for taxpayers annually and a strong sentinel effect on the provider network that discourages non-compliance with MassHealth and federal requirements.

Pre-pay Cost-avoidance

MassHealth's extensive set of pre-pay review approaches includes:

- Claims Edits: MassHealth's Medicaid Management Information System (MMIS) processes provider claims and contains an extensive suite of sophisticated edits, rules, and other program integrity checks and balances to prevent FWA before payments are issued. For example, claims edits prevent providers from making duplicate claims for the same service, prevent unbundling (i.e., cases where providers bill multiple procedures when they should be billed under a single "bundled" procedure code), and ensure that the services billed are rendered by providers with up-to-date enrollment in the program. MassHealth's MMIS has been designed with enhanced program integrity capabilities, including expanded functionality to add and update claims edits as needed to keep abreast with the latest trends in aberrant or fraudulent claims submissions.

- Advanced Analytics: In addition to MMIS claims edits, MassHealth uses an advanced analytics platform to flag claims requiring pre-pay review and prevent inappropriate payments before they are paid. Unlike MMIS, which applies rule-based edits to pay or deny claims, this advanced analytics system utilizes algorithms to provide risk assessment of claims. This monitoring of billing patterns, anomalies, and high-risk claims enables MassHealth to pause payment, review the claim, and prevent inappropriate payments before they are made.

- Clinical Reviews: MassHealth's Acute Hospital Utilization Management Program performs pre-pay reviews of medical records associated with inpatient hospital claims, which can result in payment denials for claims that do not meet medical necessity requirements and other federal and state requirements before payments are ever issued. In addition,

MassHealth performs clinical screens to ensure services are medically necessary for home and community-based services and services in institutional settings, including Nursing Facilities and Chronic Disease and Rehabilitation Hospitals.

Post-pay Overpayment Identification and Recovery

MassHealth performs a wide range of algorithmic claims analyses, post-pay provider audits, and clinical reviews to assess providers' compliance with regulatory requirements and identify overpayments for recovery. These include:

- Algorithmic Claim Reviews: MassHealth performs a wide range of algorithmic reviews of claims data to identify overpayments made to providers. Algorithmic reviews of claims data are analyses following rules-based logic that identify overpayments for recovery that do not require reviews of medical records or other claim documentation. For example, one of MassHealth's algorithmic claims reviews identifies when home-based services are billed during a member's inpatient stay within a facility. Whenever MassHealth identifies overpayments from a post-pay algorithm review, MassHealth initiates overpayment recoveries and updates pre-pay systems to the extent possible to prevent the overpayment scenario going forward. In addition, MassHealth monitors algorithm recovery findings to identify providers that may warrant review through an audit.

- Post-pay Provider Audits: Provider audits include both on-site visits to collect medical record documentation and observe the delivery of services as well as reviews of medical records and documentation submitted by providers. Provider-submitted documentation is reviewed against state and federal requirements, and instances of non-compliance are addressed through issuance of financial sanctions and recovery of identified overpayments. As part of these reviews, auditors review provider documentation to ensure that the quantity and types of services rendered are consistent with the information presented on the provider claim submitted for payment. These reviews also ensure that claim documentation contains required elements as dictated by MassHealth programmatic requirements (e.g., provider signatures and dates). MassHealth also performs financial audits of facility-based providers. These audits analyze charges, payments, and other account activity, and

can lead to the identification of overpayments. Inpatient hospitals and nursing facilities are subject to financial audits on a rolling three-year cycle.

- Clinical Reviews: MassHealth's Acute Hospital Utilization Management programs perform post-payment clinical reviews of inpatient hospital claims. In addition, MassHealth conducts post-pay utilization clinical reviews of non-institutional providers (e.g., physicians and specialists), including reviews of paid claims, medical records, and other relevant records. These reviews identify overpayments in cases where medical records do not meet medical necessity requirements or other federal and state requirements.

Managed Care Oversight

In addition to the program integrity controls described above, MassHealth engages closely with its managed care entities (MCEs). As a result of MassHealth's close oversight and coordination, MCEs serve as a valuable source of fraud referrals made to MFD. MCEs partner with MassHealth to deliver care to MassHealth members via contracted provider networks. MCEs have certain plan administrative responsibilities, such as billing and claims processing for MCE-enrolled providers. As a result of these activities, MassHealth requires MCEs to submit compliance plans and anti-FWA plans on an annual basis. MassHealth reviews these plans for completeness and adherence to federal requirements under 42 CFR 438.608 and shares best practices across MCEs. MassHealth, MFD, and MCEs meet on a quarterly basis to discuss program integrity requirements and topics related to FWA controls, including but not limited to recent trends, audits, overpayment issues, reporting, and best practices for program integrity controls. In addition, MassHealth performs regular analytic reviews of MCE-submitted provider data and conducts direct audits of providers participating within MCE networks to identify overpayments made by MCEs. Overpayments identified by MassHealth through these controls are deducted from MassHealth's capitation payments to MCEs.

3. **Describe the process for making criminal referrals for suspected Medicaid fraud to state, local, and federal law enforcement agencies.**

   MassHealth maintains a robust process for identifying, reviewing, and referring credible allegations of Medicaid fraud to the Commonwealth's federally certified Medicaid Fraud Control Unit, MFD.[2]

   MassHealth identifies potential fraud through a variety of program integrity mechanisms, including those detailed above, allegations of fraud reported internally by front-line staff, and external referrals from the public, managed care entities, providers, and others. In order to maintain clear lines of communication and coordination with MFD, MassHealth has a designated Audit Response and Fraud Enforcement team that is responsible for receiving credible allegations of fraud from MassHealth staff and external stakeholders, submitting the referrals to MFD, serving as the single point of contact for MFD, and keeping MassHealth leadership informed of referrals made to MFD. Following a referral, MassHealth coordinates closely with MFD to support their investigation and enforcement efforts. This coordination includes regular information sharing, including provider audit findings and other pertinent information, coordination on implementation of payment suspensions as described in our response to Question 4, and ongoing communication regarding matters under investigation, as requested by MFD.

   MFD's annual reports for federal fiscal years 2021-2024 are publicly available for review.[3] These reports detail total recoveries obtained through criminal prosecutions, civil settlements, and other enforcement actions. MassHealth's referrals play an important role in these investigations and enforcement efforts, and together, these referral and enforcement activities demonstrate the state's commitment and coordinated approach to identifying Medicaid fraud and recovering taxpayer funds when fraud occurs.

[2] MassHealth refers credible allegations of fraud to MFD, the state's certified Medicaid Fraud Control Unit, in accordance with 42 CFR 455 Subpart A.

[3] See Medicaid Fraud Control Units - U.S. Department of Health and Human Services.

4. **What steps are being taken to sanction or disenroll fraudulent Medicaid providers? Please provide information about any sanctions or disenrollments of fraudulent providers, including all evidence supporting disenrollment proceedings.**

   MassHealth takes swift action to sanction or disenroll providers who engage in fraudulent conduct. These actions protect taxpayer dollars, prevent providers who pose program integrity risks from continuing to participate in MassHealth, and ensure compliance with federal Medicaid program integrity requirements and state provider participation regulations.

   Consistent with federal Medicaid program integrity regulations at 42 C.F.R. Part 455, Subpart A, MassHealth refers credible allegations of fraud to MFD and implements payment suspensions. When MassHealth imposes a payment suspension, it issues a notice of withhold to the provider, directs its accounting systems to stop payments, and instructs MassHealth managed care plans to suspend payments to the provider as well.

   MassHealth also exercises its broad regulatory enforcement authority to impose provider sanctions, including administrative fines, service restrictions, and termination from participation in the MassHealth program. When MassHealth terminates a provider for fraud, MassHealth also instructs managed care plans to terminate the provider.

   Through this multipronged approach — referrals of credible allegations of fraud, implementation of payment suspensions, close coordination with MFD, and provider terminations — MassHealth protects Medicaid program funds from fraud.

   MassHealth also takes program integrity actions in cases that do not rise to the level of fraud but nonetheless involve noncompliance or poor provider performance. These actions include recovery of overpayments, the imposition of administrative sanctions, and provider terminations, among other actions. Through these additional efforts, MassHealth intervenes to bring providers into compliance and works to proactively prevent fraud.

5. **How are Medicaid service providers screened for compliance with federal law? Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits**

   MassHealth requires screening for providers as described in the table below. For providers identified as moderate-to-high risk by Medicare or, if there is no Medicare risk assignment, identified as moderate-to-high risk by MassHealth, additional screening measures are required for enrollment. A description of risk assessment is included in response to Question 6. MassHealth's screening framework for enrollment, re-enrollment and revalidation includes the following controls:

Activity	Relevant Provider Risk Level
Collection of federally required disclosures from providers and associated entities	All
Screening of providers and disclosed individuals/entities against required federal and state sanction and exclusion databases, including: • Social Security Administration Death Master File • HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) • System for Award Management (SAM) • Adverse Actions Report • Medicare Exclusion Database (MedFile) • Massachusetts Debarment List	All
Flagging of providers with disciplinary actions on their professional licenses and taking necessary remedial actions	All

Activity	Relevant Provider Risk Level
Flagging of providers with disclosed criminal convictions, sanctions, or pending legal/disciplinary proceedings	All
Verification of Medicare enrollment status through the Provider Enrollment, Chain, and Ownership System (PECOS)	All
Site visits	Moderate/High
Fingerprint-based criminal background checks	High

MassHealth providers are revalidated at least every 5 years. Between revalidations, MassHealth routinely terminates providers when informed of providers' engagement in FWA, such as appearing on the OIG's LEIE.

a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? If yes, please describe these processes.

Yes. Additional state screening is performed for providers who are subject to licensing certification or accreditation oversight. MassHealth verifies licensure, certification, and accreditation information with respective oversight authorities to ensure valid and active licensure, accreditation, or certification. These include, for example, the Massachusetts Department of Public Health, the Board of Registration in Medicine, and other bodies and authorities.

MassHealth supplements the federal provider framework with additional program integrity safeguards for providers of home and community-based services (referred to by MassHealth as "Long Term Services and Supports"), including:

- Enhanced provider credentialing review
- Targeted pre-enrollment review
- Ongoing compliance monitoring
- Enhanced ownership and affiliation monitoring
- Enhanced site visit protocols
- Cross-agency data verification

b. How frequently are on-site visits conducted by your state for Medicaid providers by federal screening risk category (limited, moderate, and high-risk), including out-of-state providers?

Providers in the moderate or high-risk category receive a site visit at enrollment, re-enrollment, and at revalidation. Providers whose risk category is moved up to moderate or high receive a site visit in accordance with federal requirements. Site visits may also be conducted if there are concerns raised about a specific provider, regardless of risk category.

c. Are any programs, provider types, or enrollment pathways exempt from on-site visits, and what statutory or regulatory authority permits those exemptions?

No. There are no programs, provider types, or enrollment pathways that are exempt from the above requirements.

6. How does your state designate and evaluate risk level of provider types in the Medicaid program in accordance with 42 C.F.R. § 455 subpart E? Please provide the state's current Medicaid programs classified by screening risk level (limited, moderate, and high categorical risk).

MassHealth utilizes the risk levels that are assigned by Medicare for programs and provider types. Provider types that are only enrolled in Medicaid are

assessed by MassHealth directly on an ongoing basis. MassHealth continuously assesses providers' risk levels based on findings from program integrity activities (such as provider audits and pre-pay denials) as well as national trends in provider FWA. Please refer to **Attachment B**: *Provider Types and Risk Levels* for the state's current Medicaid provider types classified by screening risk level.

a. **Have any Medicaid programs' categorical risk levels been reassigned since January 1, 2021? If so, please describe which program(s) were reassigned, including any supporting evidence that contributed to risk reassignment.**

   Yes. In compliance with federal regulations, nursing facilities were updated to high risk at the point of enrollment on January 1, 2023 and Hospice providers were updated to high risk at the point of enrollment on January 1, 2024.

b. **How often does your state reevaluate Medicaid provider screening risk level?**

   MassHealth reviews the provider screening risk levels of Medicaid providers, both on the program and individual bases, through continuous monitoring of Medicare classifications and in light of program integrity findings related to individual providers.

7. **Does your state collect data on Medicaid programs with abnormal or statistically significant increases in provider enrollment or claims over time, including programs which greatly exceed their estimated cost upon enactment?**

   Yes, see below.

   a. **If so, please detail the programs that have experienced abnormal or statistically significant increases since January 1, 2021, the data that was collected on the programs, and how this data has been used to inform assessments of program vulnerability to FWA.**

MassHealth analyzes above-expectation increases in provider enrollment or claims over time as one of the multi-pronged approaches to program integrity monitoring. Each month, MassHealth analyzes provider enrollment, expenditures, and service utilization data across provider types and compares fiscal year-to-date actuals against budget projections. For programs where actual spending trends are substantially deviating from projections, MassHealth conducts additional analysis to identify and explain factors driving those variances. Medicaid spending growth, both in Massachusetts and nationally,[4] reflects demographic trends,[5] inflation,[6] shifts in clinical practice, rising pharmaceutical costs including the rapid growth of new drug classes, intentional policy decisions, and other factors apart from FWA.

Above-expectation increases in spending in a program are often driven by sector-level trends described above and are not by themselves an indication of FWA. MassHealth program integrity focuses on detecting and investigating individual providers who are statistical outliers within a program. These providers are flagged for audit, recoveries, and fraud referrals to MFD as appropriate. MassHealth routinely identifies statistically aberrant providers and flags them for audit and fraud investigations across multiple provider programs.

b. Is your state utilizing innovative tools, including but not limited to identity verification, artificial intelligence, and data analytics, to detect irregular Medicaid claims activity? If so, please describe these tools.

Yes. As described above, MassHealth leverages advanced analytics within its pre-pay review and advanced analytic system, as well as data analyses performed by program integrity staff and vendors, to identify

[4] According to data published by CMS, per-enrollee spend in Medicaid grew by 16.6% nationally in 2024. See National Health Expenditures 2024 Highlights.

[5] See Demographic Turning Points for the United Sates: Population Projections for 2020 to 2060.

[6] Massachusetts has experienced a cumulative increase in the Consumer Price Index of ~17.9% from 2021. See State Inflation Tracker - U.S. Congress Joint Economic Committee.

individual providers that may be engaging in FWA. These analytic approaches include systematic surveillance of:

- Provider billing trends including abrupt spikes in billing volume by individual providers

- Provider attributes including newly enrolled providers, particularly in high-risk provider types determined by CMS or MassHealth, as well as provider comparison analyses

- Peer group benchmarking comparing providers in the same specialty with similar patient demographics to detect outliers in per-member-per-month (PMPM) expense as well as service utilization and other aberrant billing patterns

While MassHealth already utilizes sophisticated analytics to inform provider audits and claim reviews, the agency remains committed to exploring new technologies to further strengthen its program integrity controls. For example, building on MassHealth's existing technology-driven program integrity capabilities, MassHealth is issuing a Request for Information to identify emerging technologies and vendors that could further strengthen fraud detection and expand the effectiveness of its program integrity operations.

c. If you don’t collect this data, why not?

Not applicable; please see above.

8. **Please provide information on active Section 1115 and 1915 demonstrations and waivers, from January 1, 2021, to present, including:**
    a. **program name;**
    b. **provider category risk level;**
    c. **effective date;**
    d. **spending;**
    e. **enrollment;**
    f. **services offered;**
    g. **FWA measures; and**
    h. **eligibility.**

    CMS directly engages with MassHealth with regard to our various authorities, including 1915(c) and 1115 demonstration and waivers, through regular monitoring and reporting.

    Information regarding the state's ten 1915(c) waivers, including responses to requested items a, b, c and h, can be found in **Attachment C:** *1915(c) Waiver Program Descriptions*. Spending and enrollment data for these waivers (requested items d and e) can be found in **Attachment D:** *1915(c) Waiver Enrollment and Spending CY21 – CY25* and information on the services offered under these waivers (requested item f) can be found in **Attachment E:** *Waiver Services.*

    Massachusetts also operates an approved Section 1115 demonstration waiver as part of its MassHealth program, enabling the state to align a wide range of MassHealth policies and initiatives within a single, comprehensive framework approved by CMS. An independent evaluation found that Massachusetts's 1115 demonstration saved taxpayers more than half a billion dollars over five years from 2017 to 2022.[7, 8]

    Related to requested item g, 1915(c) and 1115 waiver claims are generally subject to the pre-payment edits, advanced analytics, post-payment audits, and external oversight and audit processes activities outlined in responses to prior questions. Additionally, 1915(c) waiver services are authorized by a member's

[7] See CMS Approval for Massachusetts's Evaluation Summative Report, January 2026.

[8] See Massachusetts's Independent Evaluation Summative Report, September 2025.

waiver case manager through the member's waiver plan of care. Waiver services are based on the member's assessed needs and must be tied to a goal, as established through their person-centered planning process. The waiver plan of care specifies the amount, frequency, and duration of services the member can receive and gives the provider authorization to deliver these services. Waiver billing is validated against the plan of care prior to claims submission.

9. **Please provide information regarding improper payments and recovery efforts in your state's Medicaid program, including:**

    a. **Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.**

    Please see the below table which provides a breakdown of overpayments identified across both FFS and MCE network providers through MassHealth and MCE provider post-pay program integrity operations (i.e., provider audits and algorithmic claims analyses). Overpayments include funds that a provider receives to which they are not entitled, as determined through routine program integrity reconciliation processes. Such reconciliation processes apply internal controls to detect issues such as technical discrepancies, documentation gaps, or retrospective eligibility changes, which trigger the initiation of recoupment processes to recover any overpayments. Importantly, these overpayments exclude fraud-related payments that are reported by MFD.[9]

[9] Civil and criminal enforcement recoveries for fraud-related payments are reported annually by the HHS Office of Inspector General in its publicly available Medicaid Fraud Control Unit reports. See Medicaid Fraud Control Units - U.S. Department of Health and Human Services.

$ Millions	CY21	CY22	CY23	CY24	CY25
Physical and Behavioral Health	$65.9	$73.7	$77.6	$83.1	$120.4
Long Term Supports and Services	$16.2	$16.5	$20.7	$38.7	$35.1
Pharmacy	$3.2	$2.9	$0.5	$3.8	$7.6
Other	$0.4	$4.5	$2.7	$1.4	$2.2
Total	**$85.7**	**$97.7**	**$101.5**	**$127.1**	**$165.3**

b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.

Total MassHealth recoveries and recoupments annually from January 1, 2021 to present are set forth in the table below. Please note, as provider audits and recoveries can span across years, the totals listed below will not match with the identified overpayments identified in response to Question 9a.

CY21	CY22	CY23	CY24	CY25
$76.9M	$60.9M	$91.8M	$84.4M	$117.1M

MassHealth notes that analyzing post-pay recovery figures provides an incomplete measure of a Medicaid agency's program integrity savings. As KFF observed in its March 2025 fact sheet about Medicaid program integrity, "*Historically, program integrity efforts focused on the recovery of misspent funds, but more recent initiatives move beyond "pay and chase" models to focus more heavily on prevention and early detection of fraud and abuse and other improper payments*."[10] This reflects MassHealth's own longstanding approach: as described in our response to Question 2, the majority of MassHealth's controls operate before payment — through

[10] See 5 Key Facts about Medicaid Program Integrity - KFF.

pre-pay edits, algorithmic review, and clinical authorization requirements — meaning a significant share of improper payments are stopped before dollars go out the door, ensuring that they never have to enter the payment recovery pipeline.

Echoing this philosophy, in the February 2026 CMS press release announcing the CRUSH initiative, Secretary Kennedy stated: *"We are replacing the old 'pay and chase' model with a real-time 'detect and deploy' strategy, using advanced AI tools to identify fraud instantly and stop improper payments before they go out the door*."[11] MassHealth has operated under this model since deploying its pre-pay review system, as well as clinical pre-pay reviews, many years ago. These robust pre-pay controls result in over $100M in cost avoidance annually from denying claims that might have otherwise paid.

c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.

The amount of time between the identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution varies depending on the circumstances of the case and, for allegations of fraud, based on state and federal law enforcement partners. MassHealth and its law enforcement partners will pursue recoveries for as long as it takes to develop and assess the available evidence, initiate recovery actions or legal and criminal proceedings, and bring those actions to resolution.

d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR 455.23, including the number of payment suspensions issued annually since January 1st, 2021, and the provider types or services impacted.

As noted above, and consistent with federal Medicaid program integrity regulations at 42 C.F.R. Part 455, Subpart A, MassHealth refers credible

[11] See Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud - CMS.

allegations of fraud to MFD and implements payment suspensions. When MassHealth imposes a payment suspension, it issues a notice of withhold to the provider, directs its accounting systems to stop payments, and instructs MassHealth managed care plans to suspend payments to the provider as well.

Since January 2021, MassHealth has implemented 105 payment suspensions affecting the following provider types as part of its robust program integrity program:

- Physician
- Nursing Facilities
- Dental
- Mental Health Centers
- Substance Use Disorder Treatment
- Labs
- Transportation
- Home Health
- Adult Foster Care
- Adult Day Health
- Group Practices
- HCBS Waiver Provider
- Licensed Independent Behavioral Health Clinicians
- Continuous Skilled Nursing

e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021

Massachusetts actively pursues both civil and criminal enforcement actions to address Medicaid FWA. These enforcement efforts are led primarily by MFD, which serves as the state's Medicaid Fraud Control Unit and is responsible for investigating and prosecuting fraud involving the MassHealth program. MFD is a division of the Attorney General's Office. MassHealth is aware that civil and criminal enforcement recoveries for the requested period are reported annually by the HHS Office of Inspector General in its publicly available Medicaid Fraud Control Unit reports.[12] According to that report, from federal fiscal year 2021 through federal fiscal year 2024 (federal fiscal year 2025 data is not yet publicly available), civil and criminal enforcement actions brought by MFD in Massachusetts resulted in substantial recoveries. Because these recoveries reflect actions across multiple years of investigation and prosecution, annual figures reflect the variability of case closure timelines and outcomes; for example, a single large settlement can substantially shift a single year's total. These recoveries reflect the state's ongoing and sustained use of civil and criminal enforcement tools to investigate credible allegations of fraud, pursue liability where appropriate, and recover Medicaid funds.

10. Please provide information regarding screening, oversight, and enforcement actions related to Medicaid fiscal intermediaries including:

a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.

Fiscal Intermediaries (FIs) participating in MassHealth are classified as limited-risk providers under federal Medicaid screening rules. As a result, they undergo the screening procedures outlined in response to Question 5, including ownership disclosure review, exclusion database checks, and

[12] See Medicaid Fraud Control Units - U.S. Department of Health and Human Services.

standard provider enrollment and credentialing requirements. These measures help ensure that the FI operates with appropriate oversight and financial accountability. MassHealth follows federal revalidation guidelines; revalidation of the FI[13] was last completed in early March 2026.

b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.

MassHealth uses a layered set of pre-payment and post-payment tools to monitor caregiver time reporting, billing accuracy, and verification of services furnished through the sole fiscal intermediary in the self-directed Personal Care Attendant (PCA) program. The PCA program is a member-directed program that enables MassHealth members with chronic disabilities to hire PCAs to assist them with their personal care needs. MassHealth uses Electronic Visit Verification (EVV), a technology system that electronically verifies that PCA home and community-based care visits occur as scheduled and as billed. EVV creates an electronic record that is matched against the submitted claims.

MassHealth has robust controls in place to ensure PCA billing accuracy by the FI. FI claims are only paid if an active prior authorization is in place for the member. The prior authorization ensures medical necessity criteria have been met and establishes the number of service units authorized. MassHealth runs automated claims edits and checks to block billing that exceeds authorized units, falls outside of the authorized service dates, or is for a member who is deceased. Additionally, MassHealth's claims edits review billing for duplicative services or services rendered while the member was in a skilled nursing facility or hospital and will deny claims in these instances.

The FI has additional program integrity mechanisms in place. The FI regularly completes associated quality assurance activities, including:

[13] As discussed in response to Question 10(c), MassHealth has had a single FI since 2022.

- Ensuring a prior authorization is in place prior to paying a PCA to ensure the member meets eligibility requirements

- Auditing PCA payments to ensure members and PCAs continue to meet eligibility requirements

- Auditing claims for payment of PCA services submitted to MassHealth

- Running monthly reports of PCAs with HHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) exclusion lists to ensure that no payments are made to individuals or organizations so identified by OIG

c. The frequency and scope of audits conducted on fiscal intermediaries since January 1st, 2021, including audits conducted by the state or third-party contractors.

Since 2022, MassHealth has had a single FI. MassHealth moved from contracting with three FIs to contracting with a single FI to streamline oversight and improve operations of the PCA program. In 2025, MassHealth conducted a comprehensive audit of the FI's Uniform Financial Reporting (UFR) filings, policies and procedures. MassHealth routinely conducts both pre-payment and post-payment reviews of claims submitted by the FI to ensure the accuracy and appropriateness of billed services. These reviews include, but are not limited to, verification of applicable rates and validation of services that require prior authorization.

d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended or otherwise subject to corrective action since January 1, 2021 and the basis for those actions.

Two fiscal intermediaries have been sanctioned for contract violations since January 1, 2021. As noted above, since 2022, MassHealth has had a single FI in order to streamline oversight and operations.

In Conclusion

Thank you for your interest and shared commitment to promoting program integrity best practices, safeguarding valuable state and federal resources, and investing in technologies to strengthen early detection of FWA. MassHealth is proud to operate a robust program integrity program which has been shaped by our close and ongoing collaboration with our partners at CMS and law enforcement.

Sincerely,

Dr. Kiame J. Mahaniah, MD
Secretary
Executive Office of Health and Human Services
1 Ashburton Pl., 11th Fl.
Boston, MA 02108

Enclosure

cc:

The Honorable Maura Healey
Governor
Commonwealth of Massachusetts
Massachusetts State House
24 Beacon St.
Boston, MA 02133

Michael Levine
Undersecretary for MassHealth
1 Ashburton Pl., 11th Fl.
Boston, MA 02108

Attachment A: External Audit List

Completed Reports *(Date listed represents final report date)*		
Audit Entity	**Audit Title**	**Date**
Federal Office of the Inspector General	Non-Emergency Medical Transportation (NEMT)	1/25/2021
Massachusetts Office of the Inspector General	MassHealth and Health Safety Net: 2021 Annual Report	3/8/2021
Massachusetts Office of the Inspector General	2020 Annual Report	4/30/2021
Massachusetts State Auditor's Office	Payments for Hospice-Related Services for Dual-Eligible Members	7/20/2021
Massachusetts Office of the Inspector General	MassHealth and Health Safety Net: 2022 Annual Report	3/1/2022
Federal Office of the Inspector General	Department of Developmental Supports (Critical Incident Reporting)	4/25/2022
Massachusetts State Comptroller	FY21 Single State Audit	4/28/2022
Massachusetts Office of the Inspector General	2021 Annual Report	4/29/2022
Massachusetts State Auditor's Office	Review of Claims Submitted by Dr. Melissa Hamilton	5/22/2022
Massachusetts State Auditor's Office	Review of Claims Submitted by Dr. Nicholas Franco	5/22/2022
Massachusetts State Auditor's Office	Review of Continuity of Operations Plan	7/15/2022

Attachment A: External Audit List

Audit Entity	Audit Title	Date
Massachusetts State Auditor's Office	Delivery System Reform Incentive Payment (DSRIP)	7/29/2022
Massachusetts State Auditor's Office	Review of Telehealth	11/23/2022
Massachusetts Office of the Inspector General	MassHealth and Health Safety Net: 2023 Annual Report	3/31/2023
Massachusetts Office of the Inspector General	2022 Annual Report	4/26/2023
Federal Office of the Inspector General	Penetration Audit	5/16/2023
Massachusetts State Auditor's Office	Review of Capitation Payments	6/28/2023
Massachusetts State Comptroller	FY22 Single State Audit	6/30/2023
Centers for Medicare & Medicaid Services	Payment Error Rate Measurement RY23	11/15/2023
Massachusetts Office of the Inspector General	MassHealth and Health Safety Net: 2024 Annual Report	3/1/2024
Massachusetts Office of the Inspector General	2023 Annual Report	4/30/2024
Massachusetts State Comptroller	FY23 Single State Audit	5/28/2024
Federal Office of the Inspector General	Unwinding Audit-Eligibility	8/13/2024

Attachment A: External Audit List

Audit Entity	Audit Title	Date
Federal Office of the Inspector General	Opioid Treatment Program Services	8/29/2024
Massachusetts State Auditor's Office	Review of Payment for Telehealth Adult Foster Care	9/4/2024
Centers for Medicare & Medicaid Services	Non-Emergency Medical Transportation (NEMT) Expenditures Reporting	12/24/2024
Massachusetts State Auditor's Office	Review of Capitation Payments with Multiple Identification Numbers	12/31/2024
Federal Office of the Inspector General	Safety Net Care Pool	2/19/2025
Massachusetts Office of the Inspector General	2025 Annual Report on MassHealth and the Health Safety Net	3/3/2025
Massachusetts State Auditor's Office	Review of Claims Submitted by Dental Arts Lawrence	4/2/2025
Massachusetts State Comptroller	FY24 Single State Audit	4/29/2025
Massachusetts Office of the Inspector General	2024 Annual Report	4/30/2025
Massachusetts State Auditor's Office	Review of Transportation Services	5/8/2025
Massachusetts State Auditor's Office	Review of Payment for Telehealth Adult Day Health	10/1/2025
Massachusetts State Auditor's Office	Review of Durable Medical Equipment Providers	10/30/2025

Attachment A: External Audit List

Audit Entity	Audit Title	Date
Massachusetts Office of the Inspector General	2026 Annual Report on MassHealth and the Health Safety Net	3/2/2026
Massachusetts State Comptroller	FY25 Single State Audit	3/1/2026

Ongoing Reports
(Date listed represents notification date)

Audit Entity	Audit Title	Date
Centers for Medicare & Medicaid Services/Unified Program Integrity Contractor	Hospice Review - Hospice reviews will be conducted to verify that proper documentation is in the patient file, the recipient meets eligibility requirements, and the appropriate level of care was billed. The review period is 2020-2022	4/25/2023
Centers for Medicare & Medicaid Services	Payment Error Rate Measurement RY26	4/18/2024
Centers for Medicare & Medicaid Services/Unified Program Integrity Contractor	Unified Program Integrity Contractor (UPIC) is performing a dental desk review project for Region 1. The UPIC completed a project on Limited Oral Evaluation (LOE). Time period is January 1, 2021 through August 31, 2024	1/7/2025
Massachusetts State Auditor's Office	Antipsychotics for Members in Nursing Homes	10/15/2025
Centers for Medicare & Medicaid Services/Unified Program Integrity Contractor	UPIC to perform pharmacy inventory reviews which are focused on identifying drug shortages and calculating an overpayment based on the shortage for independent retail pharmacies	1/16/2026
Massachusetts State Auditor's Office	Claim reimbursement for outpatient clinical diagnostic laboratory services	1/29/2026

Attachment B: Provider Types and Risk Levels

PROVIDER TYPE	Risk Level: L - Limited, M - Moderate, H - High
ACUPUNCTURIST	L
ACUTE INPATIENT HOSPITAL	L
ACUTE OUTPATIENT HOSPITAL	L
ADULT DAY HEALTH	L
ADULT FOSTER CARE	H
AGING SERVICES ACCESS POINTS	L
AMBULATORY SURGERY CENTER	L
AUDIOLOGIST	L
BIRTHING CENTER	L
CBHI CHILDRENS BEHAVIORAL HLTH INITIATIVE MCE ONLY	L
CERTIFIED INDEPENDENT LABORATORY	M
CERTIFIED REGISTERED NURSE ANESTHETISTS	L
CHIROPRACTOR	L
CHRONIC INPATIENT HOSPITAL	L
CHRONIC OUTPATIENT HOSPITAL	L
CLINICAL NURSE SPECIALIST (CNS)	L
COMMUNITY BEHAVIORAL HEALTH CENTER (CBHC)	L

Attachment B: Provider Types and Risk Levels

PROVIDER TYPE	Risk Level: L - Limited, M - Moderate, H - High
COMMUNITY HEALTH CENTER (CHC)	L
COMMUNITY SUPPORT PROGRAM CSP	L
CONTINUOUS SKILLED NURSING AGENCY	Once Enrolled = M Newly Enrolling = H
DAY HABILITATION	L
DENTAL CLINIC	L
DENTAL SCHOOL CLINIC GRADUATE	L
DENTAL SCHOOL CLINIC UNDERGRADUATE	L
DENTIST	L
DIETICIAN MCE ONLY	L
DIVERSIONARY SERVICES 24 HR MCE ONLY	L
DIVERSIONARY SERVICES NON 24 HR MCE ONLY	L
DOULA PROVIDER	L
DURABLE MEDICAL EQUIPMENT	Once Enrolled = M Newly Enrolling = H
EARLY INTERVENTION	L
FAMILY PLANNING AGENCY	L
GROUP ADULT FOSTER CARE (GAFC)	H
GROUP PRACTICE ORGANIZATION	Group Practices without Physical Therapists = L Physical Therapists = M

Attachment B: Provider Types and Risk Levels

PROVIDER TYPE	Risk Level: L - Limited, M - Moderate, H - High
HEARING INSTRUMENT SPECIALIST	L
HOME HEALTH AGENCY	Once Enrolled = M Newly Enrolling = H
HOSPICE CARE	Once Enrolled = M Newly Enrolling = H
HOSPITAL LICENSED HEALTH CENTER (HLHC)	L
HRSN (HEALTH-RELATED SOCIAL NEEDS) MCE ONLY	L
ICF-IDD	L
INDEPENDENT DIAGNOSTIC TESTING FACILITY (IDTF)	M
INDEPENDENT NURSE	L
INDIAN HEALTH SERVICES	L
INTENSIVE RESIDENTIAL TREATMENT PROGRAM (IRTP)	L
LICENSED MENTAL HEALTH COUNSELORS AND LICENSED MARRIAGE AND FAMILY THERAPISTS	L
LICENSED INDEPENDENT CLINICAL SOCIAL WORKER	L
LIMITED SERVICES CLINICS	L
MENTAL HEALTH CENTER	M
NURSE MIDWIFE	L
NURSE PRACTITIONER	L
NURSING FACILITY	Once Enrolled= M Newly Enrolling = H

Attachment B: Provider Types and Risk Levels

PROVIDER TYPE	Risk Level: L - Limited, M - Moderate, H - High
OCULARIST	L
OPTICIAN	L
OPTOMETRIST	L
ORTHOTICS	Once Enrolled = M Newly Enrolling = H
OXYGEN AND RESPIRATORY THERAPY EQUIP	Once Enrolled = M Newly Enrolling = H
PEER SUPPORT MCE ONLY	L
PHARMACIST	L
PHARMACY	L
PHYSICIAN	L
PHYSICIAN ASSISTANT	L
PODIATRIST	L
PROGRAM OF ASSERTIVE COMMUNITY TREATMENT (PACT)	L
PROSTHETICS	Once Enrolled = M Newly Enrolling = H
PSYCHIATRIC CLINICAL NURSE SPECIALISTS (PCNS)	L
PSYCHIATRIC DAY TREATMENT	L
PSYCHIATRIC INPATIENT HOSPITAL (ALL AGES)	L
PSYCHIATRIC OUTPATIENT HOSPITAL	L

Attachment B: Provider Types and Risk Levels

PROVIDER TYPE	Risk Level: L - Limited, M - Moderate, H - High
PSYCHOLOGIST	L
PUBLIC HEALTH DENTAL HYGIENIST	L
RADIATION ONCOLOGY TREATMENT CENTERS	L
REHABILITATION CENTER	L
RENAL DIALYSIS CLINIC	L
SCHOOL-BASED MEDICAID	L
SPECIAL PROGRAMS – such as: Certified Mastectomy Fitter (CMF) Wig Provider	L
SPEECH AND HEARING CENTER	L
STATE AGENCY SERVICES	L
STERILIZATION CLINIC	L
SUBSTANCE ADDICTION DISORDER INPATIENT HOSPITAL	L
SUBSTANCE ADDICTION DISORDER OUTPATIENT HOSPITAL	L
SUBSTANCE USE DISORDER TREATMENT	L
THERAPIST	Physical Therapy = M Speech Therapy = L Occupational Therapy = L
TRANSPORTATION	Ambulance = M Transportation Brokers = L
URGENT CARE CLINIC	L
VISION VOLUME PURCHASER	L

Attachment C: 1915(c) Waiver Program Descriptions

Program Name	Original Base Waiver Number	Provider Category Risk Level	Original Effective Date	Most Recent Renewal Effective date	Eligibility
Frail Elder Waiver (FEW)	MA.0059	Limited	1983	1/1/2024	The Frail Elder Waiver serves individuals age 60 and older, who meet the clinical eligibility criteria for nursing facility level of care.
Traumatic Brain Injury Waiver (TBI)	MA.0359	Limited	7/1/2001	7/1/2024	The Traumatic Brain Injury Waiver serves individuals age 18 and older, with a confirmed diagnosis of a traumatic brain injury, who meet the clinical eligibility criteria for nursing facility level of care or chronic/rehabilitation hospital level of care.
DDS - Intensive Supports (IS)	MA.0827	Limited	1984	7/1/2023	The DDS - Intensive Supports Waiver serves individuals age 22 and older with an intellectual disability as defined by Massachusetts Department of Developmental Services who meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care and are determined through an assessment process to require supervision and support for 24 hours, 7 days per week to avoid institutionalization.
DDS - Community Living (CL)	MA.0826	Limited	1984	7/1/2023	The DDS - Community Living Waiver serves individuals age 22 and older with an intellectual disability as defined by Massachusetts Department of Developmental Services who meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care and who are determined through an assessment process to require Community Living Supports due to a moderate level of assessed need.
DDS – Adult Supports (AS)	MA.0828	Limited	1984	7/1/2023	The DDS – Adult Supports Waiver serves individuals age 22 and older who have an intellectual disability as defined by the Massachusetts Department of Developmental Services and meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care and who are determined through an assessment process to require at least one home and community based waiver service per month to avoid institutionalization but do not require the amount of services provided under the Community Living Waiver (MA.0826).
Children's Autism Spectrum Disorder	MA.40207	Limited	10/1/2007	10/1/2025	The Children's Autism Spectrum Disorder Waiver serves children from birth through age 9 who have autism spectrum disorders and meet the Intermediate Care Facilities for Individuals with Intellectual Disabilities level of care.

Attachment C: 1915(c) Waiver Program Descriptions

Program Name	Original Base Waiver Number	Provider Category Risk Level	Original Effective Date	Most Recent Renewal Effective date	Eligibility
Acquired Brain Injury Non-Residential Habilitation (ABI-N)	MA.40702	Limited	5/1/2010	5/1/2023	The Acquired Brain Injury Non-Residential Habilitation Waiver serves individuals age 22 and older who have sustained a brain injury after age 22. Individuals must also have resided for a period of not less than 90 consecutive days in a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital, and meet the clinical eligibility criteria for nursing facility level of care or chronic, rehabilitation, or psychiatric hospital level of care.
Acquired Brain Injury with Residential Habilitation (ABI-RH)	MA.40701	Limited	5/1/2010	5/1/2023	The Acquired Brain Injury with Residential Habilitation Waiver serves individuals age 22 and older who have sustained a brain injury after age 22. Individuals must also have resided for a period of not less than 90 consecutive days in a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital, be assessed to need a residential support service, and meet the clinical eligibility criteria for nursing facility level of care or chronic, rehabilitation, or psychiatric hospital level of care.
Moving Forward Plan Community Living (MFP-CL)	MA.1027	Limited	4/1/2013	4/1/2023	The Moving Forward Plan Community Living Waiver serves adults, age 18 and older, with physical disabilities or mental illness, or both. Individuals must also have resided for a period of not less than 90 consecutive days in a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital and meet the clinical eligibility criteria for nursing facility level of care or chronic, rehabilitation, or psychiatric hospital level of care.
Moving Forward Plan Residential Supports (MFP-RS)	MA.1028	Limited	4/1/2013	4/1/2023	The Moving Forward Plan Residential Supports Waiver serves adults, age 18 and older, with physical disabilities or mental illness, or both. Individuals must also have resided for a period of not less than 90 consecutive days in a nursing facility, chronic disease or rehabilitation hospital, or psychiatric hospital and meet the clinical eligibility criteria for nursing facility level of care or chronic, rehabilitation, or psychiatric hospital level of care.

Attachment D: 1915(c) Waiver Enrollment and Spending CY21-CY25

	2021		2022		2023		2024		2025*	
	Enrollment	Spending	Enrollment	Spending	Enrollment	Spending	Enrollment	Spending	Enrollment	Spending
ABI-N	72	$ 4,879,964	64	$ 4,958,765	61	$ 5,253,515	79	$ 6,838,247	94	$ 9,325,641
ABI-RH	638	$ 133,199,055	649	$ 144,504,562	644	$ 155,518,241	658	$ 158,462,758	659	$ 86,792,848
MFP-CL	909	$ 61,319,208	927	$ 72,300,475	911	$ 84,390,142	951	$ 96,985,580	1,096	$ 107,066,809
MFP-RS	357	$ 64,575,573	359	$ 77,112,696	423	$ 93,424,136	473	$ 107,504,320	503	$ 62,863,305
Autism	281	$ 3,282,008	288	$ 3,463,056	364	$ 4,117,909	337	$ 4,310,737	167	$ 1,529,092
DDS-AS	4,426	$ 72,911,273	4,276	$ 75,026,536	3,952	$ 66,731,879	3,500	$ 61,473,807	3,362	$ 35,313,942
DDS-CL	2,266	$ 53,634,325	2,524	$ 62,036,164	2,936	$ 75,235,742	2,812	$ 83,713,178	2,572	$ 41,979,003
DDS-IS	10,085	$ 1,560,001,849	10,020	$ 1,662,683,237	10,198	$ 1,641,443,632	10,307	$ 1,614,207,116	9,971	$ 826,262,327
FEW	12,503	$ 239,769,966	11,933	$ 245,959,951	12,423	$ 288,620,785	13,518	$ 353,902,056	10,477	$ 346,832,866
TBI	90	$ 13,662,499	86	$ 14,111,349	84	$ 13,691,620	80	$ 12,731,485	73	$ 5,400,681
TOTAL	31,627	$ 2,207,235,721	31,126	$ 2,362,156,792	31,996	$ 2,428,427,601	32,715	$ 2,500,129,284	28,974	$ 1,523,366,515

*For all waivers, data from CY2025 is incomplete.

Attachment E: 1915(c) Waiver Services

Waiver services approved by CMS as of 06/24/24 grouped by category	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Community Living Waiver (DDS)	Intensive Supports Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOAI)	Traumatic Brain Injury Waiver (MRC)	Children's Autism Waiver (DDS)
Residential Support Services										
Residential Habilitation	X		X			X			X	
Shared Living - 24 Hour Supports	X		X			X			X	
Assisted Living Services	X		X							
Independent Living Supports		X		X						
Shared Home Supports		X		X						
24-Hour Self Directed Home Sharing Support						X				
Personal Care/ADL Supports										
Home Health Aide		X		X				X		
Personal Care		X		X				X		
Supportive Home Care Aide		X		X				X		
In-Home Supports/IADL Supports										
Adult Companion		X		X	X	X	X	X	X	
Chore Service		X		X	X	X	X	X		
Grocery Shopping and Home Delivery								X		
Home Delivery of Pre-packaged Medication								X		
Home-Delivered Meals		X		X				X		X
Homemaker		X		X				X	X	X

Attachment E: 1915(c) Waiver Services

Waiver services approved by CMS as of 06/24/24 grouped by category	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Community Living Waiver (DDS)	Intensive Supports Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOAI)	Traumatic Brain Injury Waiver (MRC)	Children's Autism Waiver (DDS)
Individualized Home Supports					X	X	X			
Laundry		X		X				X		
Live-in Caregiver					X	X				
Community Engagement & Skills Training										
Community Based Day Supports	X	X	X	X	X	X	X			
Community Integration										X
Day Services	X	X	X	X				X[1]	X	
Evidence Based Education Programs								X		
Goal Engagement Program								X		
Individualized Day Supports					X	X	X			
Individual Support and Community Habilitation	X[2]	X	X[2]	X					X	
Peer Support	X	X	X	X	X	X	X	X		
Prevocational Services	X	X	X	X						
Supported Employment	X	X	X	X	X[3]	X[3]	X[3]		X	
Transportation	X	X	X	X	X	X	X	X	X	
Therapy and Nursing										
Complex Care Training & Oversight								X		
Occupational Therapy	X	X	X	X						

Attachment E: 1915(c) Waiver Services

Waiver services approved by CMS as of 06/24/24 grouped by category	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Community Living Waiver (DDS)	Intensive Supports Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOAI)	Traumatic Brain Injury Waiver (MRC)	Children's Autism Waiver (DDS)
Physical Therapy	X	X	X	X						
Skilled Nursing	X	X	X	X						
Speech Therapy	X	X	X	X						
Family Support/Respite										
Alzheimer's/Dementia Coaching (Habilitation Therapy)								X		
Family Training	X	X	X	X	X	X	X			X
Respite		X		X	X	X	X	X	X	X
Stabilization					X	X	X			
Environmental Modifications and Accessibility Supports										
Assistive Technology	X	X	X	X	X	X	X	X[6]		X
Assistive Technology for Telehealth [4]								X	X	
Enhanced Technology/Cellular PERS								X		
Medication Dispensing System								X		
Home Based Wandering Response Systems								X		
Home / Environmental Accessibility Adaptations (Home mods)	X[5]	X	X[5]	X	X	X	X	X	X	X
Home Safety & Independence Evaluations (Occupational Therapy)								X		
Orientation and Mobility Services	X	X	X	X				X		
Remote Supports and Monitoring					X	X	X			

Attachment E: 1915(c) Waiver Services

Waiver services approved by CMS as of 06/24/24 grouped by category	ABI Residential Habilitation Waiver (DDS)	ABI Non-Residential Waiver (MRC)	MFP Residential Supports Waiver (DDS)	MFP Community Living Waiver (MRC)	Community Living Waiver (DDS)	Intensive Supports Waiver (DDS)	Adult Supports Waiver (DDS)	Frail Elder Waiver (EOAI)	Traumatic Brain Injury Waiver (MRC)	Children's Autism Waiver (DDS)
Specialized Medical Equipment	X	X	X	X	X	X	X		X	
Virtual Communication and Monitoring (VCAM)								X		
Vehicle Modification		X		X	X	X	X			X
Transitional Assistance/Individual Goods										
Transitional Assistance Services	X	X	X	X		X		X	X	
Individual Goods and Services					X	X	X			X
Behavioral Supports										
Behavioral Supports and Consultation					X	X	X			X
Community Behavioral Health Support & Navigation	X	X	X	X						
Expanded Habilitation, Education										X

[1] Supportive Day Program for Frail Elder Waiver.
[2] Available only in Assisted Living.
[3] DDS Waivers provide both Group Supported Employment and Individual Supported Employment services.
[4] AT for Telehealth procures devices to enable engagement in telehealth, whereas AT procures devices and may include an evaluation and training.
[5] Available only in Shared Living.
[6] Assistive Technology - Electronic Comfort Animals for Frail Elder Waiver.
MFP demonstration enrollees may receive transitional assistance, assistive technology, and community engagement navigation services.