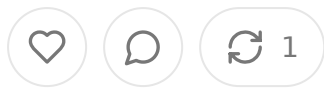


Bridging the Gap: Private Sector Solutions to Medicaid Interstate Duplication

MAR 27, 2025 • PAID



Share

Introduction

On March 27, 2025, MSN republished a Wall Street Journal investigation titled "Taxpayers Spent Billions Covering the Same Medicaid Patients Twice," revealing a systemic failure in America's healthcare administration system. The investigation exposed how taxpayers have wasted billions of dollars through simultaneous Medicaid premium payments for the same individuals in different states. This duplicative spending represents one of the most significant yet least addressed inefficiencies in America's public healthcare system.

According to the investigation, "in a single three-month period, states paid twice the healthcare of more than 400,000 people enrolled simultaneously in two state Medicaid programs." The reporting found that over time, these duplicative payments have likely cost taxpayers billions of dollars, with managed care organizations collecting monthly premiums for patients who had already moved to different states and enrolled in new Medicaid programs.

The problem persists due to a fragmented system where states operate their Medicaid programs independently with minimal interstate coordination. As the article notes, "States are supposed to disenroll people when they move away or otherwise become ineligible, but the system frequently fails." Despite federal officials being aware of the issue for years, little has been done to address it. The investigation found that "officials at the Centers for Medicare and Medicaid Services have known about the duplicate coverage problem for years but haven't fixed it."

The problem is particularly acute when considering the scale of Medicaid in American healthcare. Medicaid serves approximately 80 million Americans, with federal and state governments spending over \$800 billion annually on the program. With such massive expenditures, even small inefficiencies translate to substantial wasted taxpayer money. The investigation highlighted that "the duplicate enrollments mean that two states each pay an insurer to cover the same person, though only one can actually be providing care."

This essay explores how private sector innovation could address this systemic failure by developing business models, product architectures, and data systems that facilitate efficient interstate coordination while navigating the complex regulatory landscape of healthcare data sharing. The analysis will focus on practical, implementable solutions that could save billions in taxpayer funds by preventing duplicative Medicaid payments across state lines.

Part I: Understanding the Problem Space

The Magnitude and Mechanics of Medicaid Duplication

The Wall Street Journal investigation revealed the staggering scale of the problem: in a single three-month period, states paid twice for the healthcare of more than 40 million people enrolled simultaneously in two states' Medicaid programs. Extrapolated over multiple years, this has likely resulted in billions of dollars in wasted taxpayer money. The reporting found that while the exact amount is difficult to calculate precisely due to varying premium rates across states and programs, "the duplicate enrollments mean that two states each pay an insurer to cover the same person, though only one can actually be providing care."

These duplicative payments occur primarily through Medicaid managed care programs, where states pay private insurers a fixed monthly premium for each enrollee, typically ranging from several hundred to over a thousand dollars per person per month. When Medicaid recipients move across state lines, they naturally apply for benefits in their new state of residence. However, the state they left often continues

paying premiums for months or even years after the person has relocated, creating a situation where two different states are simultaneously paying for the same individual's coverage.

The mechanics of the problem are rooted in how Medicaid programs operate across state lines. When beneficiaries move, they typically apply for Medicaid in their new state but rarely formally disenroll from their previous state's program. The former state often has limited mechanisms to identify when beneficiaries have left their jurisdiction. As the investigation reported, "States are supposed to disenroll people when they move away or otherwise become ineligible, but the system frequently

The investigation exposed several key failure points in the current system. First, there is no national database or real-time verification system that states can use to check if an applicant is already enrolled in another state's Medicaid program. States operate their Medicaid systems independently, with limited visibility into other states' enrollment data. This creates a fundamental information gap that enables duplicate enrollments to occur and persist.

Second, the financial incentives in the system don't encourage detection of these duplications. Managed care organizations receive capitated payments for each enrollee, giving them little financial incentive to report when enrollees have likely moved out of state. As the article noted, "Insurers have no immediate financial reason to tell states when they suspect people have moved, since they collect monthly premiums for each enrollee."

Third, privacy laws and regulations create both real and perceived barriers to interstate data sharing. Healthcare data is among the most protected categories of personal information, and concerns about violating privacy regulations often inhibit information exchange that could help identify duplicate enrollments.

Fourth, the technical infrastructure for Medicaid administration varies widely across states. State Medicaid Management Information Systems (MMIS) range from modern interoperable platforms to legacy systems with limited capabilities for external communication.

exchange. This technical heterogeneity makes coordination challenging even when legal and privacy barriers can be overcome.

The investigation highlighted specific examples that illustrate the real-world impact of these systemic failures. In one case, two neighboring states paid insurers to cover the same woman for more than two years, with each state paying around \$700 a month—a total of approximately \$33,600 in duplicate payments for a single beneficiary. In another instance, a man continued to be enrolled in one state's Medicaid program more than four years after he moved to another state and signed up there—potentially resulting in over \$48,000 in wasteful spending for just one individual.

These examples demonstrate how the problem can persist for extended periods without detection, multiplied across hundreds of thousands of beneficiaries nationally. The result is billions in unnecessary taxpayer expenditures that could otherwise be directed to expanding services, improving care quality, or addressing other healthcare needs.

Furthermore, the investigation revealed that federal officials have known about the duplicate coverage problem for years but haven't implemented an effective solution. Despite the Centers for Medicare & Medicaid Services (CMS) being aware of the problem, they have not mandated or created a comprehensive approach to address it, leaving room for private sector intervention.

Regulatory and Privacy Landscape

Any solution to Medicaid duplication must navigate a complex regulatory environment. The Health Insurance Portability and Accountability Act (HIPAA) establishes strict guidelines for how protected health information (PHI) can be shared, requiring appropriate security measures, consent mechanisms, and data minimization practices. Additional federal regulations like 42 CFR Part 2, which provides enhanced protections for substance use disorder treatment records, further complicate information sharing for some Medicaid beneficiaries.

Beyond federal requirements, states often have their own privacy laws that can be more stringent. Laws like California's CCPA/CPRA, Virginia's CDPA, and similar regulations in other states create a patchwork of compliance requirements that any interstate solution must address. Many states require explicit consent from beneficiaries before their information can be shared across state lines, adding operational complexity to potential solutions.

Despite these challenges, the regulatory landscape also provides pathways forward. The 21st Century Cures Act promotes interoperability in healthcare information technology, and CMS has signaled support for solutions that reduce waste and improve program integrity. A successful private sector solution must balance compliance with innovation, treating regulatory requirements not as mere hurdles but as design parameters that can guide the development of trustworthy systems.

Part II: Potential Business Models

The Interstate Clearinghouse Model

A promising business model to address Medicaid duplication is the creation of a private interstate clearinghouse that serves as a trusted third party for verifying Medicaid enrollment across state lines. This entity would operate a specialized system that helps states identify potential duplicate enrollments in real-time during the application process and periodically for existing beneficiaries.

The clearinghouse would generate revenue through several streams. States would pay subscription fees based on their Medicaid population size, with additional transaction fees for verification queries. A particularly attractive option is performance-based pricing, where the clearinghouse receives a percentage of documented savings from prevented or terminated duplicate enrollments. This aligns incentives and ensures that states only pay for demonstrable value.

For states, the value proposition is compelling: significant reduction in improper payments with minimal disruption to existing operations. The clearinghouse would require limited integration with state systems and operate as a specialized service.

rather than a replacement for core Medicaid functions. By generating savings far exceeding its operational costs, the clearinghouse could deliver strong return on investment for participating states while creating a sustainable business.

Initial implementation would focus on a coalition of neighboring states with high interstate migration patterns, such as the Northeast corridor (New York, New Jersey, Connecticut) or the Southwest region (Texas, Arizona, New Mexico). Success with these initial partnerships would create momentum for wider adoption, eventually expanding to national coverage.

The clearinghouse model addresses key barriers in the current system. As a neutral third party with appropriate governance and security measures, it could overcome privacy concerns that might hinder direct state-to-state data sharing. Its specialized focus would enable the development of sophisticated matching algorithms specifically designed for the complexities of Medicaid beneficiary identification, addressing technical challenges that have prevented effective solutions to date.

Advanced Analytics for Program Integrity

An alternative approach focuses on developing sophisticated analytics capabilities that states can use to identify potential duplicate enrollments without necessarily requiring direct exchange of identified beneficiary data. This analytics-as-a-service model emphasizes pattern detection and risk scoring, creating value through intelligence rather than data exchange.

The business would offer tiered subscription levels, from basic duplication detection to comprehensive program integrity analytics. Revenue would come primarily from subscription fees, supplemented by performance-based contracts that tie payment to verified cost savings. Additional consulting services for implementation support and optimization would provide ancillary revenue streams.

This model could start with retrospective analysis for states, demonstrating value by identifying existing duplications before moving toward real-time applications. The initial focus would be on states with the largest Medicaid populations or those v

known duplication issues. By proving value quickly through measurable savings service could rapidly build credibility and expand its market.

The analytics approach leverages advanced techniques including machine learning, probabilistic matching, and network analysis to identify patterns indicative of duplicate enrollment across states. The sophisticated algorithms could detect potential duplicates even with incomplete or inconsistent identifying information, addressing one of the key technical challenges in the current system.

A significant advantage of this model is that it might face fewer regulatory hurdles than approaches requiring extensive exchange of identified data. By focusing on patterns and risk scores rather than raw personal information, it could navigate privacy constraints more easily while still delivering substantial value.

The Public-Private Partnership Consortium

A third model brings together multiple stakeholders—states, managed care organizations, technology providers, and privacy experts—in a formal consortium structure to jointly develop and operate solutions to the duplication problem. This approach recognizes that the challenge requires coordination across multiple entities and creates a governance structure to facilitate that coordination.

The consortium would generate revenue through membership fees from participating organizations, supplemented by service fees for specific functions provided to members. Additional funding could come from grants and shared savings arrangements, where verified cost reductions are partially returned to the consortium to fund ongoing operations.

This approach would begin by establishing the governance structure and securing commitments from key stakeholders, particularly states with significant Medicaid populations. Initial projects would focus on defining standards and protocols before moving to implementation of specific technical solutions.

The consortium creates value through collective action, addressing coordination problems that individual entities cannot solve alone. By bringing diverse stakeholders

together, it can develop solutions that balance competing interests and align incentives across the ecosystem. This model also creates a platform for addressing related challenges beyond duplicate enrollment, potentially expanding its scope to tackle other program integrity issues.

The consortium model is particularly well-suited to address the political and organizational challenges that have hindered previous efforts to solve the duplicate problem. By creating a formal structure for collaboration with appropriate governance and transparency, it can build the trust necessary for effective cross-coordination.

Part III: Product Architecture and Technical Requirements

Core System Components

A comprehensive solution to Medicaid duplication requires several key technical components working in concert. At the heart of any effective system is a sophisticated identity resolution engine capable of accurately matching beneficiary records across state systems despite variations in data quality, formatting, and completeness.

This identity resolution capability must incorporate probabilistic matching algorithms that can handle incomplete or inconsistent data, configurable matching thresholds to balance sensitivity and specificity, and the ability to incorporate multiple identifiers including name, date of birth, Social Security Number, address history, and other available data points. Machine learning capabilities would allow the system to improve matching accuracy over time based on confirmed matches and non-matches, addressing the challenge of evolving beneficiary information.

The system would also need a secure data exchange framework for transmitting and processing protected health information across organizational boundaries while maintaining compliance with all relevant regulations. This would include end-to-end encryption for all data in transit and at rest, comprehensive access controls and

authentication mechanisms, and data minimization capabilities to limit exposure of sensitive information to only what is necessary for specific functions.

To connect with diverse state Medicaid systems, the solution requires flexible integration adaptors that can accommodate various technological maturity levels and system architectures. These adaptors would support multiple integration patterns from real-time APIs to periodic batch file exchanges, along with transformation capabilities to normalize data from disparate sources. The ability to adapt to state-specific requirements without requiring major modifications to core state system architecture is essential for widespread adoption.

A comprehensive analytics and reporting platform would complete the core architecture, providing actionable insights to stakeholders through real-time dashboards, predictive models to identify high-risk scenarios, and pattern detection algorithms to identify systematic issues. Customizable reports would address the needs of different stakeholder groups, from operational staff to executive leadership, with appropriate security controls ensuring that each user only accesses information relevant to their role.

Supporting these technical components, a workflow management system would coordinate the human processes necessary for investigating potential duplication and taking appropriate action. This includes configurable workflows for different duplication scenarios, case management tools for tracking investigations, collaboration features for cross-state coordination, and integration with communication channels for notifications and updates.

Data Flow Architecture

The data flow within the system would follow several patterns depending on the specific use case. For new enrollment verification, the process would begin when a state initiates a query for a new applicant. The applicant's information would flow through the identity resolution engine, which would check for potential matches with other participating states. Results would return to the originating state with

confidence scores indicating the likelihood of matches, and the state would apply business rules to determine appropriate next steps based on the results.

For ongoing monitoring, states would periodically submit current enrollment data either in full or incrementally, to the system. Cross-matching would occur across participating states, with potential duplications identified, prioritized by confidence level and financial impact, and distributed to appropriate staff for investigation through the workflow system. Resolution actions would be tracked, and outcomes measured to continuously improve the system.

When a beneficiary disenrolls from one state's program, the system would automatically check if that person is enrolled in other states. If matches are found, notification would be sent to those states, enabling them to validate the information and determine appropriate action according to their policies.

Throughout all these processes, the system would generate comprehensive analytics, calculating aggregate metrics, updating dashboards and reports, and distributing insights to stakeholders based on their specific access rights and information needs.

Security and Privacy Architecture

The security and privacy architecture must be comprehensive, addressing both technical and governance aspects of data protection. Technical security measures would include end-to-end encryption for all data exchanges, strong authentication mechanisms including multi-factor authentication for sensitive operations, role-based access controls implementing the principle of least privilege, and comprehensive audit logging of all system activities.

Privacy controls would focus on data minimization in all exchanges, ensuring that only necessary data elements are shared for specific purposes. A robust consent management framework would handle opt-out capabilities where legally required, while automated enforcement of retention policies would ensure that data is not kept longer than necessary. The system would incorporate privacy-enhancing technologies

such as differential privacy for analytics, allowing meaningful insights to be derived without exposing individual records.

A strong governance framework would establish clear data sharing agreements defining permitted uses, transparency mechanisms for beneficiaries, and independent oversight with diverse stakeholder representation. Regular compliance audits and clearly defined incident response protocols would further strengthen the privacy and security posture of the system.

Part IV: Implementation Strategy and Roadmap

Phased Implementation Approach

Given the complexity of the Medicaid duplication challenge, a phased implementation approach offers the most practical path forward. The journey would begin with a focused proof of concept involving 2-3 states with high interstate migration. This initial phase would demonstrate technical feasibility, establish baseline metrics for duplication rates, and develop and validate matching algorithms without requiring extensive changes to state systems.

Success in this initial phase would set the stage for regional deployment, expanding to 5-10 states within a geographic region with strong migration patterns. This expansion would implement the full production version of all system components, establish operational processes for ongoing verification and resolution, and begin measuring actual (not just potential) cost savings. The regional approach allows for managing complexity while still demonstrating significant value.

The final phase would expand the solution to nationwide coverage through a cohort-based approach to national onboarding. This would include establishing regional operation centers for local support, developing automated onboarding tools and processes, and implementing advanced analytics including predictive models to further enhance the system's capabilities. The goal would be to have the majority

states participating in the system, generating documented annual savings in the billions of dollars.

Throughout this implementation journey, several critical success factors must be addressed. Executive sponsorship from state Medicaid directors and federal CMS leadership is essential, as is continuous demonstration of value through rigorous measurement of financial impact. Inclusive stakeholder engagement with meaningful roles for all participants would build the necessary trust and buy-in, while technical excellence and operational discipline would ensure reliable system performance.

Various risks must also be mitigated, including privacy concerns from beneficiaries and advocates, potential state resistance due to resource constraints or autonomy concerns, technical integration challenges with diverse state systems, and questions about long-term funding sustainability. Proactive strategies for addressing these include implementing privacy-by-design principles, developing flexible integration options requiring minimal state effort, and creating performance-based funding models tied to demonstrated savings.

Measuring Success and Impact

A comprehensive measurement framework is essential for demonstrating the value of the solution and guiding ongoing improvement. Financial metrics would track direct cost savings from prevented duplicate payments, administrative efficiencies, and overall return on investment for participating states. Operational metrics would monitor system performance, process effectiveness, and adoption rates across states.

Beyond these immediate measures, strategic impact metrics would assess the broader effects of the initiative on program integrity, interstate coordination, and public trust in government programs. The solution could serve as a model for addressing other cross-state challenges in healthcare and social services, creating value beyond the specific problem of duplicate Medicaid enrollments.

Conclusion: A Call to Action

The billions of dollars wasted through duplicate Medicaid payments represent a opportunity for private sector innovation to create significant public value. By developing business models and technical solutions that facilitate interstate coordination while navigating complex regulatory requirements, private entities help states and the federal government address a persistent problem that has defied solution through traditional government approaches.

The path forward requires collaboration across sectors, combining the technical expertise and innovation capacity of private enterprises with the public mission and authority of government agencies. Through thoughtful design that addresses the technical, regulatory, and organizational challenges involved, a solution to Medicaid duplication can emerge that saves taxpayer money, improves program integrity, and potentially creates a model for addressing other cross-state coordination challenges.

The time for action is now. With Medicaid enrollment at historic highs and public finances under pressure, eliminating wasteful duplicate payments represents a rare opportunity to improve government efficiency without reducing services or benefiting vulnerable populations. Private sector innovation, properly channeled and incentivized, can bridge the gaps in our fragmented healthcare system and deliver better value for both beneficiaries and taxpayers.

← Previous

Next →

Discussion about this post

Comments

Restacks



Write a comment...