

The Medicaid Fraud War Room Stopped 203.3 Million Dollars in 88 Days With Federal Exclusion Notices, and Program Integrity Is Now the Rare Government Software Market That Grows With Budget Cuts

AUG 01, 2026 • PAID



 **Podcast episode for paid subscriber only. Also available on Spotify.**



Thoughts on Healthcare Markets & Technology

 **The Medicaid Fraud War Room Stopped 203.3 Million Dollars in 88 Days With 42 Federal Exclusion Notices, and Program Integrity Is Now the Rare Government Software Market That Grows With Budget Cuts**

CMS stopped \$203.3M in Medicaid fraud in 88 days. Sounds like a big win. But against a \$900B program, that is 0.02%. The dollar figure is almost beside the point...

 Listen now

5 minutes ago · Thoughts on Healthcare

To listen to paid episodes in Apple or Spotify, link your Substack subscription via the settings on those platforms (instructions inside the Substack app under Subscriptions →

Podcast).

Table of Contents

1. Two hundred three million dollars is a small number and that is the point
2. What actually happened in 88 days
3. The exclusion machinery, and why 88 days is genuinely fast
4. Payment suspension is the real weapon
5. Improper payment is not fraud, and the distinction is the whole commercial question
6. The data substrate problem nobody has solved
7. Managed care is the next theater
8. How this gets bought, and the federal match nobody mentions
9. Businesses that fall out of this
10. Ways this thesis breaks
11. Dates to put on the calendar

Thoughts on Healthcare Markets &
Technology is a reader-supported
publication. To receive new posts and
support my work, consider becoming a
free or paid subscriber.

Abstract

On July 28, 2026, CMS reported first-quarter results from the Medicaid Fraud War Room, launched April 23, 2026 in coordination with the White House Task Force to Eliminate Fraud. In 88 days the initiative coordinated action against 50 unique high-risk Medicaid providers representing more than 203.3 million dollars in Medicaid payments since January 1, 2025: 42 federal Notices of Intent to Exclude issued by HHS-OIG covering roughly 160.7 million dollars, 15 state enforcement actions from War Room referrals covering roughly 46.2 million dollars, and 7 providers hit with both. The model builds on the Medicare Fraud Defense Operations Center launched in 2025, which CMS credits with preventing over 4 billion dollars in payouts and revoking billing privileges for more than 4,000 providers. One cited case: a lab that billed 4.5 million dollars for repeat once-in-a-lifetime genetic tests on 520 patients in 2025. Context includes roughly 1 billion dollars in Medicaid payments to California and Minnesota deferred on July 21, 2026 over disputed high-risk claims, following earlier pauses of 1.3 billion in California and 350 million in Minnesota; Indiana imposing a six-month moratorium on new provider enrollment in certain waiver programs effective August 1, 2026; and OIG flagging that Medicaid managed care contracts lack adequate fraud prevention requirements. This essay covers the enforcement mechanics in detail, separates the parts of this that are genuinely new from the parts that are press release, and maps what can be built on both sides of the market where the government just proved that analytics-first interception works and is politically rewarded.



Continue reading this post for free, courtesy of Thoughts on Healthcare.

[Claim my free post](#)

Or purchase a paid subscription.

[← Previous](#)

