



# Medicaid Program Integrity: More Audits, More Problems

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# Today's Focus: Medicaid Audits

CPT Code 92507 is Changing: <https://www.asha.org/news/2026/update-on-cpt-code-92507-valuation-review-underway/>

How a CPT Code Becomes a Code: <https://stream.asha.org/how-a-cpt-code-becomes-a-code>

One Big Beautiful Bill Act Predictions Webinar: <https://stream.asha.org/proposed-medicaid-funding-changes-ahead-what-audiologists-and-slps-need-to-know>

One Big Beautiful Bill Act Outcome Webinar: <https://stream.asha.org/how-and-when-upcoming-federal-policy-changes-may-impact-audiologists-slps-and-the-people-they-serve>

April 2026 State Medicaid Advocacy Webinar – link forthcoming!

**Questions?**

[Reimbursement@asha.org](mailto:Reimbursement@asha.org)

# How did we get here?

## HR 1/One Big Beautiful Bill Act (OBBBA)

- One Big Beautiful Bill Act – Signed July 4, 2025
  - Avoided FMAP cuts, per capita caps
  - Rural Health Transformation Grant \$50B
    - More politically favorable states got more money
    - **Zero dollars** from that grant can go toward *increasing* provider reimbursement rates
  - ~\$1(T)rillion cut from the Medicaid program over next ten years
    - Work requirements, eligibility redeterminations, cost-sharing for expansion population



# Another Round of Medicaid Cuts?

- Some members of Congress want more cuts to Medicaid.
- ASHA has been meeting with members of Congress to emphasize the connection between federal policymaking and the cuts to Medicaid provider payment rates already taking effect in CO, NC, ID, GA, etc.
- Main message: “Don’t make things worse!”
  - Focusing on moderate republicans in swing districts
  - Engaging ASHA members
- Medicaid Take Action: <https://ashaa.quorum.us/campaign/medicaid26/>
  - Over 4,000 letters sent in the past month!
- Medicaid Advocacy page: [Medicaid Cuts and Coverage Changes](#)

**AXIOS**

GOP weighs health care cuts to pay for Iran war



# One Reconciliation Battle After Another

THE HILL

**GOP lawmakers battle as conservatives press for third budget reconciliation bill**

- Reconciliation 2.0 is narrowly focused
  - Includes funding for DHS agencies, only carries instructions for the Senate Judiciary and Homeland Security Committees. That means provisions must fall under those committees' jurisdictions, making it virtually impossible to include healthcare cuts in reconciliation 2.0.
- Reconciliation 3.0 not yet a reality
  - Congressional majorities have not yet put pen to paper on possible "3.0" legislation. Conversations have focused on fighting "fraud, waste, and abuse," and increasing military spending.
  - Narrow window for any 3.0 package to materialize, given proximity to midterm elections, and GOP near-unanimity required to advance it.
  - ASHA will remain active and engaged to push back on any proposed Medicaid cuts.

# Medicaid: A State and Federal Partnership

- Medicaid is a health insurance program for low-income people and people with disabilities
- Medicaid is paid for by the federal AND state governments
- Medicaid is EXTREMELY different from Medicare: policy, rates, administration, etc.
  - <https://www.asha.org/siteassets/reimbursement/medicaid-vs-medicare.pdf>
- The federal government pays its share in the form of the Federal Medical Assistance Percentage (FMAP) to each state, and it ranges from 50-83% (90% for Medicaid Expansion population)
- Because Medicaid is paid for by taxpayer dollars, the government must ensure that those funds are being used appropriately under the law

# Definitions Matter (FWA)

**Fraud**: When a Medicaid provider, member, or other stakeholder provides false information to get a Medicaid agency to cover care or services in an *intentional* manner

**Waste**: When a Medicaid provider, member, or other stakeholder engages in over- or inappropriate utilization of services in a way that results in unnecessary costs to the Medicaid program in an *unintentional* manner

**Abuse**: When a Medicaid provider or member acts in a way that is not consistent with accepted medical, fiscal, or business standards (such as medical necessity, utilization management, and billing standards), resulting in unnecessary cost to the Medicaid program

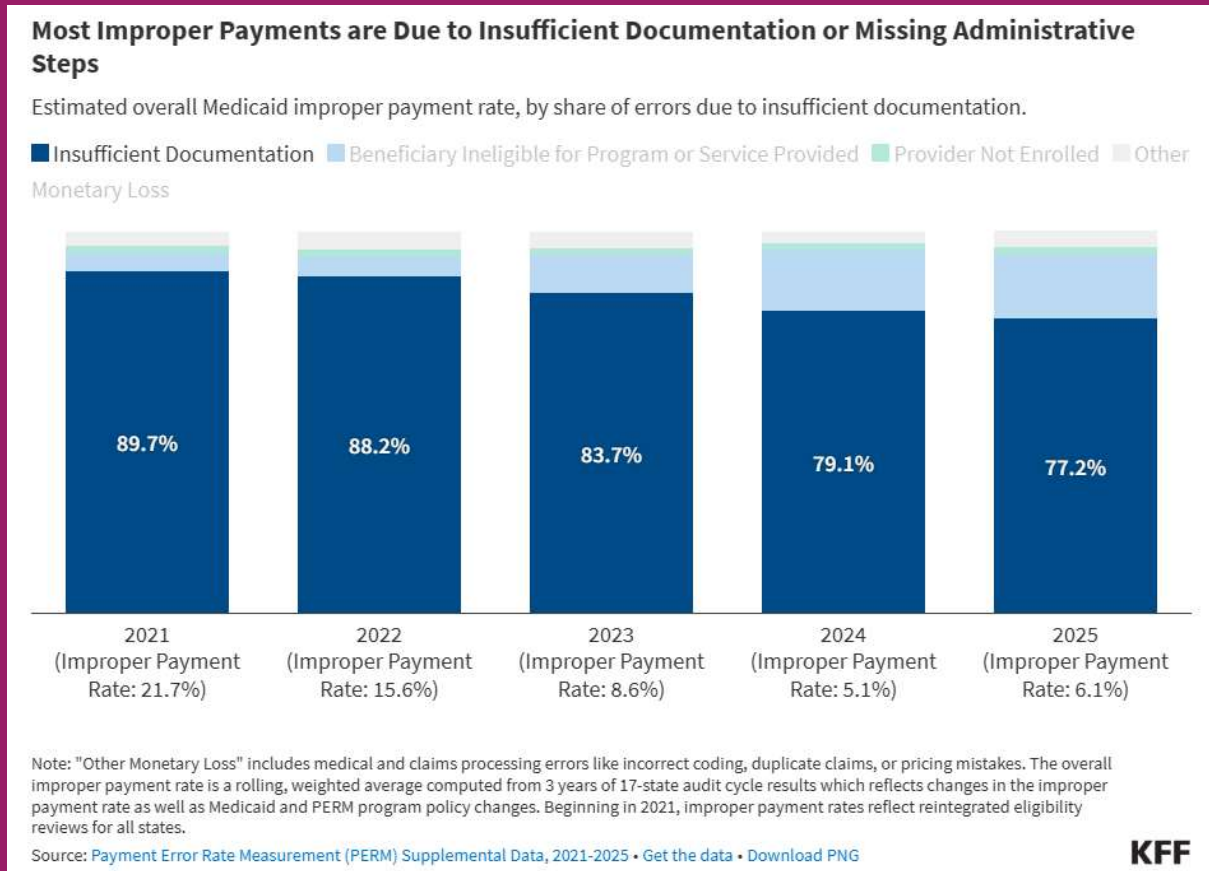
# Why does it matter how you define it?

- If you don't define the problem, you can't fight FWA consistently and thoroughly – a shared goal for US taxpayers and advocates alike
- Many lawmakers, including pre- and post-OBBBA, have focused on the improper payment rate as the main problem to be prosecuted
- The Payment Error Rate Measurement (PERM) program measures improper payments in Medicaid (PERM was created by IPIA in 2002, replaced by PIIA in 2019)
- Improper payment rate is calculated based on three component error rates (based on audits of three areas):
  - Fee For Service
  - Managed Care
  - Eligibility

# Why does this matter for AuDs and SLPs?

- OBBBA creates more incentive for states to prosecute improper payments: if the PERM rate for your state exceeds 3%, states can be subject to financial penalty by authority of the federal Health and Human Services (HHS) department
- When your state Medicaid program is penalized, there is less money flowing to your state
- States then must make cuts (e.g. decrease provider payment rates, increase administrative burden like prior authorization)
- In 2025, 77.17% of improper payments were the result of insufficient documentation
- **Even the Centers for Medicare and Medicaid (CMS) PERM program specifically articulates that improper payments are not measures of fraud or indicators of intentional wrongdoing, but are instead measures of compliance error**

# Insufficient Documentation: A Big Source of the Problem



Rate of insufficient documentation has gone down relative to beneficiary enrollment, but note that much of the reason the latter has increased was due to the moratorium on Medicaid disenrollment during the pandemic (aka the Medicaid unwinding)

# How does ASHA hear about FWA?

- ASHA hears directly from ASHA members and payers – we receive phone calls, emails, handwritten letters; thousands and thousands of messages every year ([reimbursement@asha.org](mailto:reimbursement@asha.org))
- We meet with payers (e.g. Medicaid agencies) as part of our payer summit
- Many ASHA members, both SLP and AuD, work for payers and review claims
- We hear from Medicaid Fraud Control Units (a wing of the Department of Justice) as agents of law enforcement, we respond to their inquiries
  - We do NOT report members individually or collectively, but inform payers of best practices
- **ASHA has seen an increase in members reporting audits in the last 6-8 months**

# Why would an ASHA member be audited?

- Audits can be random or can be because of outlier billing behavior
- **Audiologists and SLPs are not being specifically targeted**
- Common reasons for ASHA member audits:
  - Billing for certain extender providers (e.g. assistants, clinical fellows, or students **without permission** from the payer)
  - Increased/aberrant utilization (e.g. North Dakota Medicaid said SLPs were billing 10-minute sessions for 92507)
  - Unbundling of codes (e.g. billing separately for services that for certain should have been billed together per certain payer policy, like 97533 + 92507)
  - Insufficient documentation (e.g. “played Candyland” or “ran a test”)

# School-Based AuDs and SLPs are not Immune to Medicaid Audits

- In 2014, all school-based Audiologists and SLPs were required to get an NPI number
  - ASHA is getting reports that more state Medicaid agencies are requiring the specific AuD or SLP's NPI number (not just the NPI of the school) on claims or cost-pool reports
  - We have reached out to staff at Centers for Medicare and Medicaid staff and while there is no new federal requirement, states are ramping up provider oversight
  - As an enrolled provider, if you are billing incorrectly your behavior can implicate the False Claims Act
- Pennsylvania school-based Medicaid audit (2024) – PA schools need to refund **\$368.9m**
- Texas school-based Medicaid audit (2024) – TX schools need to refund **\$18.9m**

# School-Based AuDs and SLPs are not Immune to Medicaid Audits

- Random Moment Time Studies (RMTS) are a statistically valid sampling methodology that is often used by States and LEAs to determine how much time eligible staff spend performing Medicaid reimbursable work activities
- What are the main issues cited in school-based Medicaid audits?
  - Insufficient documentation (one sentence is not enough!)
  - Billing for services provided by individuals who are not “qualified providers” (which can include students, CFs, assistants – depending on your state)
  - Fabricated Sessions – services provided or billed on days a student was not in school
  - Overbilling – more units billed than plan of care included

# Commercial Plan Audits – A Natural Next Step



- About 78% of all Medicaid beneficiaries are enrolled in managed care
- Many managed care companies have lines of business across payers (Medicaid, Medicare, Commercial Insurance)
- Health insurance companies do not make decisions in a vacuum, they look across all their lines of business
- Increased interest in prosecuting FWA will be enforced across plans

# What is ASHA doing about it?

- **Educating members of Congress and their staff**
  - Many staffers do not know the granular details of audits or FWA
- **Communicating with Payers and Medicaid Fraud Control Units**
  - CFs should be qualified providers in TN Medicaid:  
[https://www.asha.org/siteassets/advocacy/comments/asha-and-taaslp-joint-letter-regarding-cf-enrollment\\_04162026.pdf](https://www.asha.org/siteassets/advocacy/comments/asha-and-taaslp-joint-letter-regarding-cf-enrollment_04162026.pdf)
  - Georgia Medicaid rates cut 20% because of overutilization by ABA providers (and ST/OT/PT/ABA are all in same benefit category):  
[https://www.asha.org/siteassets/advocacy/comments/asha-and-gsha-joint-letter-regarding-georgia-medicare-care-management-organizations\\_04162026.pdf](https://www.asha.org/siteassets/advocacy/comments/asha-and-gsha-joint-letter-regarding-georgia-medicare-care-management-organizations_04162026.pdf)
  - PA Jefferson Health Plan SGD authorization affected by overidentification for need by a supplier: <https://www.asha.org/siteassets/advocacy/comments/asha-letter-to-jefferson-health-plans-on-aac-coverage-05052026-.pdf>

# What is ASHA doing about it?

- **Responding to federal requests for information, proposed rules**
  - CRUSH RFI: <https://www.asha.org/siteassets/advocacy/comments/asha-comments-to-dhhs-on-crush-rfi-03272026.pdf>
  - Statements for the Record to Energy and Commerce: [https://www.asha.org/siteassets/advocacy/comments/letter-to-ec-committee-and-oi-subcommittee-regarding-medicaid-fraud-hearing\\_03312026.pdf](https://www.asha.org/siteassets/advocacy/comments/letter-to-ec-committee-and-oi-subcommittee-regarding-medicaid-fraud-hearing_03312026.pdf)
- **Medicaid Toolkit for Surviving an Audit** – made by ASHA staff and ASHA members together

# AuD Perspective

How do immigration and customs enforcement activities impact patients with and without Medicaid coverage?

- No shows among vulnerable patient classes
- Hospital financial assistance programs may require a denial from Medicaid

Changes in the (OBBBA) related to eligibility:

1. Work requirements (& work requirement red tape)
2. More frequent redeterminations
3. Added restrictions around qualified immigrants receiving Medicaid
4. Reduced retroactive coverage

# AuD Perspective

Managed Medicaid programs shifting to third party agencies (e.g. HearUSA).

- Single case agreements
- Subscriber led advocacy?

**Low provider participation** and the effect of "ghost networks": impacts specialized and less common service networks such as CI, infant diagnostic assessments, pediatric hearing aids.

# SLP Perspective

- Increased frequency of audits, retrospective reviews
- Turn-around times
- PA does not guarantee payment (or recoupment)
- Private payers
- Already seeing increase in recoupment over longer period of time
- Providers near state borders

# SMART goals

Dear Provider:

The Special Investigations Unit (SIU) is dedicated to ensuring the delivery of high-quality therapy services that meet required standards for Medicaid. As part of our routine quality initiatives, Wellpoint analyzes claims data to identify opportunities for provider collaboration. A recent review of common therapy treatment codes (e.g., CPT 92507, 97110, 97112, 97530) for dates of service from 01/07/2023 to 01/06/2026 showed that your organization billed X claims for X members during this period. For providers with similar profiles, robust goal-writing is the most effective tool for clearly documenting medical necessity, especially for ongoing care. We are proactively providing this guidance as a supportive resource to help ensure your documentation fully aligns with the valuable services you provide.

## The Importance of Functional Goals per Medicaid Guidelines

- Under Medicaid, a diagnosis alone is not enough to document the medical necessity of therapy. The Plan of Care must contain functional goals that clearly outline how therapy will lead to practical improvements in a client's daily life.
- Functional goals must align with Medicaid documentation standards and reflect the member's baseline function, identified functional deficits, and planned skilled interventions.
- Per the manual, documentation should support medical necessity and include diagnosis, baseline functional status, measurable goals, type/ amount/ frequency/ duration of services, and progress toward goals.

**Avoiding Common Mistakes:** Refrain from using ambiguous terms or non-compliant goal elements such as educational objectives or generic strategies without a specific functional purpose or measure for achievement.

- Use validated tools to establish baseline and quantify progress when clinically appropriate.

## From Vague to SMART: Practical Examples

- Vague Goal: "Client will improve expressive language."
- SMART Goal: "Within 12 weeks, the client will use 3 .. word phrases to spontaneously request desired items (e.g., 'I want juice') with no more than 1 verbal cue in 80% of opportunities during a 30-minute session."
- Vague Goal: "Client will improve swallowing."
- SMART Goal: "Within 4 weeks, the client will tolerate a pureed diet and demonstrate no signs or symptoms of aspiration (e.g., coughing, wet vocal quality) during meals, with caregiver supervision, to safely maintain oral nutrition."

Our goal is to help providers ensure their documentation supports the level of care billed for each service. No further action is being taken, and we are not seeking any other information at this time. In the future, if we determine additional information is required, your office will receive a separate request for documentation. We appreciate your time and attention to this matter. If you have questions, please call or email me.

# SLP Perspective

## Tips:

- Provider alerts for all payers
- Watch changes
  - AI
  - Track changes
- Document to your most stringent payer

## Consider:

- Current internal audit process
- Consider checks/balances system
  - What issues are "hard stops"

# Best Practices for Going Through an Audit

- Document EVERYTHING...or it didn't happen
- Respond to requests in a timely manner
- Ask for what you need (More time? More proof? Methods used?)
- Consider engaging an attorney who specializes in these audits
  - Extrapolation methodologies have been legally problematic in the past
  - Attorneys can negotiate a lower amount of payment and/or a payment plan
- If you can't find an attorney, consider contacting your state's bar for an attorney referral
  - Some have free or reduced cost attorneys
  - Some law schools have legal clinics where students can offer free advice during a designated time

# Questions?

[reimbursement@asha.org](mailto:reimbursement@asha.org)

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