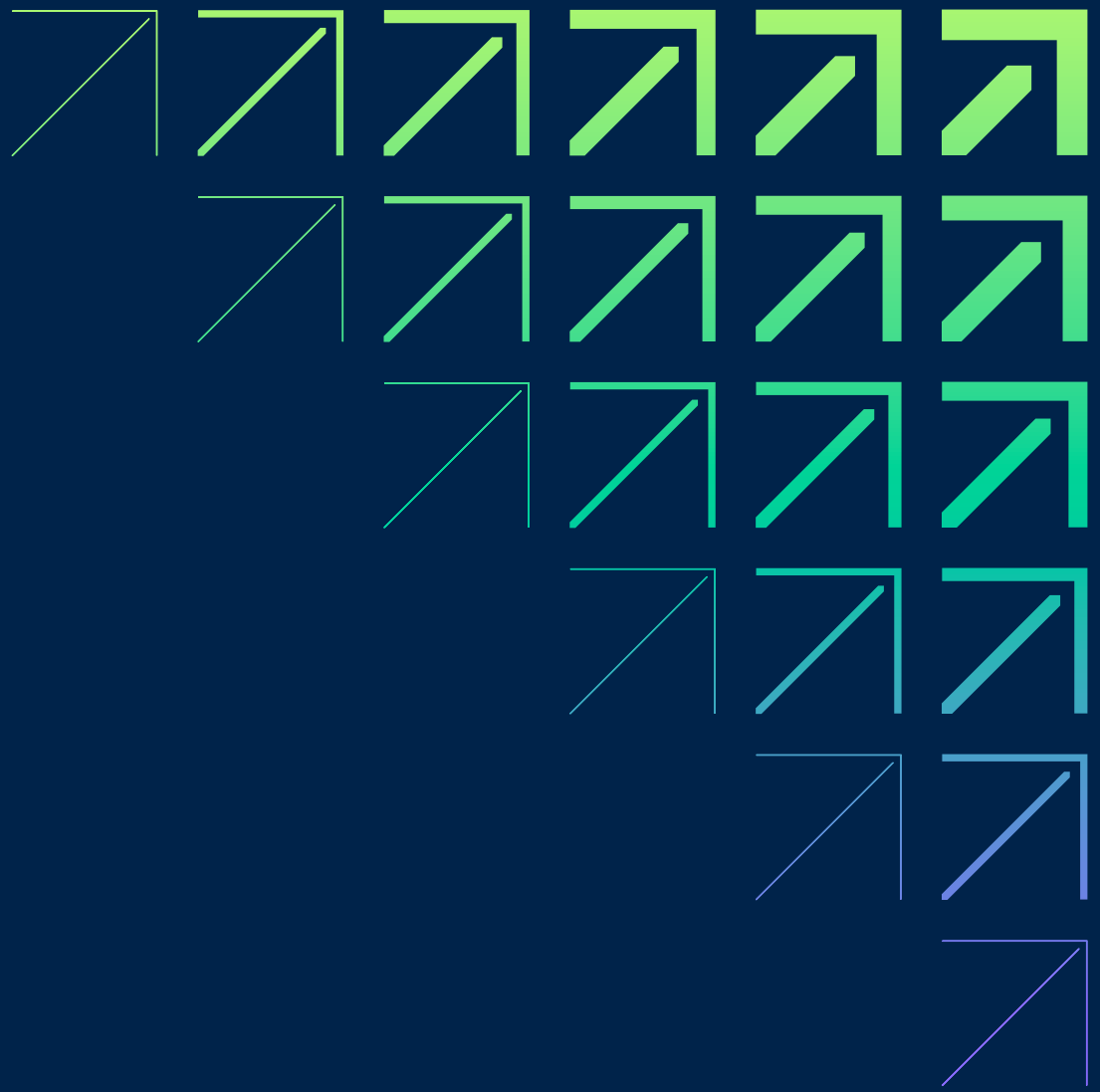
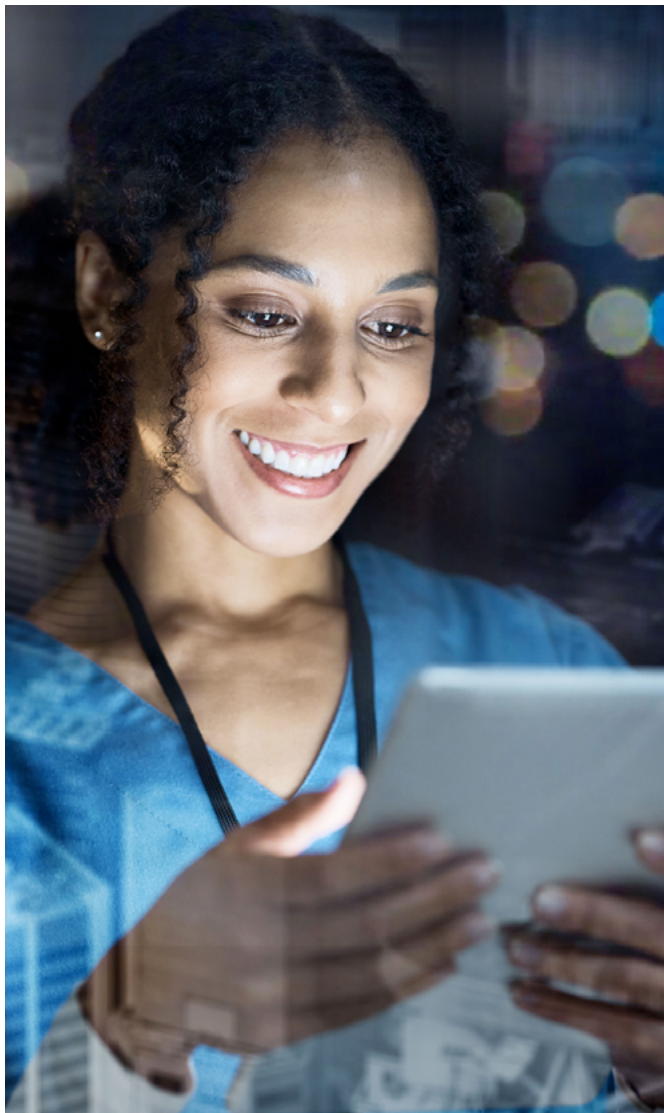




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Reducing Medicaid Total Cost of Care

Seven Strategies for Modernizing Systems, Strengthening
Program Integrity, and Enabling Outcome-Driven Programs



Introduction

A New Cost Reality for Medicaid

The need to operate efficiently while maintaining quality of care isn't new for Medicaid agencies, but recent [policy changes](#) and funding pressures have heightened concerns about rising costs and long-term program sustainability. [Some experts estimate](#) that H.R. 1 could reduce funding to individual Medicaid programs by billions of dollars.

Meanwhile healthcare costs are rising across the system. [National Health Expenditure Data](#) shows Medicaid increasing to \$931 billion annually, with [states reporting](#) increasing costs in long-term care, pharmacy, and behavioral health services. Medicaid now represents approximately [18.5% of national healthcare spending](#).

The following seven tactics can help to reduce Medicaid total cost of care(TCOC) by combining technology, oversight, operational efficiency, and data-driven decision-making.





Modernize Medicaid Systems



Whether designed as a monolithic Medicaid management information system (MMIS) or a modular Medicaid enterprise system (MES), administrative systems play a critical role in determining how effectively agencies manage healthcare costs. Payment integrity, fraud, waste, and abuse detection, coordination of benefits, and care management all rely on capabilities within an agency's MMIS or MES. When systems lack flexibility or visibility into program data, agencies may struggle to identify inefficiencies or successfully intervene to reduce costs.

Many Medicaid agencies continue to rely on systems originally developed decades ago. While these platforms reliably process claims and manage financial transactions, they often lack the flexibility needed to support evolving healthcare policies and program requirements.

Modernization can improve system capabilities that help to reduce total cost of care. Legacy MMIS systems typically require extensive custom hard-coding to adapt to new eligibility rules, reimbursement models, or reporting requirements. In some cases, upgrading to a modular MES with rule-based configuration is a better option, but agencies that have maintained their technology well or recently invested in upgrades can extend the life of their investments through targeted modernization. Both routes of modernization can help to

reduce total cost of care, based on each state's situation and historical investments in technology.

One method of accomplishing this goal is through shared services. Capabilities such as workflow management, document management, rules engines, and analytics platforms can support multiple modules across the Medicaid enterprise. Reusing these shared components reduces duplication, simplifies system maintenance, and lowers operational costs.

Many modernization efforts also incorporate cloud infrastructure, improving scalability and system resilience. Cloud environments support high system availability, often exceeding 99.9% uptime for critical operations, while simplifying disaster recovery and infrastructure maintenance. All that translates into lower overall costs.

Automation and artificial intelligence can further improve operational efficiency. Automated workflows support tasks such as claims validation, eligibility verification, and provider enrollment, reducing manual processing and administrative workload. When combined, shared services and automation can reduce ongoing operational expenses by 20–25% while improving system flexibility.

Modern systems also improve access to operational data. Integrated platforms provide real-time visibility into program performance and utilization trends. That visibility helps agencies not only identify opportunities to remove costs, but accurately assess the extent of the potential impact and track improvement.

Whichever path you take, modernizing in place or upgrading to a modular MES, modernization allows agencies to remove administrative costs and operate more efficiently.

2

Strengthen Program Integrity Through Identity and Eligibility Management



Program integrity is a key factor in controlling Medicaid costs. Agencies need to ensure that benefits are flowing to the individuals who need them, which means having strong identity and eligibility management. [Eligibility errors and documentation issues](#) account for a substantial share of Medicaid payment errors each year.

Fragmented data systems often make it difficult for agencies to maintain accurate identity and eligibility records across programs. When individuals appear under multiple identities or duplicate records across systems, agencies may unintentionally issue duplicate benefits or payments. [Federal analyses](#) have identified millions of cases in which individuals appear in multiple Medicaid or CHIP enrollment systems simultaneously.

Strengthening identity resolution and integrating eligibility verification across programs helps agencies identify errors earlier, reduce improper payments, and improve administrative efficiency. Improved identity resolution also supports better program access. Program integrity isn't just about reducing costs, though; it also helps eligible individuals receive benefits without unnecessary administrative barriers.

Modernization can help address these issues by linking records across systems through enterprise identity management tools. Using a master person index, these systems associate each beneficiary with a single identity profile. By consolidating duplicate records and aligning beneficiary information across programs, agencies can improve the accuracy of eligibility determinations and reduce improper payments.

Cross-program data verification can further strengthen program integrity. Many Medicaid beneficiaries also participate in other public assistance programs such as the Supplemental Nutrition Assistance Program (SNAP). Aligning eligibility verification processes across programs improves data consistency and helps agencies identify discrepancies earlier in the enrollment and payment process.

Administrative vulnerabilities in other public assistance programs illustrate the potential impact of these issues. For example, [SNAP reported](#) a national payment error rate of approximately 10.9% in fiscal year 2024, reflecting errors in eligibility determinations and benefit calculations. While SNAP and Medicaid have distinct financing structures, they share a susceptibility to identity verification, eligibility determination, and cross-program data sharing weaknesses that increase costs.

3

Proactively Implement Policy and Regulatory Changes



State policy and federal regulations are changing constantly. By proactively aligning systems to federal standards, states reduce their TCOC by avoiding penalties, minimizing rework, and supporting efficient data exchange to enable better care management. Delaying the start of your projects to implement regulatory updates can lead to missed deadlines, which often incurs penalties or delays program funding.

Such delays can also lead to months of claims processed under old rules. As a result, claims may need to be recalculated or payments recovered after the fact. A delay of three months, for example, would create three more months of improper payments that would then have to be recouped. These recovery efforts require additional staff time and cost for rework. Responding proactively prevents these costs.

Federal initiatives increasingly reinforce the need for timely system updates. [For example](#), federal interoperability and prior authorization rules require Medicaid programs and related payers to meet new prior authorization time frames, provide specific reasons for denials, and report certain metrics beginning in 2026, with additional data exchange requirements scheduled for 2027.

Implementing policy changes earlier also accelerates the benefits of those policies. Improvements such as more accurate eligibility determinations, streamlined reporting, and enhanced care management capabilities begin delivering value sooner when systems are updated on schedule. For some federal programs, such as the rural health transformation fund, implementing changes faster gives you more time to see the benefits of your investment, which will put you in a better position for the next grant period's application.

Upgrading to a modular MES can help agencies respond to policy changes earlier and even faster. Configurable business rules common to claim and encounter MES modules allow agencies to update eligibility criteria, reimbursement methodologies, or reporting requirements without modifying underlying application code. Enterprise systems also allow many regulatory updates to be implemented across systems. In MES modules, these updates are incorporated into standard product maintenance cycles rather than billed as custom development work, which further reduces compliance costs.

By enabling faster policy implementation, modernized technology platforms help agencies reduce rework, avoid penalties, and improve operational efficiency.

4

Improve Interoperability to Enable Real-Time Care Coordination



Interoperability is the unsung hero of timely and appropriate care delivery. Members often require care from multiple providers and in multiple settings. Care coordination relies on timely access to accurate patient information. Care management programs also depend on timely data exchange to identify emerging needs and support proactive interventions. A lack of interoperability means systems cannot exchange information efficiently, denying agencies and providers the comprehensive view needed to coordinate care effectively.

Prior authorization processes illustrate the operational impact of these delays. In some environments, authorization requests may be submitted through multiple channels, including online portals, telephone calls, and fax transmissions. Requests submitted through slower channels may take several days to process. Increasing interoperability eliminates the chance for multiple authorizations and inappropriate denials of authorizations resulting from a fragmented view of member data.

Modern interoperability technologies support faster and more reliable information sharing. Application programming interfaces (APIs) allow systems to

exchange data in real time, enabling authorization systems to connect directly with provider workflows. Real-time access to information allows providers and care managers to make decisions more quickly. Timely data exchange supports faster treatment decisions, more efficient discharge planning, and more coordinated referrals to appropriate care settings. When providers have access to more complete patient information, they can coordinate care more effectively and avoid unnecessary or duplicative testing or procedures.

Delays in authorization and information exchange can also increase healthcare costs. For example, when a patient is waiting in a hospital for authorization to transfer to another care setting, delays may extend the hospital stay unnecessarily. Federal interoperability rules, including [CMS-0057-F](#), are accelerating the adoption of electronic prior authorization and real-time data exchange.

By improving the speed and accuracy of data exchange, interoperable systems reduce administrative delays that can result in unnecessary costs.

5

Bundle modernization efforts to accelerate value



Many Medicaid modernization initiatives are implemented gradually and often involve multiple vendors and technology platforms. While modular systems provide flexibility, modernization efforts that are not coordinated within a unified architectural framework can introduce operational complexity.

When agencies deploy modules from different vendors, each system may include its own workflow tools, reporting capabilities, analytics platforms, and operational services. In many environments, core functions — such as provider data management, business rules engines, reporting platforms, and contact center services — are replicated across modules.

Fragmented systems can also create data silos that limit analytic visibility. When operational data is distributed across multiple vendor platforms, agencies must reconcile different data structures and reporting frameworks before gaining a complete view of program performance. Multi-vendor environments create coordination challenges when policies or regulatory requirements change. If updates affect multiple modules, agencies must align development schedules

and implementation timelines across several vendors, which can slow policy implementation, increase the risk of something being missed, and add costs.

Managing these environments may require additional staff to oversee vendor relationships, coordinate system integration, and manage project timelines. Modernization efforts involving multiple vendors can also create redundant planning and implementation work. Agencies often repeat discovery, planning, and requirements analysis for each module implementation.

Bundling modernization efforts into a unified architectural approach can address many of these challenges. When modernization efforts are coordinated under a shared architecture, foundational planning and design activities occur once rather than being repeated across multiple projects. Shared infrastructure, consolidated licensing, and streamlined vendor management can reduce technology and operational costs while simplifying system governance. Over time, a unified modernization strategy strengthens operational efficiency, improves analytic visibility, and accelerates the return on technology investments.

6

Enable Value-Based Care Through Integrated Data and Analytics



Value-based care (VBC) models reward providers for improving outcomes while controlling costs. Implementing these programs requires accurate, complete, and timely data coordinated across multiple administrative and clinical systems.

VBC programs depend on [integrated data and analytics](#) to measure outcomes, evaluate costs, and guide care improvement. Medicaid agencies must assess provider performance, identify high-risk populations, and monitor changes in health outcomes over time. These efforts often require coordination across multiple operational systems, including claims platforms, care management tools, provider networks, and analytic environments.

Effective value-based care management also requires comprehensive visibility into inpatient services, outpatient visits, pharmacy utilization, behavioral health services, and laboratory testing. When these data sources remain fragmented across systems—or rely on delayed data exchanges—agencies may encounter analytic blind spots that limit their ability to identify

emerging cost drivers and utilization trends. Agencies must have a unified data view to drive analytics about patient utilization, population health, and overall program performance.

Predictive analytics tools can further strengthen program management. Risk-scoring models identify individuals who are likely to experience hospitalizations or complications related to chronic conditions. Care management programs can use these insights to target early interventions for high-risk populations, allowing agencies and providers to intervene before avoidable hospitalizations occur. None of that happens without a complete, accurate view of member data.

Unified analytics platforms provide a comprehensive view of patient utilization across care settings, enabling agencies to scale value-based care programs across providers and populations. Integrated analytics also allow agencies to evaluate provider performance across multiple care environments and design incentive structures that align provider behavior with quality outcomes and cost management goals.

7

Strengthen Payment Integrity and Prevent Fraud, Waste, and Abuse



Payment integrity starts with making sure claims are paid correctly the first time. One of the primary ways Medicaid programs do that is through claims edits: rules and checks applied as a claim is processed to determine whether it is complete, appropriate and should be paid as submitted. Basic edits can confirm that a claim contains the required information and follows standard formats, while policy edits can determine whether a service is covered. Medical necessity edits can help determine whether a service is clinically appropriate. Duplicate claim checks can prevent the same service from being paid twice, and clinical bundling edits can identify when services have been billed separately or under a higher-paying code when a different payment would be appropriate. Together, these checks help states pay providers appropriately while avoiding duplicate, unnecessary, or incorrectly billed costs.

Fraud, waste, and abuse (FWA) prevention builds on this broader payment integrity strategy. Traditionally, much of this work has occurred after payment: Claims are processed and paid, then analytics are used to identify unusual billing patterns or other potential indicators of FWA. Once a questionable payment has already been made, however, states may have to investigate the claim, work through appeals, and attempt to recover the funds, a process that is historically very difficult.

Moving FWA detection earlier in the payment cycle, sometimes called a “shift-left” approach, can prevent incorrect payments from being made in the first place.

Claims can be checked against known FWA indicators during adjudication, while advanced analytics and AI can help identify unusual patterns that warrant further review. For example, analytics might flag certain laboratory tests that don’t match a member’s condition. Claims that don’t raise concerns can continue through payment, while those that do can be flagged for human review.

Doing this effectively requires close coordination between claims processing and FWA tools. When the systems are integrated, FWA indicators can be checked as part of the claims process rather than through a separate analysis after payment. Existing systems can be configured to support this integration as part of modernization, while newer modular claims solutions can be designed with these connections in place, making coordination easier from the start.

The financial benefit extends beyond the inappropriate payments themselves. Preventing questionable payments reduces investigations, appeals, recoupment, and other administrative work required to recover funds after the fact, allowing program integrity teams to focus resources on higher-value oversight activities.

Those savings can be significant enough to help fund other modernization efforts, creating opportunities to reinvest savings in further improvements.

Conclusion

Managing the total cost of care in Medicaid requires a comprehensive approach that extends beyond traditional administrative efficiency efforts. As states continue to navigate evolving healthcare demands and fiscal constraints, modern enterprise systems will play an increasingly important role in supporting program sustainability. Agencies that invest in modern architectures, integrated data platforms, and coordinated operational strategies will be better positioned to manage program costs while maintaining access to high-quality care for the populations they serve.



Ready to put your Medicaid system to work reducing your total cost of care? Contact us at gainwelltechnologies.com

About the author



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