# CMS just gave states a 30-day response window on provider integrity.

## *Rx billing is the fastest place a state can move first.*

Public reporting on April 21 indicates CMS will ask states to submit plans within 30 days to revalidate Medicaid providers in high-risk areas and determine whether they exist and have the right to provide services. That creates a practical question for every state: where can credible evidence be assembled quickly enough to answer back?

This briefing recommends Rx billing as the starting point. It is the domain where product identity, dispense records, inventory state, and claims can be brought into a single evidentiary frame within the federal timeline.

**30**
**DAYS**
Public reporting window for state response plans

**3**
**FAILURE MODES**
Rx billing FWA patterns addressable with unit-level evidence

**1**
**DOMAIN**
Recommended first move: prescription billing in Medicaid

A STATE MEMO ON HOW SERIALIZED PHARMACEUTICAL EVIDENCE CAN TURN FEDERAL PRESSURE INTO A DISCIPLINED RX-BILLING-FIRST INTEGRITY PILOT.

STRATEGIC RECOMMENDATION

# If a state needs a near-term integrity answer, Rx billing is the recommended starting point.

*This is a strategic judgment for state consideration — not an external federal conclusion. Prescription-drug billing is among the most operationally exposed and most governable FWA domains a state can realistically act on inside a 30-day response window.*

Federal and state program integrity systems are under pressure to move beyond retrospective assurance and show more disciplined control of high-risk reimbursement domains. Rx billing is not the only exposed surface — but it is one of the few where evidence can plausibly be assembled quickly.

Prescription-drug billing combines large claim volume with something rare elsewhere in healthcare oversight: product identity that can be traced, reconciled, and tested. Serialization, dispense records, and inventory state create the raw material for unit-level review.

OIG has repeatedly flagged longstanding concerns about prescription-billing fraud, inappropriate billing, and diversion — particularly in Medicare Part D (see Appendix). For a state facing a compressed response timeline, Rx billing is attractive not because it is simple, but because it is one of the few categories where a defensible evidence model is realistic in 60–90 days.

**STRATEGIC JUDGMENT · FOR STATE CONSIDERATION**

01 High-volume claims environment with complex operational handoffs

02 Recurring public-record concern around inappropriate billing and diversion

03 Physical product identity already exists through serialization

04 Dispense and inventory events are more reconcilable than most service categories

05 Pilot validation required before any enterprise control commitment

WHY THIS IS NOT A NICHE TECHNICAL ISSUE

# Rx billing is a national integrity surface — not a niche.

*The case for moving first on Rx billing is that it combines national fiscal scale, recurring federal oversight concern, and unusually strong potential for unit-level evidence.*

Prescription drugs move through one of the largest reimbursement streams in federal healthcare. CMS disclosed $86.5 billion in improper payments across Medicare, Medicaid, and CHIP in FY 2024. Medicare Part D alone recorded approximately $216 billion in gross drug costs in 2022, covering roughly 51 million beneficiaries.

OIG has issued recurring guidance — including an issue brief on Part D safeguards — noting that key Medicare safeguards against prescription-billing fraud do not fully apply to Part D the way they do elsewhere. That gap has been a federal concern for years, not a 2026 discovery.

OIG's 2026 Work Plan carries active initiatives on prescription-billing fraud in Medicare Part D. The federal signal is consistent: Rx billing integrity is an enduring attention area, not a passing one.

FEDERAL SCALE ANCHORS

**$86.5B**
CMS improper payments across Medicare, Medicaid, CHIP (FY 2024)

**~$216B**
Medicare Part D gross drug costs (CY 2022, CMS reporting)

**Active**
OIG 2026 Work Plan item on Part D prescription-billing fraud

*Figures cited are drawn from public CMS and HHS OIG reporting. Medicare and Medicaid are distinct programs; this page speaks to Rx billing as a federal integrity surface broadly. State Medicaid pilots must be scoped to state populations and Medicaid claim flows specifically.*

THE FWA MODEL AND WHY TODAY'S TOOLS FALL SHORT

# Three failure modes drive Rx billing FWA — and current tooling only responds after the fact.

MENDRx is designed around the fraud patterns that most consistently undermine Rx billing integrity. Existing state and federal mechanisms are strong, but they are reactive by design: they measure, investigate, or report after reimbursement has already moved.

FIG. · THREE FAILURE MODES

FAILURE MODE I

### Phantom Billing

Claims paid for drugs that cannot be reconciled to a real dispensed unit, a valid dispense event, or a complete evidentiary trail.

FAILURE MODE II

### Duplicate Billing

The same drug event, reimbursable unit, or prescription pathway effectively paid more than once through resubmission, crossover complexity, or fragmented benefit administration.

FAILURE MODE III

### Diverted Inventory

Product moves through inventory or out of legitimate channels in ways that do not reconcile to lawful dispensing and reimbursement records.

CURRENT TOOLING · REACTIVE POSTURE

MEASUREMENT

### PERM

Estimates improper-payment rates statistically. Reactive: produces a measurement after payments have cleared.

INVESTIGATION

### MFCU

Investigates and prosecutes serious fraud. Reactive by mandate: engages once loss has generally already occurred.

REPORTING

### T-MSIS · CMS-64 · Screening

Reports, reconciles, and validates actors. Reactive: describes historical reimbursement rather than verifying unit-level truth at claim time.

BOTTOM LINE

*The gap is not strong vs. weak oversight. It is reactive oversight vs. evidence at the point of reimbursement.*

PROPOSED RESPONSE ARCHITECTURE

# MENDRx is serialized reimbursement infrastructure.

It is designed to make product-linked evidence usable inside reimbursement integrity workflows — as a complement to existing state and federal tooling, not a replacement.

MENDRx is not a generic analytics overlay and not a traditional claims platform. It is a verification layer designed to connect serialized pharmaceutical identity, inventory state, dispense events, billing activity, prescriber context, and claim submission into one review-ready evidentiary frame.

Where infrastructure permits, MENDRx is designed to enable states and program-integrity stakeholders to ask a more disciplined question: can this reimbursed drug event be reconciled to a real unit, a real dispense event, and the beneficiary named on the claim? Pilot validation is required before any determination of fit at scale.

### CORE CAPABILITIES

01 Product-to-claim reconciliation

02 Exception-state detection

03 Claim-support evidence assembly

04 Rx-billing-focused review readiness

05 State-review-ready defensibility in high-risk populations

**STARTING POINT · EXTENDABLE**

Rx billing is the recommended starting point. The same serialized infrastructure is designed to roll out to tokenized visits and approvals after Rx billing — extending unit-level evidence into broader Medicaid integrity over time.

HOW SERIALIZATION CHANGES THE MODEL — AND WHY NO CATEGORY SOLVES IT CLEANLY

# Serialization moves Rx billing integrity from inference to evidence.

The product already carries identity. MENDRx is designed to make that identity actionable inside reimbursement integrity review. Existing categories each solve part of the problem; none tie product evidence to reimbursement.

FIG. · SERIALIZATION → REIMBURSEMENT EVIDENCE CHAIN

STEP 01
### Manufacturer
Serial identity is assigned.

STEP 02
### Distribution
Movement and possession are recorded.

STEP 03
### Dispensing
Receipt and dispensing generate events.

STEP 04
### Clinical Context
Prescription, prescriber, and beneficiary attach meaning.

STEP 05
### Claim
Reimbursement pathway is reconciled against evidence.

STEP 06
### Exception Review
Missing support, duplication, and flow mismatches surface for action.

WHY EXISTING CATEGORIES DO NOT CLOSE THE GAP

CATEGORY I
### DSCSA / Traceability
Carries the product trail for compliance. Does not make product evidence actionable inside reimbursement review.

CATEGORY II
### FWA Analytics / SIU
Surfaces anomaly patterns and retrospective fraud signals. Does not reconcile to serialized product identity.

CATEGORY III
### ERP / Dispensing Systems
Manages operations, billing, and workflow. Does not tie product identity to reimbursement integrity.

*MENDRx sits in the gap between traceability, operations, and payment integrity.*

BUILT FOR EVERY STATE

# MENDRx is designed to operate in all 50 states.

The serialized evidence framework is state-agnostic. Any Medicaid program — in any state — can pilot the Rx-billing-first integrity model described in this briefing.

50 · STATES · ONE FRAMEWORK

AN RX-BILLING-FIRST INTEGRITY PILOT

# What a state can actually do in 60–90 days.

*A contained Rx-billing-first pilot is designed to give a state something concrete to show federal, legislative, and internal oversight stakeholders — not a strategy document, but a working evidence baseline.*

FIG. · 60–90 DAY RX-BILLING-FIRST PILOT PATH

STEP 01 · WEEK 1–2

### Define pilot scope

Scope a narrow, defensible slice of state Medicaid Rx billing activity — a specific population, category, or set of provider types — where claim volume is meaningful but evidence inputs are plausibly obtainable inside the pilot window.

STEP 02 · WEEK 2–4

### Identify Rx billing populations

Select the prescription categories to review first. Prioritize high-volume or historically exception-prone categories where serialized product identity and dispense evidence can be aligned.

STEP 03 · WEEK 3–6

### Establish evidence inputs

Identify and provision required data: Rx claims, dispense records, available inventory state, serialized product references, prescriber context. Document data limitations as part of the pilot record.

STEP 04 · WEEK 5–10

### Run reconciliation

Execute unit-level reconciliation and exception review across the pilot scope. Establish baseline exception patterns tied to phantom, duplicate, and diversion-adjacent reimbursement risk. Distinguish evidence gaps from exception findings.

STEP 05 · WEEK 9–13

### State-ready findings

Produce a state-ready findings package: evidence baselines, exception patterns, operational constraints observed, recommended control model, and a forward roadmap for Medicaid Rx billing integrity.

## WHAT THE PILOT IS DESIGNED TO DELIVER

| | |
|---|---|
| EVIDENCE BASELINES | Pilot-scoped rates of unsupported, duplicated, and inventory-inconsistent claim events. |
| EXCEPTION PATTERNS | Documented classes of exceptions observed across the pilot reconciliation. |
| OPERATIONAL CONSTRAINTS | Honest record of data gaps, integration friction, and control-model limits. |
| RECOMMENDED CONTROL MODEL | Forward architecture for Medicaid Rx billing integrity, pilot-validated. |
| STATE NARRATIVE | Defensible story for CMS, legislature, and internal oversight stakeholders. |

> *This is a state response framework, not a MENDRx product claim. Every element is pilot-validated and state-owned.*

EXECUTIVE CLOSE

# The federal ask is immediate. Rx billing is where a state can move first.

*Do not begin where proof is weakest. Begin where evidence can actually be assembled inside the response window.*

Public reporting now makes clear that states are being asked to show how they will respond in high-risk Medicaid areas. The most persuasive answer is not a broad assurance memo. It is a targeted control strategy in a domain where evidence can actually be assembled. Rx billing in Medicaid meets that test.

MENDRx is designed to give a state a disciplined way to start with the Rx side first, establish evidence baselines quickly, and build a response architecture around phantom billing, duplicate billing, and diverted inventory — while remaining pilot-validated and state-owned.

## RECOMMENDED EXECUTIVE ASK

04 ITEMS

01 Commission an immediate governor's-office briefing tying the CMS news cycle to an Rx-billing-first response posture

02 Designate Rx billing as the recommended first domain for evidence-backed Medicaid FWA evaluation

03 Authorize a contained 60–90 day pilot to establish evidence baselines and exception patterns

04 Use pilot findings to turn phantom billing, duplicate billing, and diverted inventory into governable state control problems

§ NEXT STEP

## Request a 30-minute briefing *before* your CMS response is due.

MENDRx will walk your Medicaid director, integrity unit, and governor's office through a 30-day response template, a pilot product-to-claim reconciliation framework, where infrastructure permits, and the review materials a state should be prepared to assemble under heightened federal scrutiny.

CONTACT

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SELECTED PUBLIC-RECORD SOURCES

# A restrained anchor set.

A small set of high-signal public-record sources that anchor the April 21 hook, the Rx-billing thesis, and the federal program-integrity backdrop. No primary CMS written directive is cited because none has been published as of this briefing's preparation date.


**R1 · APRIL 21 HOOK**
April 21, 2026

### CMS to ask states for 30-day provider-revalidation plans in high-risk areas

STAT News report on CMS remarks delivered at Politico's Health Care Summit, April 21, 2026

Reported remarks by CMS Administrator Dr. Mehmet Oz. Anchors the 30-day response-window framing on pages 1 and 9. No primary written CMS directive cited.

**R2 · IMPROPER PAYMENTS**
November 2024

### CMS Fiscal Year 2024 Improper Payments Fact Sheet

Centers for Medicare & Medicaid Services · improper-payments reporting

Source for the $86.5 billion FY 2024 improper-payments figure cited on page 3.

**R3 · RX BILLING THESIS**
Longstanding OIG guidance

### Medicare Part D Safeguards Do Not Fully Apply

HHS Office of Inspector General · Issue Brief (OEI series)

Establishes recurring OIG concern with prescription-billing safeguards in Part D. Anchors the 'Rx billing is operationally exposed' argument on pages 2 and 3.

**R4 · PART D SCALE**
CY 2022

### Medicare Part D gross drug costs · approximately $216 billion, ~51 million beneficiaries (CY 2022)

CMS Medicare Part D program reporting

Federal Rx reimbursement scale anchor cited on page 3. Medicare-specific; not a Medicaid fraud estimate.

**R5 · RX BILLING PRIORITY**
2026

### OIG Work Plan — Reducing Pharmacy Fraud in Medicare Part D

HHS Office of Inspector General · 2026 Work Plan

Reflects active federal oversight attention to prescription-billing fraud. Supports the strategic judgment on pages 2 and 3.

**R6 · PROGRAM INTEGRITY**
2023

### Medicaid: CMS Needs to Take Additional Steps to Improve Program Integrity and Save Billions (GAO-23-106025)

U.S. Government Accountability Office · report to Congressional requesters

State-oversight anchor for the combined tooling discussion on page 4 (PERM, MFCU, T-MSIS). Each state's office should re-verify the most current GAO report applicable to its program.


*Selected references. Each state's office should independently validate all cited material against its own compliance counsel before any submission to CMS or OIG.*