



GUEST COLUMNS

What's worse than Medicaid fraud?



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Medicaid fraud drains public funds, undermines trust, and too often involves services for the frail elderly delivered on paper but not in reality.

Yet fraud, for all its damage, is not the program's most serious failing. Fraud is illegal, detectable, and, in principle, fixable with the right incentives and enforcement. The deeper problem is what Medicaid does legally every day: channel benefits upward, reward poor planning, and shortchange the poorest and most vulnerable Americans.

The structure of Medicaid, not just lax fraud oversight, creates the worst inequities. Consider how the Affordable Care Act reshaped the program. By creating a new "expansion" category for low-income, able-bodied adults, and attaching to it an extraordinarily generous federal match, Congress effectively told states: prioritize this population. States receive a 90% federal contribution for these enrollees, far higher than the average match for traditional beneficiaries, who are predominantly poor children, the disabled, and

low-income seniors in need of long-term care.

It should surprise no one that many states tilted their programs toward the newly favored group, even as elderly and disabled beneficiaries struggle with inadequate LTC options.

Failing our poorer patients

Nowhere are Medicaid's upside-down incentives clearer than in LTC, where a disproportionate share of Medicaid dollars are spent. On paper, the program is reserved for the poor. In reality, it often fails them while quietly subsidizing the middle class and affluent.

The rules for poor people are brutally simple. To qualify for LTC, they must reduce their countable assets to \$2,000 and have a monthly income below a very low threshold. Lacking financial advisors or specialized legal help, low-income families exhaust what little they have to become eligible. Their modest savings, a small nest egg in the bank, maybe a little life insurance – these are quickly wiped out. By the time they qualify, they are truly impoverished.

More prosperous households, by contrast, get an off-ramp. Medicaid lets applicants keep unlimited income as long as their medical and LTC expenses are high enough, because those private expenses are deducted from income before applying the low ceiling. The practical message is: show enough bills, and you qualify. In addition, the program exempts many major assets from “spend down,” including most home equity, and without dollar limits, tax-favored retirement accounts, one business, one automobile, prepaid funeral arrangements, and ordinary personal property. A person can appear “poor on paper” while still retaining a valuable home and holding substantial protected assets.

Then there is the cottage industry that has grown up to help well-off families navigate and exploit these rules. Medicaid planning attorneys and financial advisors openly advertise strategies to shield hundreds of thousands of dollars from LTC costs – through trusts, transfers and sophisticated rearrangements of assets – and to avoid or minimize estate recovery after death.

Built-in inequity

These techniques are legal. That is precisely the problem. The program's design invites them.

The inequity does not stop at eligibility. It extends to the quality of care people receive. Facilities and home health agencies court private-pay patients because they typically pay far more – often about 150% of Medicaid's reimbursement rates. Families with resources can therefore pay privately for a time to gain admission to higher-quality providers in better neighborhoods. Once admitted, state and federal rules prevent those facilities from discharging patients solely because their status shifts from private pay to Medicaid. "Key money" buys a ticket in, and Medicaid quietly picks up the bill thereafter.

Poor patients seldom have that option. They rely on providers in less affluent communities that depend most heavily on Medicaid's low rates. Those providers, in turn, struggle to maintain staffing, facilities and quality.

The result is a de facto two-tier system: one for people who can leverage private funds and legal guidance to secure the best care and then transition to public support, and another for those who show up poor and become poorer. Given the racial wealth gap in the United

States, these structural advantages and disadvantages often track racial lines, amplifying disparities under the guise of a safety net.

None of this requires breaking the law. It is baked into the rules. That is why it is more troubling than fraud. Fraud can, in theory, be deterred with tighter audits, better data, and stronger penalties. By contrast, the legal mechanisms that transfer Medicaid LTC benefits up the income scale are sustained by statute, regulation, and an ecosystem of professionals who profit by helping clients navigate them.

If we care about fairness, fiscal sustainability, and the integrity of the safety net, we should worry as much about fraud but even more about the quiet, legal inequities that drain resources and betray Medicaid's core promise. A program designed to protect the poor in old age too often wipes them out while preserving the wealth and choices of those better off. That is worse than fraud – and it should be the bigger scandal.

Stephen Moses is president of the Center for Long-Term Care Reform, a visiting fellow at the Paragon Health Institute and the author of "Long-Term Care: The Problem," "Long-Term Care: The Solution," "Medicaid's \$100+ Billion Leak," and "Better Long-Term Care for Billions Less."

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