PRIVATE EQUITY MIDDLEMEN IN MEDICAID

PRIVATE EQUITY STAKEHOLDER PROJECT

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TRENDS DRIVING PRIVATE EQUITY INVESTMENT IN STATE MEDICAID CONTRACTORS

Medicaid is a joint federal and state program that currently provides health care coverage to 83 million lower-income people across the United States.[1] Funding comes from both federal and state governments, but states are responsible for implementation and have historically relied heavily on private contractors[2] to carry it out. As with the healthcare sector broadly, private equity firms did not view Medicaid contracts as potentially profitable until after the Affordable Care Act (ACA) went into effect in 2014 and the federal government unleashed billions of dollars to expand Medicaid into one of the largest insurers in the country.[3] The increase of Medicaid spending increased the potential for government-backed recession-proof revenue[4] for Medicaid contractors, and the expansion of coverage to more of the population made that potential revenue more reliable by making spending cuts less politically viable.[5]

In private equity, managers pool money from investors into multi-million- or multi-billion-dollar funds, use the funds to leverage loans to buy controlling shares of businesses, and then typically resell the businesses in 4-7 years.[6] In those few years, the private equity managers seek to maximize financial returns for investors, whether by increasing business profitability to secure a higher resale price, or through other means to convert the businesses' assets into investor gain.[7] Building on research documenting private equity investment throughout the healthcare sector,[8] this report tracks recent private equity investment activity in a specific healthcare segment: state-contracted Medicaid "middlemen," which are businesses that work in the background to process claims and payments, administer treatment approvals, develop and maintain IT ecosystems, and more. This report looks closely at three Medicaid contractors with active private equity backing: Public Partnerships, LLC; Gainwell Technologies, Inc.; and Acentra Health, LLC.

KEY FINDINGS

- Private equity-backed Public Partnerships, LLC (PPL) is the largest provider of fiscal intermediary services in the US, primarily for Medicaid self-directed care programs, with over 50 programs in 20 states. In recent years additional private equity firms have acquired Medicaid self-directed care service companies with multi-state operations.

- After PPL's recent rollout in New York, advocates claim widespread problems with pay and benefits have led to 150,000 providers and 90,000 workers leaving the program, echoing similar problems reported in prior rollouts in New Jersey and Pennsylvania. A class-action lawsuit was filed against PPL for wage theft due to "systemic failures" with its administrative systems and low-value and difficult-to-access benefits.

- A state audit of PPL payments issued for emergency rental assistance in Oregon found a 28% error rate, leading to an estimated $11 million of improper payments issued in one year of program operations.

- Private equity-owned Gainwell Technologies (Gainwell) is the largest Medicaid IT contractor in the US with technology contracts in 45 states. To launch Gainwell in 2020, Veritas Capital acquired a Medicaid IT business segment for $5 billion, representing the first known mega-deal entry of a private equity firm into MMIS services.

- Gainwell failed to recover $52.2 million of third-party insurance payments in New York as found in a 2023 audit; in 2026 a follow-up investigation found recommendations to review and improve Gainwell's processes had not been implemented.

- Gainwell has faced two lawsuits in recent years from former employees alleging retaliation after raising concerns with internal issues including compromised fraud detection. Gainwell is also currently being sued under the False Claims Act for allegedly recklessly enabling fraud.

- Private equity-owned Acentra Health, LLC (Acentra) acquired three companies in two years and has grown rapidly over five years, pursuing a wide range of federal and state healthcare contracts. Acentra is positioning itself at the intersection of Medicaid IT, clinical services, and AI-driven analytics to use predictive analytics to target and deliver health care interventions to lower-income and vulnerable populations.
- Across the years and across several states Acentra's Medicaid IT services have seen technological errors and shortfalls resulting in delays, additional costs to fix, and improper payments–including in one case overpayments of $39.4 million over two years. At the same time, Acentra's business model relies on heavy investment in India-based technology workers to keep costs low.
- Acentra's prior authorization and clinical assessment services across several states have been found at times to cause serious delays and denials for care. Under previous private equity ownership, in Oregon, Acentra's prior authorization subsidiary Kepro was found to have compromised its eligibility determination process in response to state pressure, issuing a wave of ineligibility determinations that even the state chose not to follow in many cases.
- Federal and state governments are still in the early stages of understanding and addressing the applications of AI in Medicaid. In this environment, Acentra has co-launched a public-private alliance to develop frameworks for AI in Medicaid, which is positioned to shape governance of the AI uses it is developing.

THE MIDDLE LAYER

WHAT MEDICAID MIDDLEMEN DO

Private contractors sit between states and the people who rely on Medicaid—controlling Key decisions and managing billions in taxpayer dollars

public partnerships PPL

PUBLIC PARTNERSHIPS, LLC (PPL)

Public Partnerships, LLC (PPL) was founded in 1999 as a division of Public Consulting Group, Inc. (PCG).[9] PPL's core business is to secure state contracts for "fiscal intermediary" services, primarily for Medicaid self-directed care programs.[10] Self-directed care is one of several forms of long-term services and supports (LTSS) that Medicaid funds. It supports member control and choice by enabling eligible individuals to select their own known and trusted caregiver to provide care in their own home.[11] State agencies typically contract fiscal intermediaries for the day-to-day operations of enrolling providers and administering provider payroll and benefits services.

In 2022, private equity firms DW Healthcare Partners (DWHP) and Linden Capital Partners (Linden Capital) partnered to carve out and acquire significant shares of PPL from PCG.[12] One source in early 2025 shows DWHP holding 55% of shares, Linden Capital with 18%, and PCG with 16.1%, with the remaining 10.9% held by six other parties.[13] An operating partner at Linden Capital[14] was installed as PPL's Chief Executive Officer[15] and also as a PPL board member.[16] A managing director at DW Healthcare Partners[17] and a principal at DW Healthcare Partners[18] were also named to PPL's board.

Although the financial terms of the acquisition remain private, DW Healthcare Partners[19] and Linden Capital[20] had shown interest in "middle market" acquisitions around the time of the deal. In 2025, Pitchbook reported that PPL refinanced $425 million in debt.[21]

Private equity interest in Medicaid self-directed care

Medicaid self-directed care has seen rapid growth in utilization and employment in recent years.[22] The Affordable Care Act and the American Rescue Plan Act established incentives to increase the use of home- and community-based services, of which self-directed care is one type. One analysis found the number of individuals enrolled in a self-directed program in the US grew 23% percent between 2019 and 2023.[23] Another analysis projects that national demand for "home health aides" and "personal care aides" could grow by 36% and 38% respectively from 2023 until 2038.[24]

PPL is the largest provider of fiscal intermediary services in the US, primarily for but not limited to Medicaid self-directed care programs. It operates over 50 programs in 20 states,[25] up from 43 programs since the private equity acquisition in 2022.[26] In 2023, PPL publicly lobbied against a regulatory final rule that could limit the profitability of its Medicaid fiscal intermediary contracts.[27] That year the federal Centers for Medicare & Medicaid Services (CMS) proposed The Ensuring Access to Medicaid Services Final Rule which included an "80/20" provision that would require at least 80% of spending on Medicaid Home and Community-Based Services go to the workers–and thus limit the amount of spending allowed for administrative costs, including funds paid to fiscal intermediaries, to 20%. The final rule including the 80/20 provision was adopted in 2024.[28]

In recent years, other private equity firms have also acquired Medicaid self-directed care service companies with multi-state operations. In November 2025, a H.I.G. Capital affiliate made a "significant investment" in GT Independence,[29] a company operating Medicaid self-directed care services in 19 states.[30] In April 2026, General Atlantic acquired TEAM Services from Alpine Investors for $3 billion;[31] TEAM Services is parent to one or more subsidiaries that provide fiscal intermediary services for Medicaid self-directed care.[32] Other peer companies have so far remained private, such as Acumen Fiscal Agent[33] and Palco,[34] which both operate as fiscal intermediaries in multiple states. Another competitor operating as fiscal intermediary in 14 states, Consumer Direct Care Network, recently transitioned into a certified Employee Ownership Trust.[35]

States vary in how they structure fiscal intermediary contracts for self-directed care. Some states use more open models that allow for larger, variable numbers of intermediaries while other states contract directly with just one "sole" intermediary which participants are required to enroll with. It is worth taking note of states that transition from multiple fiscal intermediaries to fewer or to one, a change that can bring both benefits and drawbacks from the participant and worker standpoint, but that represent a definite opportunity for greater profit for the fiscal intermediaries that win the contract. PPL was the beneficiary of New York's 2025 transition from 600-700 fiscal intermediaries to just one.[36] In 2013, Pennsylvania transitioned from multiple agencies, 37 according to one source,[37] to a sole fiscal intermediary model with PPL. And in early 2026, Wisconsin announced its intent to contract PPL as sole fiscal employer agent for its self-directed care program, a transition from having had three fiscal employer agents.[38]

Transition disruption and systematic errors

In 2025, New York awarded a contract to PPL to serve as the state's sole fiscal intermediary for its Consumer Directed Personal Assistance Program (CDPAP).[39]

Right after the transition providers told reporters they were "not getting paid the right amount or not getting paid at all" and were experiencing "long wait time and hangups" when trying to contact PPL.[40] Four months after the transition, one provider claimed she was paid for only 12 hours out of 40 she worked and that PPL did not fix it when she called. Another provider complained PPL was less responsive than her previous fiscal intermediary, saying if she reaches out she "might get a phone call in three hours or it might be three days."[41] By the tenth month after the transition, advocates claimed widespread problems with pay and benefits had led to 150,000 providers and 90,000 workers leaving the program altogether.[42] A class-action lawsuit was filed against PPL for wage theft as a result of "systemic failures" across PPL's administrative system; the parties to that lawsuit will submit a propose settlement for court approval by June 2026..[43]

The original deadline for providers to transition to PPL was April 1, 2025, just six months after PPL was announced as the new fiscal intermediary.[44] After the transition deadline, former employees of PPL claimed the company had not been prepared for the transition and that the problems providers had started reporting across the state, such as missed paychecks, were both real and a result of this underinvestment. The former employees reported they were not given sufficient training, that the supervisors who should have been able to help them were also unprepared for the transition, and that there weren't enough staff overall to handle the volume of requests they were experiencing. In response PPL did not address specific claims but described the steps the company takes to train staff and monitor operational quality.[45]

In August 2025, when a State official was pressed for details about how the State was evaluating the performance of the contractor during the transition, the official deflected and said he had not prepared answers to those questions.[46] PPL has conducted its own surveys and published the results online showing high and growing levels of satisfaction from providers and clients.[47] In some places, PPL and State officials have blamed the previous fiscal intermediaries for intentionally disrupting the transition process.[48] [49]

But other states had also faced difficulties when transitioning to PPL as fiscal intermediary, and though those transitions took place many years ago evidence shows similar concerns and complaints to those that have emerged over the last year in New York.

New Jersey contracted with PPL as its new sole fiscal intermediary starting in June 2017. Just a month into the transition, PPL released an apology letter to members and workers to "acknowledge that many [of them] have experienced lengthy hold times for customer service, delayed responses to voicemail messages, and issues with the enrollment process."[50] In the fourth month following the transition, the State and PPL acknowledged "challenges in enrollment and payment" and held a forum and presentation to "mitigate any obstacles participants are experiencing."[51] Questions and answers raised at the forum revealed some of the difficulties being experienced, including a mention of "an error in some [payroll] deductions for some employees"[52] and a claim that "some people are telling me that money was kept from their check".[53] The following year, in 2018, an advocacy group released a public letter to the state on PPL's "poor performance" including "incorrect, inconsistent and missing payments... long delays enrolling new participants and unresponsive customer service." The letter also claimed some workers had left the program.[54] In 2025, documents show some of New Jersey's self-directed care programs switching away from PPL to Acumen Fiscal Agent[55] and Palco[56] as fiscal intermediaries.

Pennsylvania transitioned to PPL as fiscal intermediary starting in January 2013 for its self-directed care program for disabled individuals. Within a month of the transition, the Pocono Record reported many workers "have gone a month without a paycheck" and that "the biggest frustration among caregivers is an inability to even speak to someone at PCG [PPL's parent company] who can check the status of their payments." One worker said he was owed $1600 in unpaid wages but that "I keep calling, and they put me on hold."[57] A state audit report released on November 13 found the state agency had insisted on the January 2013 transition deadline despite clear indications the timeline was insufficient for the work required.[58]

The example of Pennsylvania's rollout was directly cited in a letter sent by New York advocates to the Governor of New York warning that the four months available for CDPAP participants and workers to switch to PPL was not sufficient.[59] The State and PPL proceeded with the timeline.

Potential profit from worker benefits in New York

In New York, the fiscal intermediary is meant to serve as a pass-through for compensation paid to providers. A separate fee for administrative costs, negotiated with the state and paid per member per month, is the theoretical source of profit for a company with efficient operations. But advocates claim PPL has structured wages and benefits in ways that potentially reduce overall worker compensation while creating opportunity for PPL to generate additional profit, which would be a violation of state wage and hour law.

PPL sets provider hourly rates close to the minimum required by state law,[60] paying between $18.65 to $20.65 depending on geography.[61] For home care workers employed in and around New York City, New York's "wage parity" law also requires PPL to provide an hourly supplement, to match the value of benefits provided to care workers employed by agencies. The supplement is currently $3.22 to $4.09 depending on the county. It can be provided as cash, as benefits, or as a combination.[62] For a home care provider in New York City working 40 hours a week (though many work substantially more[63]) receiving the supplement as cash could translate into an additional $8000 in pay per year.

Instead, PPL offers a benefits package including overtime, paid time off, holiday pay, health benefits, retirement.[64] Advocates have criticized the healthcare benefit in particular. PPL automatically enrolls providers in a health insurance plan paid for by an 87 cent/hour deduction from their pay. The plan provides minimal coverage that many providers can already access through other avenues, but they cannot opt out except by paying for a more expensive plan. Furthermore, the mere option to purchase the more expensive plan disqualifies providers from accessing more affordable coverage through the state exchange. PPL claims it provides health insurance options to fulfill its obligations as an employer (an interpretation of the ACA disputed by some) but critics claim that due to the rigid and insufficient program "at least some of the money PPL is claiming to use for benefits is going back to PPL in violation of the New York Labor Law and the Wage Parity Act."[65]

The healthcare plan's Flex Card has also been criticized. Providers working in New York City are issued a Flex Card pre-loaded with pretax dollars,[66] for which both the provider and PPL pay less in taxes. But NYC providers cannot opt out of the Flex Card, which is designed with several sources of friction that complicate its use. Use of the funds is limited to specific categories of spending. One reporter heard from an employee of the healthcare plan that offers the Flex Card that about 30% of funds on the cards go unspent.[67] Then, when a provider leaves employment with PPL, the company will impose a $1 monthly administrative fee until the remaining balance is gone–an arrangement also claimed to be in violation of the New York Labor Law and the Wage Parity Act.[68] PPL said it ended its use of the Flex Card on April 30, 2026 and that the remaining money will be subject to the $1 monthly administrative fee.[69]

Less than a year after PPL launched its New York operations, it announced they would switch away from its health insurance company. The company cited "confidential" reasons. While some providers and advocates have pushed for PPL to provide cash instead of benefits, PPL said it is "likely" that PPL will continue to deduct a portion of paychecks to go toward benefits.[70]

Payment processing errors in Oregon

In 2021, Oregon distributed $426 million dollars of federal funding for pandemic-era rental assistance. A state audit found a significant rate of errors in payments, including payments issued by PPL as the state contractor responsible for payment disbursement.[71]

Under pressure to disburse funds quickly, the state set up a new program that launched in May 2021, including a new and untested software platform, to centralize the work of community action agencies responsible for processing applications and disbursing payments in their service areas. After technological bumps in the hurried rollout resulted in a growing backlog of applications, Oregon hired PPL to take over and centralize the work of the community action agencies. PPL took responsibility for applications and payments starting September 2021, a year before majority acquisition by DW Healthcare Partners and Linden Capital, and continued until the program ended in June 2023.[72]

Because the emergency program had experienced notable administrative difficulties while operating and because of the danger that the federal government could claw back funds found not to be spent in compliance with requirements, the state conducted its own audit of the rental assistance program.[73] The audit found the state housing agency "did not implement many essential, foundation internal controls" and as a result it could not "provide reasonable assurance that approximately $426 million was distributed and used in accordance with federal guidance."[74]

The audit noted that PPL had developed its own "quality assurance procedures" and a "detailed fraud algorithm" that was the program's primary mechanism to detect fraud apart from a few months in 2021 when the state temporarily used its own fraud detection method (the state's method was discarded because state officials and state partners felt it was "too strict").[75] In addition to relying heavily on PPL's own internal fraud detection method, the state structured its contract with PPL to pay more for applications deemed qualified than for applications that were denied.[76] Auditors tested a sample of 61 payments processed by PPL and found 17 payments with errors, a 28% error rate. The auditors extrapolated a potential $11 million of payments made in error out of a total of $318 million payments made in the fiscal year examined.[77]

gainwell

GAINWELL TECHNOLOGIES LLC

Gainwell Technologies, LLC (Gainwell) was formed in 2020 by private equity firm Veritas Capital. Gainwell's primary product is a Medicaid Management Information Systems (MMIS) ecosystem for states to administer their Medicaid programs in compliance with federal regulations.[78] The core function of the MMIS is to process Medicaid claims for any Medicaid services that are not provided through Managed Care Organizations (MCOs), which most states contract to manage the bulk of routine Medicaid care. Moody's reported 60% of Gainwell's revenue comes from MMIS services while the remaining comes from adjacent Medicaid services.[79]

Private equity interest in Medicaid IT is relatively new

For decades following Medicaid's inception in the 1960's, MMIS technology was structured as a single monolithic system responsible for performing the numerous operations of program administration.[80] The limitations of earlier generations of technology to meet the complex needs of Medicaid administration resulted in long project time horizons and uncertain outcomes. It could take many years to develop or even just upgrade MMIS technology and in some cases, even well into the 21st century, states have spent tens of millions of dollars on MMIS projects that have ended in failure.[81] The more typical contractors were industrial-sized corporations, like International Business Machines Corporation (IBM) or Hewlett Packard (HP), for whom MMIS contracts were just one business segment of many. The nature of the business was not compatible with the standard private equity investment model.

Advances in technology and the related continuous evolution of federal regulations have changed the nature of the Medicaid IT market. The federal Centers for Medicare & Medicaid Services (CMS) sets standards for states to comply with to remain eligible for federal matching funds (at a match rate of at least 50% and in some states over 75%)[82] and those standards can be updated regularly. States rely on contractors to design and maintain the technologies needed to implement new directives,[83] and funding for such technological projects is secured by a 90% match from the federal government made permanent in 2016.[84] Fitch Ratings assessed that "new federal mandates" for Medicaid agencies represented "service expansion opportunities" for state Medicaid contractors that could potentially offset losses from lower enrollment.[85] For example, the 2024 Prior Authorization Rule mandated that states issue "real time" coverage decisions requiring technological adaption,[86] and H.R. 1 in 2025 established work requirements and more frequent eligibility verification for adults covered by the Medicaid expansion program.[87]

In 2015, CMS established a rule requiring state Medicaid IT systems to pivot away from legacy monolithic mainframes toward a "modular" model enabling states to maintain or upgrade Medicaid systems more quickly and with less overall disruption. States that have transitioned to modular systems can choose to bid out the different modules to different contractors instead of relying on one contractor.[88] The new modular landscape has lowered the barrier to entry and opened the Medicaid IT market to a greater degree of competition. Incumbents who had previously enjoyed the protection of "sticky" multi-year contracts are more vulnerable than before. But some realities still favor larger and more established companies: Although it is easier than before to switch out modules, the process still costs states time and money and introduces the risk of friction in transition. Additionally, lingering challenges with true interoperability (the ability of technologies created by different companies to communicate seamlessly) can give contractors providing all-in-one modular packages an advantage over those with only one or a few modules.

In this developing landscape over the last decade, private equity investment in healthcare information technology (healthcare IT) more broadly has been growing. Healthcare IT buyouts accounted for 19% of all healthcare buyouts in 2025, up from 12% in 2015.[89] Recent years have also seen more "mega-deals" (deals exceeding $5 billion[90]) in healthcare IT, such as the $17 billion buyout of Athenahealth in 2021.[91] The 2018 majority share acquisition of MMIS developer Client Network Services, Inc. (CNSI) by private equity firm Alvarez & Marsal (A&M) Capital may be the first example of private equity investment specifically in the Medicaid IT subsector, although CNSI's handful of state MMIS contracts was only one part of a broader portfolio of government-tailored healthcare IT.[92] Veritas Capital's 2020 acquisition of DXC Technology's MMIS business segment for $5 billion, the platform upon which Gainwell has been built, represents the first known mega-deal entry of a private equity firm into MMIS services.[93]

Gainwell is the largest Medicaid IT company in the US

When Veritas Capital acquired DXC Technology's MMIS business segment and launched Gainwell, it took over a dominant share of the Medicaid IT market. In 2019, the year before the acquisition, DXC's then-CEO Mike Salvino asserted the segment was "strong" and a "market leader" and that DXC would sell it only to streamline its business and reduce its debt load.[94] The DXC segment was the continuation of a Medicaid IT legacy system with roots all the way back in 1962's Electronic Data Systems (EDS) company and included dozens of active state Medicaid contracts.[95]

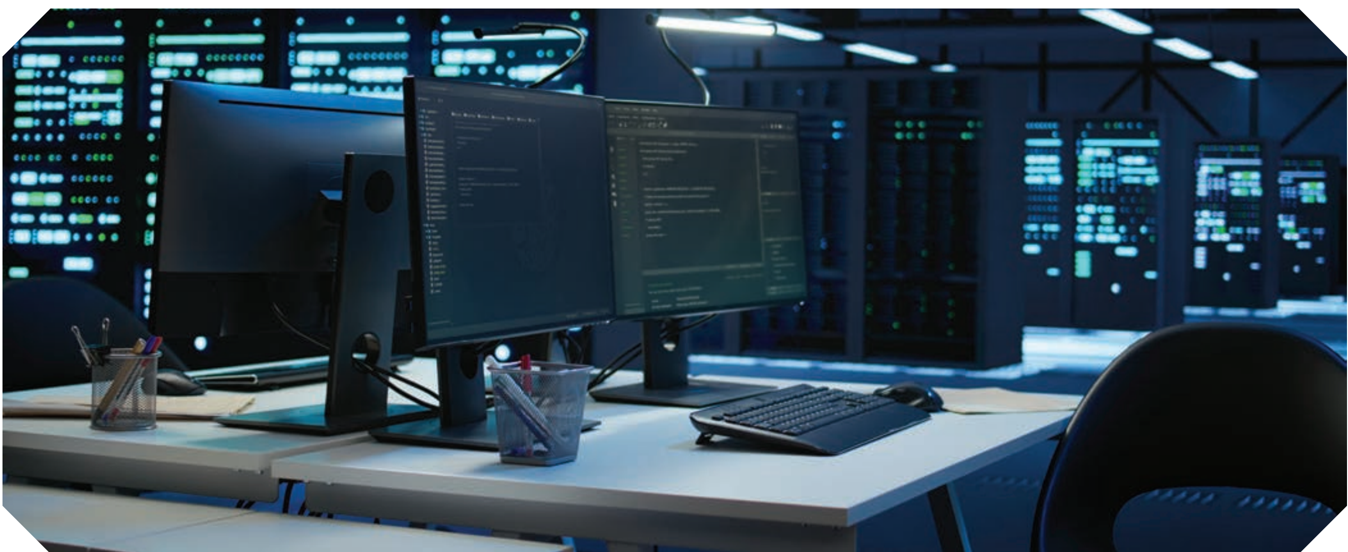
In April 2021, Veritas Capital acquired HMS Holdings Corp. (HMS) for another $3.4 billion dollars and placed its Medicaid-compatible products and services under Gainwell as a subsidiary. (HMS' commercial-, Medicare-, and federal-compatible services were merged into another Veritas-backed company, Cotiviti.)[96] HMS focuses on securing contracts for Medicaid coordination of benefits (COB) and payment integrity (PI), complementary to Gainwell's MMIS technology and contracts for claims processing and provider services. According to S&P Global Ratings, HMS accounts for nearly a third of the size of Gainwell overall, representing a substantial add-on.[97]

Gainwell Technologies is the largest Medicaid IT contractor in the United States. 45 states[98] use Gainwell's claims processing services. 40 states[99] use Gainwell's coordination of benefits services to ensure patients also covered by non-Medicaid insurance apply that insurance first, and its payment integrity service, to audit Medicaid payments issued for mistakes or misuse. Overall, Gainwell reported contracts with 51 states and territories across the United States as of March 2025.[100]

Veritas Capital has held Gainwell Technologies for close to six years as of this report publication. Even with private equity firms starting to hold onto portfolio companies for longer periods, it is likely that Veritas is looking for opportunities to sell Gainwell to another company or take it public through an Initial Public Offering (IPO).

Leveraged buyouts and profit maximization

A "leveraged buyout" is a common practice in private equity: a firm borrows heavily to finance an acquisition and then puts the debt on the books of the acquired company rather than the investors. It insulates the private equity partners from risk by shifting it onto the company, its workers, and customers. Higher levels of debt intensify pressure to cut costs and chase revenue, potentially undermining the quality and timeliness of work produced; they also squeeze the margin of error for operations and increase the risk of default or insolvency.



To buy DXC Technology's government healthcare IT business segment for $5 billion, Veritas Capital borrowed $3.5 billion.[101] To bolt on HMS Holdings Corp.'s Medicaid segment, Veritas Capital borrowed another $1.83 billion.[102] This is separate from over $90 million in general debt the company has borrowed over its six years under Veritas Capital.[103] That combined debt sits on Gainwell's books, not Veritas Capital's. S&P Global[104] and Moody's[105] credit ratings of Gainwell Technologies indicate the level of debt Gainwell holds has been a significant burden on the company. S&P Global noted that even though Gainwell had reduced costs by $200 million at that point, it had also experienced unexpected cost overruns around the same amount.[106] Both agencies downgraded Gainwell's creditworthiness for a period from 2024 to 2025.

By July 2025 S&P Global reported that Gainwell's "aggressive cost-savings initiatives" and revenue growth had stabilized the company's financial footing, leading the agency to upgrade Gainwell's rating outlook.[107] In March 2026, Fitch Ratings reported Gainwell had achieved about 87% of its goal of $329 million in cost savings, suggesting about $286 million in cost reductions at that point.[108] Those "cost savings" included "workforce reductions" and "offshoring of certain technology functions to India."[109] In some cases below, insufficient staffing was a key factor in problems with Gainwell's operations that impacted both providers and patients. On the revenue side, in some of the cases detailed below, Gainwell was accused of allowing fraudulent activity that boosted its own revenue.

To protect and grow its revenues, Gainwell must maintain its state contracts, renew them, and secure new ones where possible. A central promise of healthcare IT companies is to increase efficiency and reduce costs; past savings metrics and future promises of savings are a major selling point for states considering potential contractors. Gainwell calculates that it saves $11 billion yearly in savings and recoveries.[110] In a video presentation, Gainwell reported $2-3 billion annual savings across 18 states just using its coordination of benefits (COB), third-party liability (TPL), and program integrity (PI) modules.[111] But it can be difficult for states to measure and realize actual cost savings. In one study attempting to calculate the true costs and savings of the widespread adoption of Electronic Health Records (the technological precursor to the software solutions offered by companies like Gainwell today) the authors found the cost-benefit assessment impossible to complete, in particular due to the many unanticipated costs and errors that had not been measured or that were unmeasurable.[112] This is a dynamic also observable in the cases below.

Delays, Errors, and Accusations of Enabling Fraud

In New York, Gainwell (as HMS Holdings) is contracted to provide "third party liability" services. For patients with both Medicaid coverage and another health insurance plan, the "third party" health insurance plan is required to pay first so that Medicaid funds are only tapped as a last resort. Gainwell's role is to review cases where Medicaid has already issued payment for a service, determine whether the patient had a third party health insurance plan apart from Medicaid, and if warranted pursue recovery payments from those third-party plans.[113]

An audit by the state comptroller of claims paid between 2017 and 2021 found Gainwell has systemically failed to identify cases where patients had third-party plans and thus did not pursue the recovery payments, totaling in $52.2 million in claims that should not have been covered by Medicaid funds. For a significant portion of those claims, Gainwell had missed the 1- or 3-year statute of limitations to secure the recovery payments, such that the losses to the Medicaid fund from the improper payments had become permanent. The audit stated "in many instances, lack of recovery likely stemmed from deficiencies in Gainwell's business rules."[114]

In 2026, the state comptroller conducted a follow-up investigation and found that state officials had made only "minimal progress" addressing the problems identified. In particular, several recommendations involving the review and improvement of Gainwell's processes had not been implemented.[115]

In Ohio, where Gainwell was contracted in 2021 for $158 million over 7.5 years[116] to run the state's pharmacy benefit system for Medicaid prescription drug coverage, numerous problems have been reported by Bloomberg Law. In January 2023, the state Medicaid agency filed a corrective action plan with Gainwell to address understaffing for processing claims and member complaints, which had led to patients reporting delays in getting prescriptions filled and to the state pulling state employees away from their own work to process Gainwell's backlog.[117] When granting Gainwell the contract, state officials announced it would save the state more than $200 million per year. But in testimony to the Ohio Joint Medicaid Oversight Committee (JMOC) in 2025 it was reported that actual spending in the first nine months was $585 million above projections.[118]

Ohio also contracted with Gainwell in 2021 to expedite Medicaid claims processing for provider services. Providers claimed that Gainwell's system was riddled with delayed payments and errors in claims adjustment for the full three years after it was adopted. In one case, a skilled nursing facility received 90,000 pages of compiled adjustments at once. The clawback payment Gainwell sought for its errors threatened the financial solvency of the facility.[119]

A former Gainwell compliance officer filed a lawsuit against Gainwell in 2023 alleging she was fired for elevating concerns that Gainwell failed to comply with federal regulations and terms of the contract and that "[Gainwell] knowingly submitted falsified claims and/or records to the Ohio Department of Medicaid." The employee said her managers had denied access to an analytics tool Gainwell used in at least two other states called FraudCapture. The US district judge assigned to the case declined to dismiss the lawsuit, citing the evidence the employee had submitted showing that Gainwell "undermined the role of its compliance program." The case was settled in January 2025.[120]

In a related case, a former Gainwell pharmacist supervisor also sued Gainwell for retaliation claiming he was fired for flagging suspected billing violations during a temporary pause on prior authorization for Medicaid prescription drugs. He alleged both Gainwell leadership and state Medicaid officials pressed him to ignore claims that should not have been approved in order to maximize rebates to the state from drug manufacturers. The case was settled in October 2024.[121]

In Rhode Island, in December 2025, a judge reinstated a False Claims Act lawsuit against Gainwell related to an established case of fraud perpetrated by a Rhode Island hospital where Gainwell was and still is the state-contracted Medicaid claims processor.[122] The fraud involved claims made from 2018 to 2021 (starting before Veritas' acquisition and continuing up to a year after) submitted by hospital administrators who classified a facility as a nursing home, covered by Medicaid, when in reality it was a mental health center ineligible for Medicaid.

The lawsuit claims Gainwell ignored misclassified claims. Gainwell was responsible for flagging non-compliant claims but approved virtually every claim. The state drew potentially hundreds of millions of dollars in federal funds it was not entitled to. Gainwell as the contractor was paid "more than $100 million between 2013 and 2020" according to Bloomberg Law.[123] The judge's opinion was that the lawsuit plausibly alleged that Gainwell acted "beyond mere mistake or negligence" and "at least with reckless disregard" to billing fraud perpetrated by the Rhode Island hospital.[124] The case is still in progress.

Job Offshoring and Threats to Data Security

Gainwell's predecessor companies[125] had major operations in India although it is not clear specifically when India-based subcontractors began to work on US state Medicaid healthcare IT assignments. Bloomberg Law reported that Gainwell increased the number of jobs offshored to India "by around 50%" over two years, with Gainwell currently reporting over 2,000 jobs located in India.[126] This offshoring has been identified as part of over 200 million in spending cuts reported by S&P Global partly spurred by the company's high debt load.[127]

One major concern with offshoring, apart from a preference for public money to support local jobs, is the increased difficulty in ensuring Protected Health Information (PHI) is handled in accordance with federal requirements. While comprehensive datasets are valuable for the relatively aboveboard uses of marketing and analytics, the isolated personal information of individuals holds value for more criminal uses by fraudsters and thieves. Experts say maintaining data within the US and thus within the reach of the US justice system if something goes wrong is crucial to protecting data.[128]

While the federal government does not prohibit offshoring Medicaid-related activities, many states require Medicaid contractors to perform work within the US unless granted an explicit waiver. However, Bloomberg Law reported that some Medicaid officials in Gainwell-contracted states "didn't know about Gainwell's India operations until being asked about them by Bloomberg Law." Later, Bloomberg Law reported that five Gainwell workers had told Bloomberg Law that "they have been ordered to never discuss the India operations with any state Medicaid officials." Three former employees interviewed claimed certain company executives were rushing to offshore jobs without sufficient concern for maintaining data security, even to the point of "side-stepping the rules" according to one of the three that resigned with "ethical concerns."[129]

One employee told Bloomberg Law that Gainwell directed her to train workers based in India to take over her responsibilities even though it would be impossible to do her job without access to complete US patient information such as PHI and social security numbers. Another former employee who had worked on California's Medicaid contract for 14 years and was laid off in October 2025 told Bloomberg Law she found 20 India-based engineers who had improper access to company data including social security numbers, tax identification number, and dates of birth. In one incident investigated by Bloomberg Law, PHI from Nevada's Medicaid system was shared in a company chat session that included India-based workers, with information visible on a shared screen before the offshore workers could be removed.[130]

Bloomberg Law noted that Gainwell leadership disputed most of the claims of data security breaches and claimed the current and former employees who reported otherwise were not being truthful.[131]

Positioning to Profit from Patient Data and AI-Driven Analytics

As a major MMIS developer and operator, Gainwell has access to a significant amount of patient health data across the US. Individuals datasets can be highly lucrative–for marketing, data analytics, biomedical research, and more[132]–and interoperability requirements have also made it increasingly possible to aggregate data extracted from different systems. The Health Insurance Portability and Accountability Act (HIPAA) passed in 1996 set federal standards for the protection of patient health data but has limitations: it permits contractors to share identifiable data with "business associates" and to share "de-identified" data without restriction.

A 2025 report by the Center for Economic and Policy Research (CEPR) points out "the lack of transparency" about how data is shared and for what uses means "the public cannot assess the extent to which patient data is being used for private gain versus the public good."[133] The rise of AI-driven analytics introduces another threat to patient privacy: these tools can be used to re-identify "anonymized" patients.[134]

CEPR research has identified concerns with AI-driven analytics even used within the scope of work of healthcare contractors. The narrative of all-but-guaranteed cost savings through technological modernization continues in relation to the newest technologies of today, particularly the AI technologies of large language models and other machine learning applications. Gainwell Technologies is fully onboard with this movement, having announced in November 2025 a major expansion of its eligibility verification system using a "next-generation AI-driven matching engine" using "40 advanced algorithms across all relevant data sources."[135]

Acentra HEALTH

ACENTRA HEALTH, LLC

Acentra Health, LLC (Acentra) was launched in 2023 as a merger of two well-established healthcare companies with numerous state Medicaid contracts between them: Client Network Services, Inc. and Keystone Peer Review Organization, Inc.[136] It acquired a third company in 2024, and is seeking further acquisitions.[137]

Acentra positions itself as a public health solutions company serving federal and state healthcare agencies. Its current suite of products and services includes healthcare IT, data analysis, fiscal agent services, care management, clinical assessments, and employee benefits.[138] Beyond competing for more public contracts for these individual segments, Acentra's growth strategy depends on integrating the assets of its different segments to develop new capabilities, particularly in AI-driven predictive data analysis to inform improved health care delivery to vulnerable populations.[139]

Client Network Services, Inc. (CNSI) was the first acquisition by private equity firm The Carlyle Group (Carlyle) that would turn into the technological foundation of Acentra Health. CNSI was a healthcare IT company founded in 1994 that, by 2018, had firmly established itself as a major government health solutions contractor. Apart from its Medicaid Management Information Systems (MMIS) segment, it had contracts for Medicare IT services and for healthcare IT services for other federal agencies. CNSI sold a majority stake to private equity firm Alvarez & Marsal (A&M) Capital in 2018, apparently its first private equity investor.[140] A&M held CNSI for an short period before Carlyle acquired CNSI in 2021 for an undisclosed amount.[141]

Keystone Peer Review Organization, Inc. (Kepro) was the second company Carlyle acquired. Founded in 1985 as a nonprofit,[142] it was already well established in clinical services, care management, and care quality improvement. Kepro offered utilization management services, particularly prior authorization services, a process to assess whether a treatment or procedure is "medically necessary". It conducted clinical assessments to determine if Medicaid members who are elderly or have disabilities qualify for home-based services or long-term care. Kepro had been bought and sold by several private equity firms before being acquired by Carlyle. It was acquired by private equity firm Consonance Capital in 2014[143] and then sold to private equity firm Apax Partners, LLP (Apax) in 2017.[144] Carlyle acquired Kepro in 2022, although the overall purchase price was not disclosed.[145]

Friction in MMIS modernization

MMIS technology systems are notoriously complex, especially in the current era of modernization in which older legacy IT systems are operating concurrently with newer cloud-based platforms. CNSI was involved in a prominent MMIS implementation failure in South Dakota in the mid 2010s.[146] But by 2018 CNSI was touting the launch of the first cloud-based MMIS system in the US, Michigan's Community Health Automated Processing System (CHAMPS). CNSI's underlying technology is a platform called evoBrix, organized into different modules focused on different functions that state Medicaid agencies commonly procure by contract such as processing claims, enrolling providers, prior authorization, and data analytics.[147]

Acentra markets its products and services to states as solutions to meet modernization requirements and produce cost savings while speeding up service. In practice, friction and errors that affect patients and providers and cost the state money are more common than either the state or its contractors would like to admit; and state agencies are often so dependent on MMIS contractors that even when more serious problems emerge agencies have little recourse beyond paying for repairs and upgrades.

In 2023, Utah implemented its new Medicaid provider services module developed by CNSI called the Provider Reimbursement Information System for Medicaid (PRISM). The modernization project was launched in 2013.[148] An annual report documented an array of problems that occurred during the rollout of PRISM, which the report authors felt were "anticipated". For instance, the report said that many providers had not enrolled "correctly" prior to PRISM going live which formed a "backlog of provider enrollment applications and modifications". This resulted in claims being "denied at a high rate" and the need for additional staff to assist with addressing the backlog.[149] In another report by the Utah Office of Inspector General it was noted that the implementation of PRISM left the Office "partially blind to Medicaid data for the last quarter of the fiscal year" which led to substantially decreased recoveries of Medicaid funds improperly billed by providers.[150]

In 2022, Michigan amended its contract with CNSI to add $2.35 million to fix a critical database mismatch between the patient enrollment Bridges platform and the core MMIS platform CHAMPS that CNSI developed.[151]

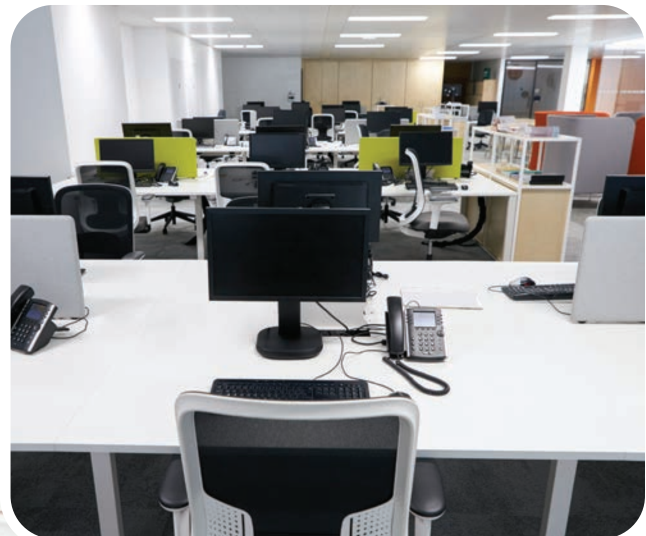
In 2020, a Michigan Auditor General reported on an audit of the state's Medicaid Home Help Program (HHP) from October 2017 through September 2019. It found the Department of Health and Human Services had overpaid 43.1% of the sample of payment audited and estimated the Department issued overpayment totaling $39.4 million in that two-year period.[152] These payments were processed through the Community Health Automated Medicaid Processing System (CHAMPS) developed for the state by CNSI. The Department acknowledged "the current payment system in conjunction with the CHAMPS provider invoice process does not have an edit in place to review" such payments before automatic payments are issued.[153]

In 2023 a medical equipment company, Lincare Inc., was accused of knowingly billing the Washington Medicaid program for equipment rental fees beyond the allowed amount.[154] In Washington State, Medicaid only pays for medical equipment rental fees for the first three years. It was estimated that Lincare overbilled Washington Medicaid for 565 patients totalling over half a million dollars.[155] The state's Medicaid claims processing system, ProviderOne, was both developed and operated by CNSI as fiscal agent.[156]

Official audits of Medicaid payments in Washington have highlighted other errors within CNSI's ProviderOne systems. In one case, it was found that ProviderOne in 2018-2019 in multiple instances "assigned an existing provider a new identifying number allowing claims to process that normally would be denied" and that a rule was "not updated" in ProviderOne to prevent certain providers from billing for clients more than once every four months, resulting in the improper payment of 2,940 claims totalling $79,425.[157] In another case, over $400,000 for home health services was improperly billed because the state, through its fiscal agent CNSI, "lacked adequate procedures" and the MMIS, developed by CNSI, did not have the proper system rules.[158]

Controlling technology labor costs

A key strategy enabling Acentra to pursue more healthcare IT contract opportunities as well as more complex data analytics capabilities is to control labor costs by continuing and expanding investment in its technology center in Chennai, India. CNSI first launched this overseas hub of software engineers in 2004. Executive leadership promotes the Chennai location as essential to and well-integrated in the company rather than as a back-up or support-only site.[159] Although Acentra does not report employment figures by location, a press release mentioned "a growing 500+ workforce" in Chennai in July 2023[160] while an ISI Markets profile reported 585 employees in 2025.[161] Acentra reports a global workforce (excluding its network of clinicians that perform medical assessments) of 3,000[162] to 3,200[163] so its India-based employees account for potentially 17-19% of the total.



Delays and denials in prior authorizations and clinical assessments

Keystone Peer Review Organization, Inc. ("Kepro") has provided prior authorization services for state Medicaid programs for decades.[164] Medicaid programs may require a prior authorization process for certain treatments to determine if the treatment is medically necessary; typically clinicians will submit medical documents and the prior authorization vendor like Kepro will review the documents and render a decision remotely. In other cases, where patients require in-person medical assessment, Kepro will send a clinician to conduct the assessment.

Delays and improper denials in the prior authorization process can lead to delays in treatments. State documentation and journalistic reporting have shown several states have experienced systematic delays and improper denials with Kepro's prior authorization services both while Kepro was held by private equity firms Consonance Capital, Apax Partners, and Carlyle.

In Colorado, Kepro acquired eQHealth Solutions in late 2021,[165] just over a year before Carlyle acquired Kepro from Apax Partners. Kepro took over eQHealth Solutions's contract as Independent Assessment Entity with Colorado to provide prior authorization services for children needing long-term home health and home health therapy. By early 2022 providers were complaining of systematic delays and denials.

One provider said right after the transition, children were suddenly denied nursing services that they had been receiving for years. At a virtual listening session between the state and providers, a speech language pathologist said it took 50 days to get approval and chose to conduct 14 sessions with the patient at the risk of not getting paid.[166] In a written FAQ, one provider question mentioned "waiting on hold for long periods" and not receiving answers "from Kepro's customer service" while another asked about long turnaround times from Kepro that "exceed[ed] 10 days, sometimes reaching 30 days". The written FAQ response acknowledged "timeliness standards were not met" when Kepro first took over, but noted that turnaround time had decreased after Kepro increased automation, increased staffing, and cross-trained staff.[167] At the virtual listening session, state officials are reported to have said "only about 10%" of claims were being denied. One state official denied that the problems had to do with the transition to Kepro and claimed it was a matter of staying in federal compliance.[168]

In North Carolina in 2023, shortly after Acentra acquired Kepro, Acentra secured a new 3-year contract to conduct Level II Preadmission Screening and Resident Reviews (PASRR). This is a type of service authorization typically involving in-person clinical assessments to determine eligibility for specialized care such as long-term care or behavioral health supports. Today, Acentra holds these PASRR contracts in at least eight states. In a September 2023 special bulletin to providers, the North Carolina Medicaid Division of Health Benefits acknowledged that following the transition "Acentra has experienced delays in scheduling and completing Level II evaluation" and that the State would implement "a process to mitigate any adverse impact... if a PASRR authorization is delayed."[169]

Months later, a transcript of questions and responses from a stakeholder meeting in January 2024 illustrated some of the ongoing problems North Carolina providers were experiencing: One question requested a 3-month extension of expiring prior authorizations "since the [Independent Assessment Entity, Acentra] is unable to complete the volume of assessments" needed.[170] Another question referenced being "unable to reach a scheduler and calls are not being returned for days"[171] and a similar one referred to "having to make multiple calls and it's taken a week or more at time just to finally reach someone to be able to schedule assessments" as well as "5+ hours spent on hold trying to schedule our residents' assessments." Another provider who had been able to schedule assessments said they "have seen an increase of cancellations and no-shows since the transition."[172]

Later that same January, an official memo from the North Carolina Medicaid agency reported that the ongoing delays in assessments had affected "more than 800 individuals… as of 1/19/24" and that the review process was taking up to 60 days from the date a referral was first submitted.[173]

In Maine, a team of officials reviewing vendor proposals to provide assessment services noted historical issues: Kepro in 2017-2018 (before the Acentra acquisition, the year it was acquired by Apax Partners and the year after) while contracted with the Office of Aging and Disability Services "allowed a significant backlog of incomplete assessments to develop causing many individuals to have a delay in receiving needed services." They also noted Kepro was "deficient in meeting performance metrics" and then "failed to meet key milestones in the corrective action plan" such that Maine was not able to meet its obligations to the federal Medicaid agency.[174] Ultimately Maine switched to a different vendor "that was able to eliminate the backlog."[175]

More recently, in March 2026, as Maine began implementation of a newly required single assessment process to determine children's needs for behavioral health services, the Office of MaineCare Services issued a special bulletin to providers. The bulletin noted "we have heard from providers and observed that the time required to schedule and complete Single Assessments is longer than anticipated" and they are "working with Acentra and system partners to improve timeliness and reduce delays."[176]

In Oregon, between 2016 to 2019, after Kepro was bought by private equity firm Consonance Capital in 2015 and through its sale to private equity firm Apax Partners in 2017, Kepro was found by The Oregonian to have played a troubling role in Oregon's effort to reduce the number of people placed in restrictive mental health facilities.

Under pressure from the federal government, Oregon launched a three-year initiative in 2016 to move mental health patients out of restrictive facilities into more independent housing. Kepro was contracted to provide the medical determinations to assess what care patients were eligible for. The Oregonian found state officials pressured Kepro to help reduce placements in restrictive facilities, seeking a written plan "for reducing average length of stay in locked facilities" and providing a bonus of up to $10,000 per month for discharging patients from locked facilities.[177]

Confronted with these concerning directives, Kepro went along with it: According to The Oregonian Kepro adjusted its assessment criteria resulting in a surge of ineligible determinations that raised alarm not only among Kepro's own employees but also state officials. The officials, despite the state's own goals, chose to ignore hundreds of ineligibility determinations issued by Kepro and not remove certain patients from the facilities Kepro had found them ineligible for. Kepro stated it was not responsible for state policy and that its determinations were based on state criteria. As Kepro's contract came to an end, the state started to look for new contractors, and Kepro chose not to compete for the contract again.[178]

Acentra's growth strategy reflects a broader vision for value-based healthcare IT

Acentra has achieved high levels of growth since first acquiring CNSI in 2021. In 2024, Acentra touted its "triple digit revenue growth" from 2021 to 2023 and a 158% growth of its global workforce.[179] Acentra executives projected that fiscal year's revenue to be $500-600 million and announced the company will continue to look for strategic acquisitions.[180] In late 2025, Acentra was named as one of the Washington DC metro's fastest growing companies for the second year, a list of companies with the highest sustained revenue growth rate over a three-year period.[181] In March 2026, Acentra announced it had hired a Senior Vice President of Growth Acceleration and Performance responsible for "accelerating strong revenue growth".[182]

Some of Acentra's growth comes from straightforward bundling, upselling, and cross-selling of the different product and service segments acquired through its first companies. In 2024 Acentra acquired a third company, EAP Consultants, LLC ("Espyr"), borrowing $66.43 million for the purchase.[183] Espyr brings a range of Employee Assistance Program (EAP) services including workplace mental health and wellbeing programs. Federal agencies, several of which CNSI had already held healthcare IT contracts with, such as the Department of Veterans Affairs (VA), the Department of Labor (DOL), and the Centers for Medicare & Medicaid Services (CMS), had recently been directed to expand their EAP offerings to their own workers.[184] Acentra's opportunity is to cross-sell Espyr's EAPs to existing clients.

Industry analysts recently raised the financial bar for healthcare IT companies to be considered high value, a key concern for private equity firms positioning their portfolio companies for profitable exit sales. Historically, the most successful healthcare IT companies could meet or beat the "rule of 40"--meaning the company's yearly revenue growth rate added to its EBITDA profitability metric (earnings before interest, taxes, depreciation and amortization) totalled 40% or more. In recent years, analysts have observed healthcare IT companies achieving record high financial performance, going well beyond the "rule of 40" to a set a new "rule of 60". To unlock this higher level of growth and profitability, analysts suggest, healthcare IT companies must go beyond expanding their client base to other more potent strategies.[185]

As part of the modern moment of frenzied experimentation with generative AI, agentic AI, AI-driven analytics, predictive AI, natural language processing, robotic process automation, and more,[186] state governments are seeking applications for these new technological capabilities to address the historical and continuing challenges for Medicaid administration of controlling costs and improving health outcomes.[187] Contractors are racing to be the first to develop workable implementations. A key growth strategy for Acentra, which reflects the strategies analysts observed in firms poised for greatest growth, involves integrating the assets of its different segments to develop new capabilities, particularly in AI-driven predictive data analysis to inform improved health care delivery to vulnerable populations.[188]

A growing body of research theorizes about social determinants of health (SDOH) such as housing, education, environment, economic stability, and more and their impacts on both individual health and population health. As a result, states have been using Medicaid waiver programs to experiment with spending Medicaid funds to directly address SDOH as a strategy of preventative care.[189] States rely on contractors not only to physically deliver the SDOH interventions but also to wrangle and analyze population data to target delivery more precisely.[190] In a late 2024 interview, the CEO of Acentra expressed interest in continuing to identify complementary companies to acquire, particularly those that could add expertise in data analysis for population health insights and working with social determinants of health, health-related social needs, and behavioral health,[191] but even with the three companies already acquired Acentra has already been experimenting in these areas.

Acentra has secured contracts in three states to implement new Medicaid waiver programs focused on social determinants of health: As part of a New York Medicaid waiver program, Acentra manages care for incarcerated individuals who need inpatient medical care outside of their detention facilities and also performs post-discharge clinical assessments. In a Maine Medicaid waiver program, Acentra provides assessments for youth transition from state detention to help match them to out-of-home residential placements and behavioral health providers.[192] And in an Oregon Medicaid waiver program, the first in the US to allow Medicaid dollars to be spent directly on health-related social needs, Acentra administers the provision of housing resources including financial support for rent and household goods alongside clinical screenings and assessments;[193] equipment for household climate resilience;[194] and referrals to medically-tailored meal providers for patients receiving medical dietary guidance.[195]

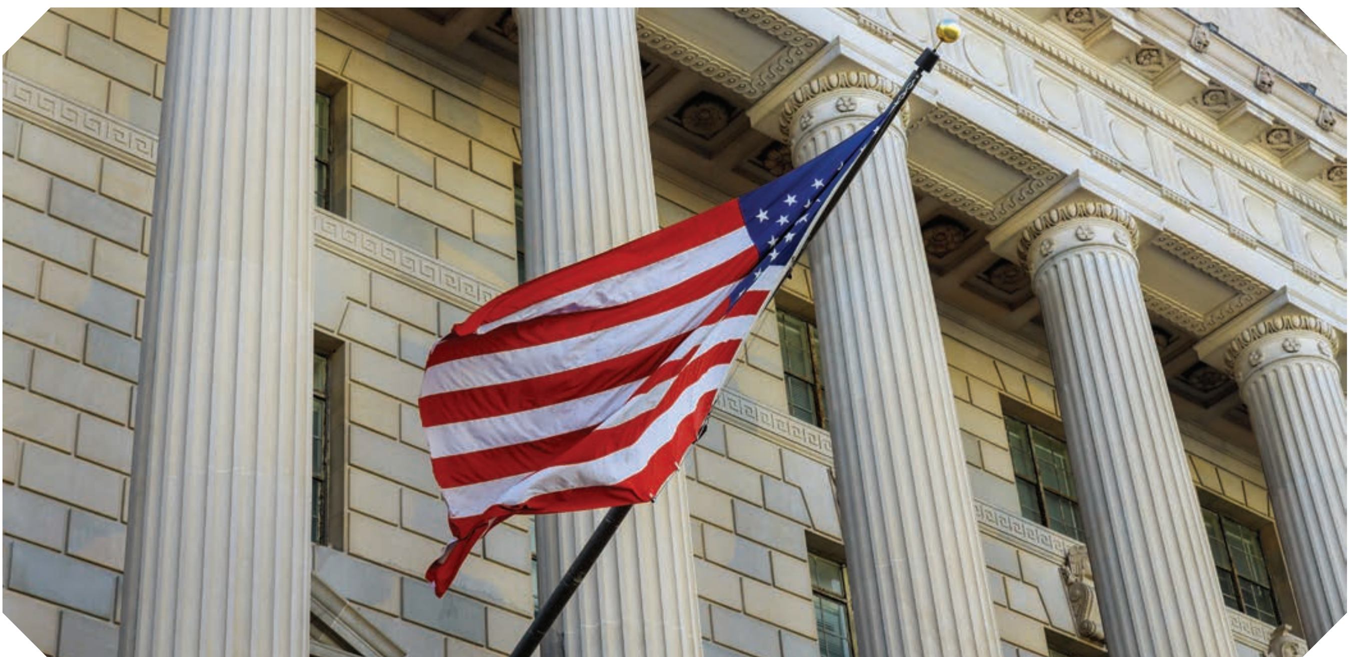
Acentra does not share detailed information about how it is experimenting with AI technology. One more straightforward use it reports is to "detect fraud, waste, and abuse in real time."[196] In 2025, Acentra announced a partnership with Socially Determined, a company that specializes in "social risk analytics" and has access to "proprietary advances social risk data and derived risk scores", to work together to "deliver the power of data, raw computing, and AI analytics to help state healthcare agencies more accurately predict and target interventions that improve health outcomes."[197]

THE EMERGING PUBLIC POLICY RESPONSE

In the realm of Medicaid, the use of federal and state funding for care and the nature of the client-contractor relationship between states and their Medicaid vendors provide concrete levers for governments to set and enforce standards and requirements. Most policies focus on managed care organizations (MCOs), which administer the bulk of Medicaid care, rather than the types of "middlemen" contractor functions described above that administer more limited and specific "fee-for-service" types of care.

Private equity investment is relatively new in the Medicaid middlemen contractor landscape and it is not yet clear to what extent state agencies are considering the need for new or modified approaches to contractor accountability specifically due to dynamics particular to private equity business models. In the case of PPL in New York, the presence of private equity backing for PPL seems to be at least one factor in current efforts to increase the oversight[198] and transparency[199] powers of the state legislature over such contracts.

Two relevant areas of policymaking that have seen significant recent development concern 1) the use of predictive AI and automation in healthcare, including Medicaid, and 2) the security and potential misuse of patient health data.



Governing the use of predictive AI and automation in Medicaid

An Urban Institute's study found as recently as 2024 most states were not yet publicly addressing the use of AI and automation in Medicaid administration.[200] Because federal and state governments are still in the early stages of understanding and developing policy frameworks to address the use of AI in Medicaid, there has been an open window of opportunity for the industry itself to take a proactive role in shaping the potential future frameworks that would govern their own work. In 2025, Acentra co-launched the Safe AI in Medicaid Alliance (SAMA) with a group of state Medicaid agencies, Amazon Web Services, McKinsey & Co. and others. The stated intent is to develop practical frameworks for the responsible use of AI for Medicaid applications.[201]

Washington State was a first mover in establishing an AI Ethics Committee within the state Health Care Authority. The committee published an "Artificial Intelligence Ethics Framework" in 2024, intended to evaluate specific usages of AI in health care and provide recommendations.[202]

One area in which states have been moving quickly is limiting the use of AI in prior authorization, the process that determines what medical care for patients requested by providers will be covered by insurance. California was one of the earliest movers, passing the Physicians Make Decisions Act in late 2024. It requires that any denials, delays, or changes to care based on medical necessity be made and reviewed by licensed human providers instead of solely by AI algorithms. It also established standards for companies using AI in prior authorization to ensure processes are being applied fairly and equitably.[203] Many other states have followed, using California's legislation as a template or starting basis to develop their own policy frameworks, including but not limited to Arizona,[204] Maryland,[205] Nebraska,[206] Texas,[207] Washington,[208] and Alabama.[209]

Protecting patient health information and medical datasets against misuse

In Washington, the My Health My Data Act gives individuals the private right of action to sue if their health data is sold without authorization. It also forces vendors to disclose to whom they would be selling the data.[210]

Maryland passed a bill in October 2025, the Maryland Online Data Privacy Act (MODPA), which fully prohibits the sale of sensitive data, including patient health information, regardless of patient consent–meaning even if patients were persuaded to "opt in" to the sale of their data, it would still be illegal.[211]

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