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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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March 13, 2026

MEMORANDUM

TO: Members of the Subcommittee on Oversight and Investigations
FROM: Committee Majority Staff
RE: Subcommittee on Oversight and Investigations Hearing on March 17, 2026

I. INTRODUCTION

The Subcommittee on Oversight and Investigations will hold a hearing on Tuesday, March 17, 2026, at 2:00 p.m. (ET), in 2123 Rayburn House Office Building. The hearing is entitled "Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud."

II. WITNESS

- **Kimberly Brandt**, Deputy Administrator and Chief Operating Officer, U.S. Centers for Medicare and Medicaid Services.

III. BACKGROUND

Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars a year.[1] Fraud is prevalent in all sectors of health care and is especially egregious in taxpayer-funded health care programs that are intended to serve vulnerable populations, including the elderly, disabled, children, and pregnant women.[2] Every dollar stolen from federal health care programs is a dollar that is not spent on high quality health care for those that need it most. Efforts to crack down on health care fraud are ongoing, but there is more that can be done to reform Medicare and Medicaid to reduce susceptibility to fraud.[3] The U.S. Centers for

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[1] Memorandum from H. Comm. on Energy and Commerce Majority Staff to Subcomm. on Oversight and Investigations Members, *Subcommittee on Oversight and Investigations Hearing on February 3, 2026* (Jan. 31, 2026), https://d1dth6e84htgma.cloudfront net/02_03_2026_O_and_I_Hearing_Memorandum_408bb55582.pdf.
[2] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (last visited Mar. 5, 2026).
[3] *See* Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with over $14.6 Billion in Alleged Fraud (Jun. 30, 2026),

Medicare and Medicaid Services (CMS), states, and other relevant federal and law enforcement agencies have a duty to prevent and investigate fraud, implement reforms to Medicare and Medicaid, and hold bad actors accountable.[4]

CMS, a subagency of the U.S. Department of Health and Human Services (HHS), administers Medicare (69.7 million enrollees) and Medicaid (68.8 million enrollees).[5] Medicare is a federal program, which provides health insurance for seniors aged 65 and older, as well as certain groups that are eligible due to disability or disease.[6] Medicaid is a jointly administered federal and state health insurance program for means-eligible vulnerable groups, including children, pregnant women, seniors, and individuals with disabilities.[7] As a shared federal-state program, each state, district, and territory must operate its Medicaid program within federal guidelines, and contributes a portion to its operation that is matched by the federal government via the Federal Medical Assistance Percentage (FMAP).[8] CMS is responsible for providing states with guidance and approving state plan amendments, waivers, and demonstrations.[9] Through these pathways, states may modify their Medicaid program to fit specific needs in their state or implement new ways to deliver health care services.[10]

Both the federal government and states are responsible for program integrity measures to reduce fraud, waste, and abuse (FWA) in the Medicaid program.[11] The CMS Center for Program Integrity (CPI) "[p]romotes the integrity of the Medicare and Medicaid programs and CHIP [Children's Health Insurance Program] through provider/contractor audits and policy reviews, identification and monitoring of program vulnerabilities, and providing support and assistance to

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https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[4] Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud (Jun. 30, 2025), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146; *see also* Press Release, U.S. Dep't of Justice, False Claims Act Settlements and Judgements Exceed $6.8B in Fiscal Year 2025 (Jan. 16, 2026), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025.

[5] U.S. Centers for Medicare and Medicaid Services, Medicare Monthly Enrollment – November 2025, https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment (last visited Mar. 5, 2026); U.S. Centers for Medicare and Medicaid Services, November 2025 Medicaid & CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/november-2025-medicaid-chip-enrollment-data-highlights (last visited Mar. 5, 2026).

[6] U.S. Dep't of Health and Human Services, Who's eligible for Medicare?, https://www hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index html (last visited Mar. 5, 2026).

[7] U.S. Centers for Medicare and Medicaid Services, Medicaid Eligibility Policy, https://www medicaid.gov/medicaid/eligibility-policy (last visited Mar. 5, 2026).

[8] Medicaid and CHIP Payment and Access Commission, Administration, https://www.macpac.gov/medicaid-101/administration/ (last visited Mar. 5, 2026).

[9] *Id.*

[10] U.S. Centers for Medicare and Medicaid Services, About Section 1115 Demonstrations, https://www medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations (last visited Mar. 5, 2026).

[11] Medicaid and CHIP Payment and Access Commission, Administration, https://www.macpac.gov/medicaid-101/administration/ (last visited Mar. 5, 2026).

States."[12] CPI is responsible for managing provider enrollment systems, FWA audits, and advanced data analytics to prevent FWA, and collaborating with states to provide resources and best practices for improving Medicaid program integrity.[13] State Medicaid agencies are required to have fraud detection and investigation programs in place.[14] All 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate Medicaid Fraud Control Units (MFCUs), which investigate and prosecute Medicaid fraud, in addition to patient abuse and neglect.[15]

There are a handful of ways that Medicare and Medicaid fraud schemes are commonly carried out.[16] Overarching types of health care fraud schemes in Medicare and Medicaid include medical identity theft (patients and physicians), billing for unnecessary services or items, billing for services not rendered or furnished, upcoding, unbundling, and kickbacks.[17]

A. Medicare Benefits that are High-Risk for Fraud

Medicare benefits commonly targeted by fraudsters include, but are not limited to, Durable Medical Equipment, Prosthetic Devices, Orthotics, and Supplies (DMEPOS, also commonly referred to as DME), genetic and clinical laboratory testing, and hospice.[18] The cases highlighted below are a few examples of Medicare provider categories that experience high rates of fraud. These cases are only a snapshot of fraud in these programs as Medicare fraud is not isolated to certain states.

1. *DMEPOS*

In DMEPOS fraud schemes, criminals acquire Medicare beneficiary and physician information (in some cases, in concert with beneficiaries or physicians in exchange for kickbacks) to fraudulently bill for medically unnecessary or not provided medical equipment such as urinary catheters, continuous glucose monitors, surgical dressings, orthotic braces, and

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[12] U.S. Centers for Medicare and Medicaid Services, Center for Program Integrity, https://www.cms.gov/about-cms/leadership/center-program-integrity (last visited Mar. 9, 2026); *see* 42 C.F.R. §§ 430.32, 431.16, 433.32, 455.12, 456.
[13] *Id.*
[14] Medicaid Agency Fraud Detection and Investigation Program, 42 C.F.R. § 455 subpart A (2011).
[15] U.S. Dep't of Health and Human Services Office of Inspector General, Medicaid Fraud Control Units, https://oig hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ (last visited Mar. 9, 2026).
[16] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf.
[17] *Id.; See also* Memorandum from H. Comm. on Energy and Commerce Majority Staff to Subcomm. on Oversight and Investigations Members, *Subcommittee on Oversight and Investigations Hearing on February 3, 2026,* 3-5 (Jan. 31, 2026), https://d1dth6e84htgma.cloudfront net/02_03_2026_O_and_I_Hearing_Memorandum_408bb55582.pdf.
[18] Senior Medicare Patrol, Fraud Schemes, https://smpresource.org/medicare-fraud/fraud-schemes/ (last visited Mar. 5, 2026).*See* U.S. Centers for Medicare and Medicaid Services, CMS Fraud Hot Spot: DMEPOS Suppliers (Sept. 2025), https://www.cms.gov/files/document/hot-spot-dmepos-suppliers.pdf; *see also* U.S. Dep't of Heath and Human Services Office of Inspector General, Nationwide Genetic Testing Fraud, https://oig hhs.gov/newsroom/media-materials/media-materials-nationwide-genetic-testing-fraud/ (last visited Mar. 5, 2026); *see also* Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 7 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf; *see also* U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.

positive airway pressure (PAP) devices and supplies.[19] Last year, the U.S. Department of Justice (DOJ) fraud takedown known as Operation Gold Rush, resulted in 15 individuals being charged in "the largest case by loss amount ever charged by the Department of Justice."[20] This scheme involved members of Russian organized crime who purchased 30 small medical supply companies already enrolled in Medicare and billed more than $10.6 billion for fraudulent urinary catheter claims using stolen beneficiary information.[21] CMS flagged the claims as suspicious and the government was able to prevent more than 99 percent of the payments from being made to the criminal organization.[22]

Last month, a Russian citizen, Nika Machutadze, was charged for his role in an alleged $3.4 billion money laundering scheme involving two DMEPOS companies based in Texas and Florida, that fraudulently billed Medicare for identical medical products and backdated claims for equipment allegedly prescribed to deceased beneficiaries.[23] Mr. Machutadze's first company allegedly billed Medicare for $3.3 billion in claims, in which over half were processed ($1.78 billion) before Medicare suspended reimbursements.[24] Mr. Machutadze's second company purportedly billed $134 million in the course of one month in 2025, with Medicare paying over $90 million of the claims before halting reimbursements.[25] Medicare beneficiaries noticed the claims and reported that they did not receive the medical equipment or that it was not medically necessary, while some physicians reported they were listed as the authorizing physician on claims despite having no knowledge of the referrals or companies involved.[26] This month, DOJ announced charges against another Russian citizen, Nikolai Buzolin, who is accused of laundering $1.2 million of proceeds from a fraudulent DMEPOS scheme targeting Medicare Advantage plans.[27]

Earlier this month, a Texas man was sentenced to prison for his role in a $59.9 million DMEPOS fraud scheme.[28] In this scheme, the man operated three DMEPOS companies, one of

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[19] *Id.*; Erin Rutzler, *FWA Insights: How to catch a DME scheme,* COTIVITI, https://resources.cotiviti.com/fraud-waste-and-abuse/dme-scheme (last visited Mar. 6, 2026).
[20] Press Release, U.S. Attorney's Office, Eastern District of New York, 11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice (Jun. 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.
[21] *Id.*
[22] Dan Diamond and Lauren Weber, *Inside Operation Gold Rush, largest health care fraud bust in U.S. history*, THE WASH. POST (Jun. 30, 2025), https://www.washingtonpost.com/health/2025/06/30/health-care-fraud-bust-largest-in-us-history/.
[23] Dalton Huey, *Feds allege $3.4 billion Medicare fraud scheme tied to Russian citizen living in Austin*, KXAN (Feb. 2, 2026), https://www.kxan.com/investigations/feds-allege-3-4-billion-medicare-fraud-scheme-tied-to-russian-citizen-living-in-austin/; Brian New, *Russian-run Texas medical supplier at center of massive Medicare billing scheme, feds say*, CBS NEWS (Feb. 24, 2026), https://www.cbsnews.com/texas/news/russian-run-texas-medical-supplier-massive-medicare-billing-scheme-feds-say/.
[24] *Id.* at Huey.
[25] *Id.*
[26] *Id.*
[27] Press Release, U.S. Dep't of Justice, Russian citizen charged with laundering over $1.2M connected to $400M in fraudulent Medicare claims (Mar. 5, 2026), https://www.justice.gov/opa/pr/russian-citizen-charged-laundering-over-12m-connected-400m-fraudulent-medicare-claims.
[28] Press Release, U.S. Dep't of Justice, Owner of durable medical equipment company sentenced for $59M Medicare fraud (Mar. 9, 2026), https://www.justice.gov/opa/pr/owner-durable-medical-equipment-company-sentenced-59m-medicare-fraud.

which he falsely represented as being owned by someone else, and paid illegal kickbacks to co-conspirators who gave him signed physicians' orders and paperwork for the purpose of fraudulently billing Medicare for orthotic braces without a provider examining or treating the patient.[29]

2. *Genetic and Clinical Laboratory Testing*

Genetic and clinical laboratory testing claims have been identified as high-risk for fraud due to the number and variability of laboratories; the high-volume, low-dollar nature of laboratory services; and technical complexity of laboratory services.[30] Last month, a former National Football League player, Keith J. Gray, was convicted for orchestrating a $328 million genetic testing fraud scheme.[31] In this fraud scheme, Mr. Gray billed Medicare for medically unnecessary tests and offered and paid kickbacks to marketers to obtain "Medicare beneficiaries' DNA samples, personally identifiable information (including Medicare numbers) and signed test orders."[32] Patient marketers, at the behest of Mr. Gray, contacted Medicare beneficiaries through telemarketing and "doctor chased" by contacting beneficiaries' physicians to pressure their authorization of medically unnecessary tests.[33]

Similar to genetic testing fraud, clinical laboratory fraud schemes may involve medically unnecessary testing and billing practices to inflate costs.[34] In a recent criminal case, a California man was convicted of billing Medicare over $4 million in fraudulent claims for urine drug testing for patients under pain management treatment.[35] In this scheme, urine testing, which has a high Medicare reimbursement rate, was fraudulently ordered by paying patient marketers kickbacks to conspire with physician office staff to forward testing orders that a doctor did not authorize for their patients.[36]

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[29] *Id.*
[30] U.S. Dep't of Health and Human Services Office of Inspector General, Nationwide Genetic Testing Fraud, https://oig hhs.gov/newsroom/media-materials/media-materials-nationwide-genetic-testing-fraud/ (last visited Mar. 9, 2026); Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 6 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf.
[31] Press Release, U.S. Dep't of Justice, Former NFL Player and Laboratory Owner Convicted in $328M Genetic Testing Fraud Scheme (Feb. 20, 2026), https://www.justice.gov/opa/pr/former-nfl-player-and-laboratory-owner-convicted-328m-genetic-testing-fraud-scheme.
[32] *Id.*
[33] *Id.*
[34] Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 9-12 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf.
[35] Press Release, U.S. Dep't of Justice, Lab operator convicted of $4M Medicare fraud scheme (Feb. 25, 2025), https://www.justice.gov/opa/pr/lab-operator-convicted-4m-medicare-fraud-scheme.
[36] *Id.*

3. *Hospice*

Medicare hospice benefits are increasingly being targeted for fraud.[37] Illegal patient marketers have been found to enroll Medicare beneficiaries that do not have a terminal illness in hospice without their knowledge.[38] Amid increasing utilization of hospice benefits, CMS has identified hospice as a high-risk provider type, and observed that patients are staying in hospice too long, hospice agencies are highly concentrated in certain geographic locations, and there are high rates of patients discharged from hospice alive.[39] Due to these patterns, in July 2023, CMS implemented additional oversight of hospice agencies via a Provisional Period of Enhanced Oversight (PPEO) for new hospices enrolling in Medicare or changing ownership in Arizona, California, Nevada, and Texas.[40] Not only is hospice fraud egregious, it causes patient harm because a hospice designation on a Medicare beneficiary's patient file limits their ability to receive care for serious health conditions they may need outside of hospice.[41]

Last year, a California man pleaded guilty to more than $17 million in Medicare hospice and home health fraud.[42] In this scheme, the man and his co-conspirators fraudulently enrolled in Medicare as hospice providers using sham provider information and subsequently submitted fraudulent claims for hospice services that were medically unnecessary and not provided for patients that were not in need of hospice.[43] In addition to the hospice scheme, the defendant was found to have fraudulently used physician information to falsely certify Medicare beneficiaries for home health care services they did not order.[44] This conviction followed $2.8 million and $9 million Medicare hospice fraud cases in California that were resolved the previous year.[45]

B. <u>Medicaid Benefits that are High-Risk for Fraud</u>

While Medicaid program offerings vary state-by-state, there are Medicaid programs operating in many states that have been identified as high-risk for fraud. These include, but are not limited to, Applied Behavior Analysis (ABA) services for children with autism spectrum disorder (ASD), personal care services (PCS), and non-emergency medical transportation

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[37] *See* William La Jeunesse, *Los Angeles hospice fraud reaches billions as Medicare providers scam federal system with fake companies*, FOX NEWS (Jan. 30, 2026), https://www foxnews.com/us/los-angeles-hospice-fraud-reaches-billions-medicare-providers-scam-federal-system-fake-companies.

[38] Colin May, *Safeguarding hospice care: Addressing fraud and upholding patient trust,* Association of Certified Fraud Examiners (Jan. 2026), https://www.acfe.com/acfe-insights-blog/blog-detail?s=safeguarding-hospice-care-fraud.

[39] U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.

[40] *Id.*

[41] William La Jeunesse, *Los Angeles hospice fraud reaches billions as Medicare providers scam federal system with fake companies*, FOX NEWS (Jan. 30, 2026), https://www foxnews.com/us/l

[42] Press Release, U.S. Dep't of Justice, Man pleads guilty in connection with $17M Medicare hospice fraud and home health care fraud schemes (Feb. 3, 2025), https://www.justice.gov/opa/pr/man-pleads-guilty-connection-17m-medicare-hospice-fraud-and-home-health-care-fraud-schemes.

[43] *Id.*

[44] *Id.*

[45] Press Release, U.S. Dep't of Justice, Doctor convicted of $2.8M Medicare fraud scheme (Feb. 16, 2024), https://www.justice.gov/archives/opa/pr/doctor-convicted-28m-medicare-fraud-scheme; Press Release, U.S. Dep't of Justice, Two men sentenced for role in $9M hospice fraud scheme (Mar. 29, 2024), https://www.justice.gov/archives/opa/pr/two-men-sentenced-role-9m-hospice-fraud-scheme.

(NEMT).[46] The cases highlighted below are a few examples of Medicaid provider categories that experience high rates of fraud. These cases are only a snapshot of fraud in these programs as Medicaid fraud is not isolated to certain states.

1. *Applied Behavior Analysis Services*

Medicaid covers ABA therapy and services for eligible children with ASD.[47] ABA programs and other services for children with ASD have been identified to have "questionable billing patterns…as well as Federal and State payments for providers for unallowable services."[48] As part of an ongoing review, the HHS Office of Inspector General (OIG) is auditing select states' ABA payments to assess compliance with federal and state requirements.[49] In reviews completed so far in Indiana, Wisconsin, Maine, and Colorado, HHS-OIG identified patterns in improper payments that reveal ABA providers billing for services that are not covered under the ABA benefit, are not properly documented to show that services are being provided in compliance with federal requirements, and in some instances by providers who do not have the proper credentials to perform reimbursable therapy.[50] While not all improper payments are fraud, the billing patterns found in HHS-OIG's reviews indicate that without proper documentation, millions of dollars in payments for ABA services cannot be properly substantiated to rule out FWA.[51]

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[46] *See* Isaac Asamoah Amponsah, *Ethics at Risk: Addressing Fraudulent Behavior in ABA Therapy,* Association of Certified Fraud Examiners (July 2024), https://www.acfe.com/acfe-insights-blog/blog-detail?s=ethics-risk-addressing-fraudulent-behavior-aba-therapy; *see also* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Erin Rutzler, *FWA insights: Spotting red flags in adult day care claims*, COTIVITI, https://resources.cotiviti.com/fraud-waste-and-abuse/fwa-insights-spotting-red-flags-in-adult-day-care-claims (last visited Mar. 6, 2026); *see also* U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation: Medicaid Non-Emergency Medical Transportation Booklet for Providers, 7, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf.

[47] *See* U.S. Centers for Medicare and Medicaid Services, Division of Quality and Health Outcomes, 2024 Medicaid & CHIP beneficiaries at a glance: Autism (July 2024), https://www medicaid.gov/medicaid/benefits/downloads/2024-autism-infographic.pdf.

[48] U.S. Dep't of Health and Human Services Office of Inspector General, Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/ (last visited Mar. 6, 2026).

[49] *Id.*

[50] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-09-22-02002, INDIANA MADE AT LEAST $56 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (Dec. 16, 2024), https://oig hhs.gov/documents/audit/10123/A-09-22-02002.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-06-23-01002, WISCONSIN MADE AT LEAST $18.5 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (July 10, 2025), https://oig hhs.gov/documents/audit/10497/A-06-23-01002.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-01-24-00006, MAINE MADE AT LEAST $45.6 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR REHABILITATIVE AND COMMUNITY SUPPORT SERVICES PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (Jan. 16, 2026), https://oig.hhs.gov/documents/audit/11447/A-01-24-00006.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-09-24-02004, COLORADO MADE AT LEAST $77.8 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN (Feb. 25, 2026), https://oig.hhs.gov/documents/audit/11493/A-09-24-02004.pdf.

[51] *See* U.S. Centers for Medicare and Medicaid Services, Fiscal Year 2025 Improper Payments Fact Sheet (Jan. 15, 2026), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet; *see also* The

In Minnesota, ongoing criminal investigations into the state's Early Intensive and Developmental Behavioral Intervention (EIDBI) program, which provides Medicaid ABA services for children with ASD, have patterns of documentation errors and unqualified providers.[52] Abdinajib Hassan Yussuf was charged and pleaded guilty to allegations that he perpetrated $6 million in fraud against Minnesota's Medicaid program as an EIDBI provider.[53] Mr. Yussuf and his colleagues "employed unqualified individuals as 'behavioral technicians'" and recruited children to enroll in ABA services by paying cash kickbacks to parents and ensuring the children obtained ASD diagnoses to qualify for the services.[54] In his plea hearing, Mr. Yussuf admitted that he did not know anyone with ASD and worked with his co-conspirators to recruit children who could be diagnosed for the purposes of qualifying for EIDBI.[55] Another individual, Asha Farhan Hassan, who recently pleaded guilty for her role in a $14 million ASD services fraud scheme in Minnesota, had previously been charged in the Feeding Our Future fraud scheme.[56]

2. *Personal Care Services*

PCS, which provides eligible individuals assistance with daily living needs within their own home, have been identified as high-risk for fraud due to "high rate of utilization," "collusion among multiple people," and "billing for services that were never rendered or billing for services supposedly rendered."[57] Under Section 1915(c) Home and Community-Based Waivers, many states offer self-directed PCS programs that allow patients to hire their own caregiver to provide services in their home.[58] CMS regulations require that state "written plan[s] must prevent the provision of unnecessary or inappropriate services and supports" in PCS.[59]

In New York, the Community-Driven Personal Assistance Program (CDPAP) delivers self-directed PCS reimbursed by Medicaid.[60] In 2018, Ballal Hossain was sentenced to prison for fraudulently registering himself and more than a dozen friends and family members to work as CDPAP caregivers.[61] Over several years, Mr. Hossain and ten others were paid to be caregivers

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Editorial Board, *The Medicaid Autism Racket*, WALL ST. JOURNAL (Mar. 8, 2026), https://www.wsj.com/opinion/the-medicaid-autism-racket-a9d20f30?mod=hp_opin_pos_1.

[52] Lou Raguse, *Autism center fraud suspect pleads guilty to $6 million scheme*, KARE 11 (Mar. 2, 2026), https://www kare11.com/article/news/local/courts-news/autism-center-fraud-suspect-pleads-guilty-6-million-scheme/89-a0835aa2-5587-4d8e-900e-215500eaf4b7.

[53] Press Release, U.S. Attorney's Office, District of Minnesota, Six Additional Defendants Charged, One Defendant Pleads Guilty in Ongoing Fraud Schemes (Dec. 18, 2025), https://www.justice.gov/usao-mn/pr/six-additional-defendants-charged-one-defendant-pleads-guilty-ongoing-fraud-schemes.

[54] *Id.*; *Supra,* note 52.

[55] *Id.*

[56] *Id.*

[57] U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf.

[58] *Id.* at 7.

[59] *Id.* at 12.

[60] New York State Department of Health, Consumer Directed Personal Assistance Program (CDPAP), https://www health ny.gov/health_care/medicaid/program/longterm/cdpap/ (last visited Mar. 6, 2026).

[61] News Release, Office of the New York State Welfare Inspector General, Catherine Leahy Scott, Manhattan man sentenced to prison and pays restitution for his $600,000 theft of welfare and unemployment insurance benefits

for his mother, who resided out of the country.[62] To carry out the scheme, Mr. Hossain's brother posed as the mother during routine site visits.[63]

In California, self-directed personal care services are provided by the In-Home Supportive Services (IHSS) program.[64] As part of sweeping indictments announced by DOJ in the 2025 National Health Care Fraud Takedown, five individuals were charged for their role in fraudulent Medi-Cal billing for IHSS services.[65] These defendants are alleged to have submitted time sheets for services not rendered when recipients of the services were unable to receive care due to being admitted to care facilities, out of the country, incarcerated, or hospitalized.[66]

3. *Non-Emergency Medical Transportation*

NEMT services are a critical Medicaid benefit providing no-cost transportation to eligible patients needing assistance getting to non-emergency medical appointments. NEMT "can pose a significant risk of fraud, waste, and abuse in Medicaid," and HHS-OIG recently announced it is conducting a targeted review to reduce FWA in Medicaid NEMT.[67]

Last month, the U.S. Attorney for the District of Colorado and the Colorado Attorney General's Office announced charges of two individuals for defrauding Health First Colorado's NEMT program.[68] The first defendant, Ashley Marie Stevens, is alleged to have billed over $1 million in NEMT rides, $400,000 of which were billed for rides for herself and family members, and most of which were not associated with transportation to medical appointments.[69] Ms. Stevens also billed "ghost rides" for rides that did not occur at all and for rides that did not include a medical destination, in addition to over $450,000 for rides that were 400 miles or more, improbable for a single beneficiary in a single day.[70] The second defendant, Wesam Yassin, billed Health First Colorado for $3.3 million in NEMT rides, including $283,000 for 64 rides for a single beneficiary, $165,000 of which occurred after the beneficiary had died.[71] Ms. Yassin similarly billed ghost rides and beneficiary rides that were not associated with a medical destination.[72]

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through fraud schemes using more than a dozen friends and relatives (Feb. 23, 2018), https://ig ny.gov/system/files/documents/2018/05/hossainsentencepr2-23-18.pdf.

[62] *Id.*

[63] *Id.*

[64] California Dep't of Social Services, In-Home Supportive Services (IHSS) Program, https://www.cdss.ca.gov/in-home-supportive-services (last visited Mar. 9, 2026).

[65] U.S. Dep't of Justice, 2025 National Health Care Fraud Takedown Case Summaries, https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit/2025-national-hcf-case-summaries (last visited Mar. 9, 2026).

[66] *Id.*

[67] *Id.*

[68] Press Release, U.S. Attorney's Office, District of Colorado, Federal charges filed in two separate cases involving non-emergent medical transportation fraud (Feb. 10, 2026), https://www.justice.gov/usao-co/pr/federal-charges-filed-two-separate-cases-involving-non-emergent-medical-transportation.

[69] *Id.*

[70] *Id.*

[71] *Id.*

[72] *Id.*

C. Recent CMS Initiatives to Curb Fraud

Under the Trump Administration, CMS is pursuing many initiatives to improve monitoring and oversight of fraudulent claims in both Medicare and Medicaid.[73] In 2025, CMS' fraud enforcement successes included:

- Suspending $5.7 billion in suspected fraudulent Medicare payments by leveraging advanced analytics, cross-agency coordination, and law enforcement partnerships;
- Preventing $1.5 billion in suspected fraudulent DMEPOS billing;
- Denying 122,658 Medicare claims for unnecessary items and services because they failed to satisfy Medicare's preliminary approval checks that confirm medical necessity and other coverage requirements;
- Revoking the ability of 5,586 providers and suppliers to bill the Medicare program due to inappropriate behavior;
- Sending 372 fraud referrals encompassing $3.7 billion in billing to law enforcement for potential legal action; and
- Initiating a CMS-State Tax Fraud partnership with 28 states and the US Virgin Islands to strengthen state-federal enforcement against healthcare providers and suppliers who commit healthcare and tax fraud.[74]

CMS is leveraging emerging technologies, including artificial intelligence (AI), to combat fraud more efficiently and identify questionable provider applications.[75] According to Kimberly Brandt, Deputy Administrator and Chief Operating Officer of CMS, the agency has saved $2 billion since March 2025 by using AI to identify duplicative contracts and fraudulent claims.[76] Through an algorithm, the AI technology is able to identify potentially high-risk providers upon application and monitor them through an internal watch list for enhanced monitoring.[77]

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[73] *See* Memorandum from H. Comm. on Energy and Commerce Majority Staff to Subcomm. on Oversight and Investigations Members, *Subcommittee on Oversight and Investigations Hearing on February 3, 2026,* 8 (Jan. 31, 2026), https://d1dth6e84htgma.cloudfront net/02_03_2026_O_and_I_Hearing_Memorandum_408bb55582.pdf.
[74] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.
[75] Alexandra Kelley, *CMS saved $2 billion by using AI to fight fraud, official says,* NEXTGOV/FCW (Feb. 24, 2026), https://www nextgov.com/artificial-intelligence/2026/02/cms-saved-2-billion-using-ai-fight-fraud-official-says/411661/.
[76] *Id.*
[77] *Id.*

In June 2025, CMS launched the Fraud Defense Operations Center (FDOC), also known as the Fraud War Room, and announced cross-agency efforts to combat suspected fraud and improper payments in Medicare.[78] The FDOC brings together a "specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement" to use data analytics to identify irregular billing practices.[79] In 2025, the FDOC's actions resulted in over $1.8 billion in payment suspensions, investigations of over 347 providers, and suspension of payment to 249 providers due to suspected fraud.[80]

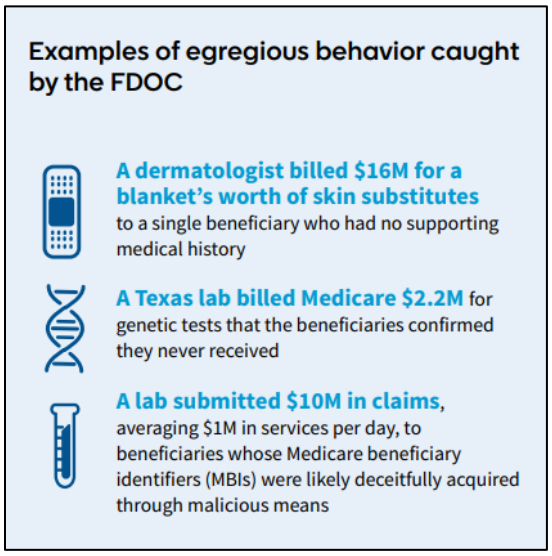

Figure 2: Examples of Medicare Fraud Caught by the FDOC Pilot Program.[81]

On June 6, 2025, President Trump issued a Presidential Memorandum for the Secretary of HHS and the Administrator of CMS entitled, "Eliminating Waste, Fraud, and Abuse in Medicaid."[82] State-directed payments in the Medicaid program have "rapidly accelerated," allowing states to pay less money towards their Medicaid services and reducing state incentives to responsibly steward Medicaid funds.[83] The Memorandum directs HHS and CMS to "take appropriate action to eliminate waste, fraud, and abuse in Medicaid, including by ensuring Medicaid payments rates are not higher than Medicare, to the extent permitted by applicable law."[84]

On June 22, 2025, CMS announced the Wasteful and Inappropriate Service Reduction (WISeR) model, a new innovation program that uses AI, machine learning (ML), and human clinical review to assess coverage determinations for certain Medicare services that are high-risk

[78] U.S. Centers for Medicare and Medicaid Services, Fraud Defense Operations Center, Fast Facts: CMS' Fraud, Waste, and Abuse Sprint Strategy (Jun. 2025), https://www.cms.gov/files/document/cms-fraud-waste-and-abuse-sprint-strategy.pdf.
[79] *Id.*
[80] U.S. Centers for Medicare and Medicaid Services, Fraud Defense Operations Center, Fast Facts (Jan. 2026), https://www.cms.gov/files/document/fdoc-fact-sheet-updated.pdf.
[81] *Supra,* note 78.
[82] The White House, Presidential Memoranda, Eliminating Waste, Fraud, and Abuse in Medicaid (Jun. 6, 2025), https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/.
[83] *Id.*
[84] *Id.*

for fraud, waste, and abuse.[85] These services include skin substitutes, electrical nerve stimulator implants, and knee arthroscopy for knee osteoarthritis.[86] WISeR is being implemented in New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington from January 1, 2026, to December 31, 2031.[87]

On November 25, 2025, CMS Administrator Mehmet Oz wrote a letter to all state governors providing more information about a joint state and federal partnership between CMS and state tax agencies to "identify and take action against providers and suppliers who commit both health care and tax fraud."[88] If participating in this partnership, state tax agencies will share information with CMS about tax fraud cases on their radar and CMS will share information about providers in the state that have billing behavior that draws suspicion of potential Medicare fraud.[89] This partnership will make it easier for states to prosecute tax fraud and for CMS to take action to revoke billing privileges for criminals operating in Medicare and Medicaid.[90]

In response to widespread allegations of Medicaid fraud in Minnesota, CMS launched an audit of the Minnesota Medicaid program, freezing provider enrollment and deferring payments on 14 high-risk programs including adult companion, autism behavioral therapy, rehabilitative mental health services, individualized home supports, and residential treatment services.[91] CMS warned Minnesota that if it does not take sufficient corrective actions to remedy the program integrity failures of its Medicaid programs, it risks the withholding of federal Medicaid funds.[92]

On January 14, 2026, CMS announced it intends to withhold quarterly federal funding for Minnesota's 14 high-risk Medicaid programs, totaling $515,154,947.56, or approximately $2 billion a year, until "Minnesota demonstrates full and sustained compliance with federal Medicaid requirements."[93] Subsequently, on February 25, 2026, CMS announced it was deferring $259.5 million of Minnesota Medicaid's fourth quarter 2025 federal matching funds

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[85] Centers for Medicare and Medicaid Services, WISeR (Wasteful Inappropriate Service Reduction) Model, https://www.cms.gov/priorities/innovation/innovation-models/wiser (last visited Jan. 26, 2026).
[86] *Id.*
[87] *Id.*
[88] Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to state Governors (Nov. 25, 2025), https://www.cms.gov/files/document/tax-fraud-letter-oz.pdf.
[89] *Id.*
[90] *Id.*
[91] Joe Walsh, What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraudscandal-more-charges-filed-trump-walz/; Letter from Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services to Tim Walz, Governor, State of Minnesota (Jan. 6, 2026), https://x.com/DrOzCMS/status/2008737551016968580/photo/1.
[92] Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse with Title XIX (Medicaid) of the Social Security Act, 91 Fed. Reg. 1539 (Jan. 14, 2026), https://www.federalregister.gov/documents/2026/01/14/2026-00512/notice-of-opportunity-for-hearingon-compliance-of-minnesota-state-plan-provisions-concerning.
[93] Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse With Title XIX (Medicaid) of the Social Security Act, 92 Fed. Reg. 1,542 (Jan. 14, 2026) https://www.govinfo.gov/content/pkg/FR-2026-01-14/pdf/2026-00512.pdf.

pending further review of questionable claims.[94] CMS observed "unusually high spending and rapid growth" in certain Medicaid provider types, including "[p]ersonal care services; [h]ome and community-based services; and [o]ther practitioner services."[95] CMS reserves the right to withhold further Medicaid funds should Minnesota fail to implement its corrective action plan and institute program integrity reforms in the state.[96]

On January 22, 2026, HHS announced it was shoring up its anti-fraud efforts in the Office of General Counsel by hiring a second former U.S. Attorney, Scott Brady, former U.S. Attorney for the Western District of Pennsylvania, to lead HHS' anti-fraud task force.[97] During his time as U.S. Attorney for the Western District of Pennsylvania, Mr. Brady prosecuted significant health care fraud schemes, including COVID-related fraud.[98]

On January 27, 2026, CMS Administrator Dr. Mehmet Oz sent a letter to California Governor Gavin Newsom requesting information on "program integrity, eligibility verification, and provider oversight within California's Medi-Cal program."[99] CMS is demanding that California produce a comprehensive program integrity action plan to address concerns regarding exploding costs in the IHSS program, Medi-Cal coverage for illegal aliens using federal funds, and the exponential growth of home health care agencies and expenses concentrated in Los Angeles (L.A.) County, California.[100]

On February 6, 2026, CMS Administrator Oz wrote to Maine Governor Janet Mills requesting information about "program integrity, eligibility verification, and provider oversight within Maine's MaineCare program," amid concerning trends in behavioral health billing, including Rehabilitative and Community Support (RCS) services for children with ASD, interpreting services, psychosocial rehabilitation services, PCS, and residential habilitation services.[101]

On February 25, 2026, CMS announced that it is imposing a six-month nationwide moratorium on new Medicare enrollments for certain DMEPOS suppliers after stopping over $1.5 billion in suspected fraud in claims last year.[102] During the moratorium, CMS will focus on additional safeguards to prevent fraud in Medicare DMEPOS claims.[103] CMS plans to increase

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[94] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.
[95] *Id.*
[96] *Id.*
[97] Press Release, U.S. Department of Health and Human Services, HHS Adds Former U.S. Attorney for Fraud Efforts (Jan. 22, 2026), https://www hhs.gov/press-room/hhs-adds-former-us-attorney-fraud-efforts.html.
[98] *Id.*
[99] Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Gavin Newsom, Governor, State of California (Jan. 27, 2026), https://x.com/DrOzCMS/status/2016259818013552852.
[100] *Id.*
[101] Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.
[102] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.
[103] *Id.*

transparency by publishing information on the providers and suppliers whose participation in the Medicare program has been revoked to ensure these providers are not permitted to enroll in private insurance or other health care programs.[104]

Furthermore, CMS issued a request for information (RFI) to help inform the development of a possible future rule under CMS' Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative by seeking input on ways to strengthen CMS' ability to prevent, detect, and respond to FWA, and program inefficiencies in Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.[105]

On March 3, 2026, CMS Administrator Oz sent a letter to New York Governor Kathy Hochul, requesting more information on the state's Medicaid program integrity efforts.[106] In the letter, Administrator Oz highlighted high levels of Medicaid spending in New York, concerns about accelerated growth in billing in certain programs, including CDPAP, significant provider concentration, and recent fraud cases in "personal care, home health, adult day care programming, NEMT, and behavioral health services."[107] Administrator Oz requested that New York answer questions about its program integrity efforts, provider screening and enrollment, and specific concerns with programs in the state that have "high-risk billing patterns and systemic vulnerabilities."[108]

D. Prior Committee Activity

The Committee on Energy and Commerce (the Committee) has an established track record of robust oversight of Medicare and Medicaid fraud.[109] On January 9, 2026, the Committee, alongside the House Committee on Ways and Means sent a letter to HHS Inspector General T. March Bell about concerning evidence and trends in home health and hospice fraud in L.A. County, California.[110] The Committees shared information with Inspector General Bell about an influx of home health and hospice agencies in L.A. County that may indicate fraudulent billing practices and potentially be tied to transnational criminal organizations.[111] The same day, CMS Administrator Oz along with the top-ranking prosecutor in the U.S. Attorney's Office in L.A., announced that CMS and DOJ were cracking down on home health and hospice fraud in L.A. County, where billing rates have reached $3.5 billion for these two health care sectors.[112]

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[104] *Id.*
[105] *Id.*
[106] Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Kathy Hochul, Governor, State of New York, et al. (Mar. 3, 2026), https://x.com/DrOzCMS/status/2028930123013976543.
[107] *Id.* at 2.
[108] *Id.* at 6.
[109] *See e.g. Waste, Fraud, and Abuse: A Continuing Threat to Medicare and Medicaid: Hearing Before H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations,* 112th Cong. (Mar. 2, 2011), https://www.govinfo.gov/content/pkg/CHRG-112hhrg66547/pdf/CHRG-112hhrg66547.pdf.
[110] Letter from Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., to T. March Bell, Inspector General, U.S. Department of Health and Human Services (Jan. 9, 2026), https://d1dth6e84htgma.cloudfront.net/1_9_2026_HHS_OIG_Letter_1_4ad020643d.pdf.
[111] *Id.*
[112] Sonja Sharp, *Dr. Oz touts federal crackdown on healthcare fraud by 'foreign influences' in L.A.,* LOS ANGELES TIMES (Jan. 9, 2026), https://www.latimes.com/california/story/2026-01-09/dr-oz-healthcare-fraud-crackdown.

Recent reports have continued to highlight concerning trends in Medicare hospice billing patterns in L.A. County.[113] Specifically, one recent report found almost 500 hospice companies registered within a three-mile radius (137 companies on Van Nuys Boulevard alone), and 82 companies registered to a single building in Van Nuys.[114] Furthermore, about 42 percent (742) of hospice companies in L.A. County are still operating despite having multiple warning signs of fraud that have been identified by the California State Auditor, including, "[m]ultiple hospices in one building, [g]eographic clustering, [l]ow patient counts, High rates of terminally ill patients later discharged alive, Excessive billing, and Staff shared across multiple companies."[115]

On January 16, 2026, the Committee launched an investigation into Minnesota's Medicaid program after prosecutions and alarming allegations of widescale fraud were recently uncovered.[116] Numerous individuals have been charged and convicted in various Medicaid fraud schemes, including the Housing Stabilization Services (HSS), EIDBI program, and PCS programs.[117] Some of these programs had "low barriers to entry and minimal records requirements for reimbursement," allowing criminals to perpetrate fraud.[118] The Committee requested documents, communications, and information about Minnesota's Medicaid program design and efforts it is taking to curb fraud in its programs and is reviewing information that has been produced to the Committee on an ongoing basis.[119]

Last month, the Subcommittee on Oversight and Investigations held a hearing entitled, "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[120] This hearing featured experts investigating Medicare and Medicaid fraud across the United States.[121] Fraud experts discussed the common schemes fraudsters are using to perpetrate Medicare and Medicaid fraud across the U.S., how fraud schemes have changed over time, and aspects of program design that make certain provider types more vulnerable to fraud.[122] With respect to Medicare, the Subcommittee examined the role of transnational criminal actors in recent Medicare fraud schemes targeting DMEPOS, the vulnerability of hospice, genetic testing, clinical laboratory services, and skin substitutes to FWA, and the harm to beneficiaries from medical identity theft.[123] The hearing also reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes across state lines far more

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[113] Rachel Gold et al., *We visited "ground zero" for hospice fraud: Los Angeles, California*, CBS NEWS (Mar. 10, 2026), https://www.cbsnews.com/projects/2026/hospice-fraud/.
[114] *Id.*
[115] *Id.*
[116] Letter from Brett Guthrie, Chairman, Committee on Energy and Commerce, et al., to Tim Walz, Governor, State of Minnesota and Shireen Gandhi, Temporary Commissioner, Minnesota Department of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[117] *Id.*
[118] Press Release, U.S. Attorney's Office, District of Minnesota, Six Additional Defendants Charged, One Defendant Pleads Guilty in Ongoing Fraud Schemes (Dec. 18, 2025), https://www.justice.gov/usao-mn/pr/six-additional-defendants-charged-one-defendant-pleads-guilty-ongoing-fraud-schemes.
[119] *Supra,* note 116.
[120] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Transcript-20260203.pdf.
[121] *Id.*
[122] *Id.*
[123] *Id.*

than they used to."[124] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services for children with ASD, NEMT, home and community-based services (HCBS), laboratory services, substance use disorder (SUD) treatment, and hospice.[125]

On March 3, 2026, the Committee expanded its investigation into Medicaid program integrity by sending letters to a sample of ten additional states across the country experiencing Medicaid fraud.[126] The Committee requested more information about states' efforts to identify, investigate, and mitigate the risk of fraud in their state's Medicaid program.[127]

IV. KEY QUESTIONS

The hearing may include discussion around the following key questions:

- What Medicare and Medicaid services has CMS identified as being particularly vulnerable to fraud, and why?
- What trends is CMS seeing in the incidence of transnational criminal actors exploiting Medicare and Medicaid to perpetrate fraud?
- What actions are being taken by CMS to combat Medicare and Medicaid fraud?
- How is CMS leveraging emerging technologies, including data analytics and AI, to prevent, identify, and stop fraud?
- What, from CMS' perspective, can states do to improve Medicaid program integrity?

V. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Majority Committee staff at (202) 225-3641.

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[124] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Transcript-20260203.pdf.
[125] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.
[126] Press Release, H. Comm. on Energy and Commerce, E&C Leaders Expand Investigation into Medicaid Fraud Nationwide (Mar. 5, 2026), https://energycommerce house.gov/posts/e-and-c-leaders-expand-investigation-into-medicaid-fraud-nationwide.
[127] *Id.*