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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 3, 2026

The Honorable Jared Polis
Governor
State of Colorado
State Capitol Building
200 E. Colfax Ave., Rm. 136
Denver, CO 80203

Ms. Kim Bimestefer
Executive Director
Colorado Department of Health Care Policy and Financing
303 E. 17th Ave., Ste. 1100
Denver, CO 80203

Dear Governor Polis and Executive Director Bimestefer:

Pursuant to Rules X and XI of the U.S. House of Representatives, the Committee on Energy and Commerce (Committee) writes to request information related to program integrity and fraud, waste, and abuse (FWA) in your state's Medicaid program.

Recent reports and law enforcement actions have exposed unprecedented levels of Medicaid fraud in the State of Minnesota and other states. The magnitude of the fraud demands states proactively address FWA in Medicaid programs.[1] The swath of criminal schemes coming to light in Minnesota include overbilling, falsifying records, identity theft, and phantom claims in Medicaid social service and health programs for the elderly and disabled, children with autism, people struggling with substance use disorders, and homelessness.[2] The Committee is concerned that your state's Medicaid programs may be similarly vulnerable to FWA that harms Medicaid enrollees, legitimate providers, and taxpayers. To inform the Committee's oversight and potential legislative reforms, we are examining Medicaid program integrity and actions your state has taken, and is taking, to proactively identify and root out FWA.

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from 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 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] 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-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Colorado Medicaid (Health First Colorado) spending surpassed $14.6 billion ($8.6 billion in federal funding) and covered over 1 million people.[3] Despite only 7 percent enrollment growth in the last decade, Medicaid spending in Colorado has more than doubled.[4] Colorado broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[5] In Colorado, these include non-emergency medical transportation (NEMT), which provides transportation services intended to assist Medicaid patients traveling to and from non-emergency medical appointments, Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), and genetic laboratory services.[6]

Recent spending patterns and fraud investigations related to services reimbursed by Health First Colorado are concerning. NEMT spending in Colorado jumped 436 percent between 2019 and 2025, partly due to Colorado Department of Health Care Policy and Financing (HCPF) officials providing incorrect guidance to NEMT providers to upcode NEMT services for beneficiaries with extra-large wheelchairs as specialty ambulances.[7] The state cannot recoup tens of millions of dollars of payments associated with wasteful NEMT spending due to HCPF being responsible for much of the coding errors.[8] HCPF has since corrected the NEMT billing code guidance, which is expected to save $60.5 million in fiscal year 2026-2027 alone.[9]

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 45, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, Dec. 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 26 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

[4] Greg D'Argonne et al., *Challenges Facing Medicaid and Department of Health Care Policy and Financing in Colorado: A Guide for Policymakers*, COMMON SENSE INSTITUTE COLORADO (Feb. 17, 2026), https://www.commonsenseinstituteus.org/colorado/research/healthcare/challenges-facing-medicaid-and-department-of-health-care-policy-and-financing-in-colorado-guide-for-policymakers.

[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from 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.

[6] *See* 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; *see also* 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. 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 Feb. 20, 2026).

[7] Seth Klamann, *Colorado Medicaid driver fraud cost $25 million – and state blocked payments worth nearly as much, officials say,* THE DENVER POST (Jan. 21, 2026), https://www.denverpost.com/2026/01/21/colorado-medicaid-fraud-investigation/; Spencer Soicher, *Colorado Medicaid overpaid wheelchair transport providers tens of millions in 5-year upcoding error*, 9NEWS (Jan. 30, 2026), https://www.9news.com/article/news/local/next/next-with-kyle-clark/colorado-medicaid-overpaid-wheelchair-transport-providers-tens-of-millions-in-5-year-upcoding-error/73-328bb50d-2903-4332-a27c-9883044643a7.

[8] *Id.* at Klamann.

[9] *Supra*, note 7 at Soicher.

In addition to waste driven by coding errors, HCPF estimates $25 million has been lost due to fraudulent billing in the NEMT program.[10] After reviewing provider claims, HCPF stopped payments on nearly $25 million in in-progress claims.[11] NEMT drivers are reported to have "packed their cars with patients, some of whom were homeless, and drove them hundreds of miles to maximize their payouts."[12]

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.[13] 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.[14] 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.[15] 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.[16] Ms. Yassin similarly billed ghost rides and beneficiary rides that were not associated with a medical destination.[17]

Additionally, ABA service costs are skyrocketing in Colorado, reportedly increasing from $60.1 million in 2019 to $163.5 million in 2023.[18] A recent review of Colorado's ABA services issued by the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) found that the state made at least $77.8 million ($42.6 million in federal funding) of improper payments.[19] HHS-OIG observed deficiencies in Colorado's ABA session notes and electronic visit verification (EVV) records, credentialing of staff providing ABA services, and documentation of comprehensive diagnostic evaluation or treatment referrals for ABA.[20] For example, ABA session notes failed to describe the therapeutic services provided, included unallowable recreational, academic, day care, or custodial activities, billed for nontherapy time, and included group activities despite billing for individual therapy.[21] Further, Colorado does not require all types of behavioral technicians to be subjected to background

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[10] *Supra,* note 7 at Klamann.
[11] *Id.*
[12] *Id.*
[13] 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.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] 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.
[19] *Id.*
[20] *Id.* at 9.
[21] *Id.* at 10.

checks, qualifications, or supervision.[22] Alarmingly, "after reviewing background checks from those ABA facilities that completed them, [HHS-OIG] identified some ABA facility staff who had background checks with offenses that could have put children in danger. "[23]

As noted in the Oversight and Investigations Subcommittee's recent hearing on common schemes in Medicare and Medicaid, "[l]aboratory services and genetic testing continue to be a problem."[24] In September 2024, seven executives of a genetic testing laboratory company were indicted by a federal grand jury for $40 million in alleged fraud to Medicare and Colorado Medicaid.[25] In the scheme, it is alleged that the defendants paid kickbacks and bribes to patient marketers that solicited patients, including the elderly, to order unnecessary genetic testing for the purpose of defrauding public and private health insurance payers.[26]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[27] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[28] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[29] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[30] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services for children with ASD, NEMT, home and

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[22] *Id*. at 4-5; 30; Jennifer Brown, *Colorado could have to pay back $60 million to feds in autism therapy for children*, THE COLORADO SUN (Dec. 24, 2025), https://coloradosun.com/2025/12/24/autism-therapy-colorado-federal-payback/.
[23] *Supra,* note 18 at 30.
[24] *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://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[25] Press Release, U.S. Attorney's Office, District of Colorado, Seven people charged with over $40 million in Medicare and Medicaid fraud (Sept. 24, 2024), https://www.justice.gov/usao-co/pr/seven-people-charged-over-40-million-medicare-and-medicaid-fraud.
[26] *Id.*
[27] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[28] *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://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[29] *Id.*
[30] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

community based services (HCBS), laboratory services, substance use disorder (SUD) treatment, and hospice.[31] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[32]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[33] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [34]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters

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[31] *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.

[32] *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.

[33] *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 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

[34] *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 11 (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.

is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

1. What actions, if any, are being taken to identify, assess fraud risk, and investigate Medicaid fraud schemes that may be occurring in the state?

    a. Please provide all audits related to fraud, waste, and abuse in the state's Medicaid programs including audits completed by third-party contract auditors, from January 1, 2021, to present.

    b. Are any audits of the Medicaid program ongoing? If so, please detail the type of audits that are ongoing.

2. What program integrity measures are currently in place to prevent FWA in your state's Medicaid programs?

3. Describe the process for making criminal referrals for suspected Medicaid fraud to state, local, and federal law enforcement agencies.

4. What steps are being taken to sanction or disenroll fraudulent Medicaid providers? Please provide information about any sanctions or disenrollments of fraudulent providers, including all evidence supporting disenrollment proceedings.

5. How are Medicaid service providers screened for compliance with federal law?[35] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

    a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [36] If yes, please describe these processes.

    b. How frequently are on-site visits conducted by your state for Medicaid providers by federal screening risk category (limited, moderate, and high-risk), including out-of-state providers?

    c. Are any programs, provider types, or enrollment pathways exempt from on-site visits, and what statutory or regulatory authority permits those exemptions?

[35] Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).
[36] *Id.*

6. How does your state designate and evaluate risk level of provider types in the Medicaid program in accordance with 42 C.F.R. § 455 subpart E? Please provide the state's current Medicaid programs classified by screening risk level (limited, moderate, and high categorical risk).

    a. Have any Medicaid programs' categorical risk levels been reassigned since January 1, 2021? If so, please describe which program(s) were reassigned, including any supporting evidence that contributed to risk reassignment.

    b. How often does your state reevaluate Medicaid provider screening risk level?

7. Does your state collect data on Medicaid programs with abnormal or statistically significant increases in provider enrollment or claims over time, including programs which greatly exceed their estimated cost upon enactment?

    a. If so, please detail the programs that have experienced abnormal or statistically significant increases since January 1, 2021, the data that was collected on the programs, and how this data has been used to inform assessments of program vulnerability to FWA.

    b. Is your state utilizing innovative tools, including but not limited to identity verification, artificial intelligence, and data analytics, to detect irregular Medicaid claims activity? If so, please describe these tools.

    c. If you don't collect this data, why not?

8. Please provide information on active Section 1115 and 1915 demonstrations and waivers, from January 1, 2021, to present, including:

    a. program name;
    b. provider category risk level;
    c. effective date;
    d. spending;
    e. enrollment;
    f. services offered;
    g. FWA measures; and
    h. eligibility.

9. Please provide information regarding improper payments and recovery efforts in your state's Medicaid program, including:

    a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
    b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.

c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

10. Please provide information regarding screening, oversight, and enforcement actions related to Medicaid fiscal intermediaries, including:

a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.
b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.
c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.
d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

If you have any questions about this request, please contact the Majority Committee Staff at (202) 225-3641.

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

John Joyce, M.D.
Chairman
Subcommittee on Oversight and Investigations

H. Morgan Griffith
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Committee on Energy and Commerce
The Honorable Yvette D. Clarke, Ranking Member, Subcommittee on Oversight and Investigations
The Honorable Diana DeGette, Ranking Member, Subcommittee on Health