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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 Janet T. Mills
Governor
State of Maine
1 State House Station
August, ME 04333

Ms. Sara Gagné-Holmes
Commissioner
Maine Department of Health and Human Services
109 Capitol St.
11 State House Station
Augusta, ME 04333

Dear Governor Mills and Commissioner Gagné-Holmes:

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, Maine Medicaid (MaineCare) spending totaled $4.7 billion ($3.1 billion in federal funding) and covered 343,000 people.[3] Maine broadly defines Medicaid eligibility and MaineCare's recent $118 million budget shortfall was partly driven by unsustainable costs of care that have increased 33 percent since 2019 despite declining enrollment.[4] MaineCare administers several Medicaid programs that are considered high risk for FWA.[5] In Maine, these include Rehabilitative and Community Support (RCS) services for children with Autism Spectrum Disorder (ASD), and home and community based services (HCBS), such as home health and interpreting services.[6] On February 6, 2026, U.S. Centers for Medicare and Medicaid Services (CMS) Administrator, Dr. Mehmet Oz, wrote to you, requesting more information about "program integrity, eligibility verification, and provider oversight within Maine's MaineCare program," and concerning trends in the behavioral health billing, including the RCS program, interpreting services, psychosocial rehabilitation services, HCBS personal care services, and residential habilitation services.[7]

In January 2026, U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) published a report, finding that MaineCare's RCS Services for children with ASD, which includes Applied Behavior Analysis (ABA), suffered from concerning levels of improper payments of at least $45.6 million in 2023.[8] The HHS-OIG's findings concluded that:

- RCS services were provided to children who either did not receive the required comprehensive assessments or the assessments did not include signatures of the staff who conducted the assessments or the parents or guardians (81 sampled enrollee-months).

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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, December 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] 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. 18, 2026); Harris Van Pate, *Maine's predictable MaineCare funding shortfall,* MAINE POLICY INSTITUTE (Sept. 16, 2025), https://mainepolicy.org/maines-predictable-mainecare-funding-shortfall/.

[5] *See* 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] 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; *See* U.S. Centers for Medicare and Medicaid Services, Fact Sheet, Preventing Fraud, Waste, and Abuse in Medicaid Home Health Services and Durable Medical Equipment (May 2016), https://www.cms.gov/files/document/hcbs-preventingfwahhdmefs050216pdf; *see also* Sawyer Loftus, *A Maine cop warned of interpreter fraud 5 years ago. The state is just catching up.,* BANGOR DAILY NEWS (Dec. 24, 2025), https://www.bangordailynews.com/2025/12/24/mainefocus/mainefocus-government/maine-interpreter-fraud-warning-joam40zk0w/.

[7] *Supra*, note 5.

[8] *Supra*, note 6.

- Session notes describing the RCS services provided did not meet documentation requirements (e.g., session notes did not support the number of units billed) (64 sampled enrollee-months).

- The [individual treatment plans] ITPs did not include parent signatures, or the ITP was missing (30 sampled enrollee-months).

- Documentation did not include provider credentials (20 sampled enrollee-months)

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- Session notes did not contain a full description of the services provided or did not include the goals addressed or data collected (94 sampled enrollee-months).

- Session notes included nontherapy time (e.g., lunch, naps, and breaks) (92 sampled enrollee-months).

- Session notes referred to recreational or academic activities that may not have been allowable RCS activities (34 sampled enrollee-months).[9]

The HHS-OIG resolved that "the State agency made improper and potentially improper payments because it did not provide effective oversight of [fee-for-service] FFS Medicaid payments for RCS services."[10] Moreover, HHS-OIG found that "since the program began in 2010, the State agency had not performed a statewide postpayment review of payments to RCS providers to verify that providers complied with Federal and State requirements related to documentation."[11]

In December 2025, Maine halted MaineCare payments to Gateway Community Services Maine, a community and behavioral health company predominantly servicing immigrants, refugees, and asylees, after a whistleblower disclosed that Gateway was fraudulently manipulating medical records and employee time sheets to maximize MaineCare reimbursements.[12] Maine Department of Health and Human Services is currently investigating Gateway for "credible allegations of fraud," involving over $1 million in improper billing of

[9] *Id.* at 6.
[10] *Id.* at 8.
[11] *Id.*
[12] Edward Tomic, *Maine agencies funneled grants to nonprofits tied to dark money front's voter outreach campaign, "New Mainer" groups and top level Democrats,* THE MAINE WIRE (May 21, 2025), https://www.themainewire.com/2025/05/maine-agencies-funneled-grants-to-nonprofits-tied-to-dark-money-fronts-voter-outreach-campaign-new-mainer-groups-and-top-level-democrats/.

MaineCare for interpreter services.[13] This is not the first time that Gateway has been found to have overbilled MaineCare.[14] In two audits which reviewed years 2015 to 2018, Gateway was found to have overbilled MaineCare almost $660,000.[15] Another behavioral and community health company, Bright Future Healthier You, is under scrutiny for its connection to a tax fraud case in which MaineCare was billed for interpreter services that were not rendered.[16] Bright Future Healthier You was previously ordered by the Maine Department of Health and Human Services to repay nearly $204,000 in improper billing to MaineCare in 2017.[17]

Last year, a Portland personal care and home health care agency, 5 Stars Home Health Care, was required to pay back $390,000 to the state after an audit revealed that it overbilled MaineCare from 2021 and 2023.[18] Since ordered to repay the state, 5 Stars has allowed its state license to expire and closed its doors, reportedly owing seven months' rent to the office building's owner.[19] Investigations into other suspicious home health company billing patterns have revealed that the same Portland office building that was home to 5 Stars also houses 10 other home health care businesses.[20] The building's manager revealed to reporters that apart from one tenant, "they're never here."[21]

At the Committee's request, 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.[22] 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."[23] 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

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[13] Sawyer Loftus, *Maine stops payments to embattled health care provider facing fraud allegations*, THE MAINE MONITOR (Dec. 26, 2025), https://themainemonitor.org/mainecare-payments-gateway-halted/.
[14] *Id.*
[15] *Id.*
[16] Sawyer Loftus, *Criminal case focuses on immigrant health provider that billed millions to MaineCare*, BANGOR DAILY NEWS (Jan. 9, 2026), https://www.bangordailynews.com/2026/01/09/mainefocus/mainefocus-government/criminal-case-immigrant-health-provider-mainecare-joam40zk0w/.
[17] *Id.*
[18] Seamus Othot, *Five Star Fraud: Records Show Home Health Agency Over-Billed MaineCare by Nearly $400K, Disappeared*, THE MAINE WIRE (Jan. 19, 2026), https://www.themainewire.com/2026/01/five-star-fraud-records-show-home-health-agency-over-billed-mainecare-by-nearly-400k-disppeared/.
[19] *Id.;* Rich McHugh, *Maine building houses 10 health care firms; landlord rarely sees anyone,* NEWSNATION (Jan. 20, 2026), https://www newsnationnow.com/vargasreports/maine-healthcare-firms-landlord/.
[20] *Id.* at McHugh.
[21] *Id.*
[22] 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.
[23] *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.

vulnerable to fraud; and high risk areas for fraud in these programs.[24] 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."[25] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services for children with ASD, non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[26] 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.[27]

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."[28] 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

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[24] *Id.*
[25] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.
[26] *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.
[27] *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.
[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. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [29]

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 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?[30] 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? [31] If yes, please describe these processes.

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[29] *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.
[30] Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).
[31] *Id.*

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?

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