

ONE HUNDRED NINETEENTH CONGRESS

# Congress of the United States

## House of Representatives

### COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515-6115

Majority (202) 225-3641

Minority (202) 225-2927

June 23, 2026

#### MEMORANDUM

To: Subcommittee on Oversight and Investigations Members and Staff  
From: Committee Majority Staff  
Re: Subcommittee on Oversight and Investigations Hearing on June 25, 2026

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#### I. INTRODUCTION

The Subcommittee on Oversight and Investigations will hold a hearing on Thursday, June 25, 2026, at 10:15 a.m. (ET), in 2123 Rayburn House Office Building. The hearing is entitled “State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies.”

#### II. WITNESSES

- **John Connolly**, Temporary Commissioner and State Medicaid Director, Minnesota Department of Human Services;
- **Tyler Sadwith**, State Medicaid Director, California Department of Health Care Services;
- **Amir Bassiri**, State Medicaid Director, New York State Department of Health; and
- **Scott Partika**, Director, Ohio Department of Medicaid.

#### III. BACKGROUND

Medicaid fraud occurs in every state, district, and territory, squandering American taxpayer dollars and driving up health care costs.<sup>1</sup> States are the first line of defense in the fight against fraud, which occurs in many health care sectors and exploits taxpayer-funded government health care programs that are intended to serve vulnerable populations, including the elderly, disabled, children, and pregnant women.<sup>2</sup> Every Medicaid dollar that is paid to fraudsters, scammers, and criminal organizations is a dollar that is not spent on high quality

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<sup>1</sup> 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](https://d1dth6e84htgma.cloudfront.net/02_03_2026_O_and_I_Hearing_Memorandum_408bb55582.pdf).

<sup>2</sup> *Id.*

health care for those that need it most. In recent months, the Trump Administration has unleashed the War on Fraud, dedicating unprecedented resources and attention to eliminating fraud across all government programs, including Medicaid.<sup>3</sup>

The U.S. Centers for Medicare and Medicaid Services (CMS), states, and relevant federal and state law enforcement agencies all play a part in Medicaid program integrity.<sup>4</sup> CMS, as a subagency of the U.S. Department of Health and Human Services (HHS), administers Medicaid and the Children's Health Insurance (CHIP) program, which together provided health care for 88.2 million enrollees at the cost of \$949 billion in Fiscal Year (FY) 2024.<sup>5</sup> Medicaid, a means tested health insurance program, is jointly funded and administered by the federal and state governments.<sup>6</sup> Each state contributes a portion to the Medicaid program that is matched by the federal government by the Federal Medical Assistance Percentage (FMAP).<sup>7</sup> FMAP is determined by a state's per capita income, with a statutory floor of 50 percent.<sup>8</sup>

As a requirement of receiving federal financial participation (FFP), the single state Medicaid agency must enter into a state plan agreement with CMS that specifies the policies and procedures of the Medicaid program.<sup>9</sup> State plans include details such as commitments to operate within federal rules; guidelines for optional eligibility tiers and services; and state-specific eligibility standards, provider reimbursement, and other administrative procedures.<sup>10</sup> In addition to approving state plans and providing federal funds, CMS is responsible for providing states with guidance and approving state plan amendments, waivers, and demonstrations.<sup>11</sup> 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.<sup>12</sup>

#### **A. The Federal Government's Role in Medicaid Program Integrity**

Both the federal government and states are responsible for program integrity efforts to reduce fraud, waste, and abuse (FWA) in the Medicaid program.<sup>13</sup> The CMS Center for Program

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<sup>3</sup> Press Release, The White House, Trump Administration's Full-Scale War on Fraud (May 26, 2026), <https://www.whitehouse.gov/releases/2026/05/trump-administrations-full-scale-war-on-fraud/>.

<sup>4</sup> U.S. Centers for Medicare and Medicaid Servs., Program Integrity, <https://www.medicare.gov/medicaid/program-integrity>, (last visited June 16, 2026).

<sup>5</sup> Medicaid and CHIP Payment and Access Commission, Exhibit 10. Medicaid Enrollment and Total Spending Levels and Annual Growth (Feb. 2026), <https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-10.-Medicaid-Enrollment-and-Total-Spending-Levels-and-Annual-Growth-FYs-1974%E2%80%932024.pdf>.

<sup>6</sup> U.S. Centers for Medicare and Medicaid Servs., Medicaid Eligibility Policy, <https://www.medicare.gov/medicaid/eligibility-policy> (last visited June 16, 2026).

<sup>7</sup> Allison Mitchell, CONG. RESEARCH SERV., R43847, MEDICAID'S FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP) (Apr. 2, 2025), <https://www.congress.gov/crs-product/R43847>.

<sup>8</sup> *Id.*

<sup>9</sup> 42 C.F.R. § 431.10.

<sup>10</sup> Medicaid and CHIP Payment and Access Commission, State Plan (Aug. 14, 2019), <https://www.macpac.gov/subtopic/state-plan/>.

<sup>11</sup> Medicaid and CHIP Payment and Access Commission, Administration, <https://www.macpac.gov/medicaid-101/administration/> (last visited June 16, 2026).

<sup>12</sup> U.S. Centers for Medicare and Medicaid Servs., About Section 1115 Demonstrations, <https://www.medicare.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations> (last visited June 16, 2026).

<sup>13</sup> *Supra*, note 11.

Integrity (CPI) “[p]romotes the integrity of the Medicare and Medicaid programs and CHIP through provider/contractor audits and policy reviews, identification and monitoring of program vulnerabilities, and providing support and assistance to States.”<sup>14</sup> 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.<sup>15</sup> One way that CMS provides state Medicaid agencies (SMA) with program integrity resources is through the CMS Medicaid Integrity Institute (MII), which offers in person and virtual trainings to state employees on “fraud investigations, data mining and analysis, provider enrollment, managed care oversight, emerging trends, and case development.”<sup>16</sup>

CMS has the authority to take administrative action to protect federal Medicaid funds when states fail to meet program integrity requirements and there is suspected fraud.<sup>17</sup> Three formal CMS processes for holding states accountable and preventing the payment of improper or fraudulent claims are deferrals, disallowances, and withholding of federal financial participation (FFP).<sup>18</sup> A deferral temporarily delays payment while CMS reviews questioned costs.<sup>19</sup> A disallowance is made to deny federal payment after a state fails to provide necessary documentation substantiating a claim or CMS determined that a claim is not allowable under federal requirements.<sup>20</sup> Lastly, CMS may withhold future FFP when a state fails to comply with federal requirements or implement a prescribed corrective action plan.<sup>21</sup> CMS may continue withholding FFP until the state comes into compliance.<sup>22</sup> These mechanisms give CMS the leverage needed to enforce program standards, promote fiscal responsibility, and ensure that federal Medicaid dollars are used appropriately.

## **B. States’ Role in Medicaid Program Integrity**

SMAs are the first line of defense against Medicaid fraud.<sup>23</sup> Each state manages its Medicaid program within federal guidelines by “setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming Federal Financial Participation for their Medicaid and CHIP expenditures.”<sup>24</sup> Federal regulations require that SMAs have FWA detection and investigation programs.<sup>25</sup> States must investigate all

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<sup>14</sup> U.S. Centers for Medicare and Medicaid Servs., Center for Program Integrity, <https://www.cms.gov/about-cms/leadership/center-program-integrity> (last visited June 16, 2026); *see* 42 C.F.R. §§ 430.32, 431.16, 433.32, 455.12, 456.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.* at 38; U. S. Centers for Medicare and Medicaid Servs., Medicaid Integrity Institute (MII), <https://www.cms.gov/medicaid-chip/medicare-coordination/integrity-institute> (last visited June 16, 2026).

<sup>17</sup> 42 C.F.R. § 430 et seq.

<sup>18</sup> *Id.*

<sup>19</sup> 42 C.F.R. § 430.40.

<sup>20</sup> 42 C.F.R. § 430.42.

<sup>21</sup> 42 C.F.R. § 430.35.

<sup>22</sup> *Id.*

<sup>23</sup> *See* 42 C.F.R. § 455 Subpart A.

<sup>24</sup> U.S. DEP’T OF HEALTH AND HUMAN SERVS., CENTERS FOR MEDICARE AND MEDICAID SERVS., REPORT TO CONGRESS – MEDICARE AND MEDICAID INTEGRITY PROGRAMS FOR FISCAL YEAR (FY) 2024, 11 (Sept. 2025), <https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf>.

<sup>25</sup> *Supra*, note 23.

complaints of Medicaid fraud or abuse and take appropriate corrective action, including suspending or terminating providers from Medicaid participation, recovering payments, or imposing sanctions in cases of fraud.<sup>26</sup>

CMS provides sub-regulatory guidance and technical assistance to states on provider enrollment in the Medicaid Provider Enrollment Compendium (MPEC).<sup>27</sup> SMAs are primarily responsible for facilitating provider screening, enrollment, and revalidation processes as outlined by applicable laws and regulations.<sup>28</sup> Accordingly, SMAs must assign and screen Medicaid providers according to three designated risk categories: “high,” “moderate,” and “limited” risk.<sup>29</sup> To make it easier for SMAs to process provider enrollment, in provider types that exist in both Medicare and Medicaid, states may defer to the Medicare provider risk category assigned by CMS, and rely upon Medicare’s screening process for those providers.<sup>30</sup> Additionally, states may share data and information with other SMAs or CHIP agencies to expedite screening of providers with active registration in other states.<sup>31</sup> Examples of providers that exist in both Medicare and Medicaid include durable medical equipment (DME), home health agencies, and hospices, while Medicaid-only providers include non-emergency medical transportation (NEMT), Applied Behavior Analysis (ABA) services, and personal care services (PCS).<sup>32</sup> According to CMS, “state non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments.”<sup>33</sup>

According to federal regulations for limited risk providers, SMAs must, at a minimum:

- (1) Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.
- (2) Conduct license verifications, including State licensure verifications in States other than where the provider is enrolling, in accordance with [42 C.F.R.] § 455.412.
- (3) Conduct database checks on a pre- and post-enrollment basis to ensure that providers continue to meet the enrollment criteria for their provider type, in accordance with [42 C.F.R.] § 455.436.<sup>34</sup>

For moderate risk Medicaid providers, SMAs must conduct the designated verification and federal database checks for limited risk providers, in addition to conducting on-site visits.<sup>35</sup>

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<sup>26</sup> 42 C.F.R. § 455.13 et seq.

<sup>27</sup> Medicaid Provider Enrollment Compendium (Nov. 17, 2025), <https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf>.

<sup>28</sup> 42 C.F.R. § 455 Subpart E.

<sup>29</sup> 42 C.F.R. § 455.450.

<sup>30</sup> 42 C.F.R. § 455.410.

<sup>31</sup> *Id.*; *Supra*, note 24 at 37.

<sup>32</sup> *Supra*, note 27.

<sup>33</sup> *Supra*, note 24 at 37.

<sup>34</sup> 42 C.F.R. § 455.450(a).

<sup>35</sup> 42 C.F.R. § 455.450(b).

High-risk providers must be verified by the limited and moderate screening methods, in addition to criminal background checks and fingerprinting.<sup>36</sup> SMAs are required to elevate the risk category of a provider in certain situations, including when it imposes payment suspensions for credible allegations of FWA.<sup>37</sup>

Federal regulations require SMAs to refer all cases of suspected Medicaid provider fraud to the state's Medicaid Fraud Control Unit (MFCU) and cooperate with MFCU investigations.<sup>38</sup> All 50 states (except for Hawaii), the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate federally certified MFCUs, which are typically housed in the state Attorney General's Office.<sup>39</sup> MFCUs investigate and prosecute Medicaid fraud, in addition to patient abuse and neglect.<sup>40</sup> Certified MFCUs receive 75 percent of their operating funds from HHS Office of Inspector General (OIG), which oversees this award by annually assessing performance and compliance with federal regulations.<sup>41</sup>

Federal law requires states to establish Medicaid Recovery Audit Contractor (RAC) programs, which identify and correct improper payments on fee-for-service (FFS) Medicaid claims.<sup>42</sup> States may seek full exemptions or partial exceptions to the RAC requirement due to "state-specific circumstances, including the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS, or issues related to procuring a contractor."<sup>43</sup> RACs are oriented towards identifying improper payments, rather than fraud, but may come across cases of suspected fraud and in those instances are required to coordinate with state and federal law enforcement to their findings.<sup>44</sup>

## **C. Case Studies**

### **1. Minnesota**

Beginning in 2025, numerous individuals in Minnesota have been charged and convicted in various Medicaid fraud schemes targeting services designed for vulnerable populations.<sup>45</sup>

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<sup>36</sup> 42 C.F.R. § 455.450(c).

<sup>37</sup> 42 C.F.R. § 455.450(e).

<sup>38</sup> 42 C.F.R. § 455.21.

<sup>39</sup> U.S. Dep't of Health and Human Servs. Off. of Inspector Gen., Medicaid Fraud Control Units, <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/> (last visited June 16, 2026); *See* Letter from The Hon. T. March Bell, Inspector Gen., U.S. Dep't of Health and Human Servs., to The Hon. Anne E. Lopez, Attorney Gen., State of Hawaii, and Landon M. M. Murata, Dir., Medicaid Fraud Control Unit, State of Hawaii (June 4, 2026), [https://oig.hhs.gov/documents/medicaid-fraud-control-units/11679/Hawaii\\_Denial\\_of\\_Recertification\\_Letter.pdf](https://oig.hhs.gov/documents/medicaid-fraud-control-units/11679/Hawaii_Denial_of_Recertification_Letter.pdf) (on June 4, 2026, HHS-OIG decertified the Hawaii MFCU, citing ineffective case outcomes for Medicaid fraud enforcement actions).

<sup>40</sup> *Id.*

<sup>41</sup> U.S. Dep't of Health and Human Servs. Off. of Inspector Gen., Medicaid Fraud Control Units, General Terms and Conditions, <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/terms-conditions/> (last visited June 1, 2026).

<sup>42</sup> Social Security Act, as amended § 1902(a)(42); *Supra*, note 24 at 28.

<sup>43</sup> *Id.* at 28.

<sup>44</sup> 42 C.F.R. § 455.508(h).

<sup>45</sup> Press Release, U.S. Attorney's Off., 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>; Press Release, U. S. Dep't of Justice,

These programs include the Housing Stabilization Services (HSS), Early Intensive and Developmental Behavioral Intervention (EIDBI) program, Integrated Community Supports (ICS), and Individualized Home Supports (IHS).<sup>46</sup> Some of these Medicaid programs had “low barriers to entry and minimal records requirements for reimbursement,” making them a magnet for criminals to perpetrate fraud.<sup>47</sup> These programs also experienced skyrocketing program costs in recent years.<sup>48</sup> Fraud became so rampant in the HSS program that the state shut it down in October 2025.<sup>49</sup>

In Minnesota, ongoing criminal investigations into the state’s EIDBI program, which provides Medicaid ABA services for children with autism spectrum disorder (ASD), have patterns of documentation errors and unqualified providers.<sup>50</sup> Abdinajib Hassan Yussuf was charged with and pleaded guilty to allegations that he perpetrated \$6 million in fraud against Minnesota’s Medicaid program as an EIDBI provider.<sup>51</sup> 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.<sup>52</sup> 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.<sup>53</sup> Another individual, Asha Farhan Hassan, who recently pleaded guilty for her role in a \$14 million EIDBI fraud scheme in Minnesota, had previously been charged in the Feeding Our Future fraud scheme.<sup>54</sup>

In response to the allegations of Medicaid fraud, CMS launched an audit of the Minnesota Medicaid program, freezing provider enrollment and deferring payments on 14 high-risk programs including adult companion, rehabilitative mental health services, EIDBI, HSS, ICS, and IHS.<sup>55</sup> CMS warned Minnesota that if it did not take sufficient corrective actions to

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Minnesota Health Care Fraud Takedown Results in Charges Against 15 Defendants for Over \$90M in Fraud (May 21, 2026), <https://www.justice.gov/opa/pr/minnesota-health-care-fraud-takedown-results-charges-against-15-defendants-over-90m-fraud>.

<sup>46</sup> *Id.*

<sup>47</sup> *Id.*

<sup>48</sup> Alyssa Chen and Max Nesterak, *Minnesota’s spending doubled across 14 Medicaid programs at ‘high risk’ of fraud in past 5 years*, MINNESOTA REFORMER (Apr. 21, 2026), <https://minnesotareformer.com/2026/04/21/minnesotas-spending-doubled-across-14-medicaid-programs-at-high-risk-of-fraud-in-past-5-years/>.

<sup>49</sup> News Release, Minnesota Dep’t of Human Servs., Housing Stabilization Services program ends Oct. 2025, (Oct. 31, 2025), <https://mn.gov/dhs/media/news/?id=1053-711321>.

<sup>50</sup> 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>.

<sup>51</sup> *Supra*, note 45.

<sup>52</sup> *Id.*; *Supra*, note 50.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> 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 Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs. to The Hon. Tim Walz, Governor, State of Minnesota (Jan. 6, 2026), <https://x.com/DrOzCMS/status/2008737551016968580/photo/1>.

remedy the program integrity failures of its Medicaid programs, it risked withholding of federal Medicaid funds.<sup>56</sup>

Subsequently, on January 14, 2026, CMS announced it intended 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."<sup>57</sup> On February 25, 2026, CMS announced it was deferring \$259.5 million of Minnesota Medicaid's fourth quarter FY 2025 FFP pending further review of questionable claims.<sup>58</sup> In its audit, 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."<sup>59</sup> On April 30, 2026, Administrator Oz notified Minnesota that CMS was deferring an additional \$91 million in Medicaid funding, with \$76 million of that being related to the 14 high-risk services under scrutiny in the state.<sup>60</sup> 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.<sup>61</sup>

As part of its corrective actions, Minnesota hired a third-party auditor, Optum, to conduct a vulnerability assessment of the state's Medicaid program, focusing on 14 high-risk services.<sup>62</sup> Optum found that poorly crafted state Medicaid policies may have cost the Medicaid program \$1 billion from January 2022 to October 2025.<sup>63</sup> Alarming, the Optum review found that EIDBI was particularly vulnerable, flagging over 90 percent of claims for not matching state policies or procedures.<sup>64</sup> The review also found that \$52.3 million in program costs were attributable to Medicaid claims that violated state policies.<sup>65</sup>

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<sup>56</sup> 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-hearing-on-compliance-of-minnesota-state-plan-provisions-concerning>.

<sup>57</sup> 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>.

<sup>58</sup> Press Release, U.S. Centers for Medicare and Medicaid Servs., 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>.

<sup>59</sup> *Id.*

<sup>60</sup> Eric Henderson, *Feds defer additional \$91 million in Minnesota Medicaid funds; Gov. Walz calls it "campaign of retribution."* CBS NEWS (Apr. 30, 2026), <https://www.cbsnews.com/minnesota/news/minnesota-medicare-funding-deferred-fraud-cms-mehmet-oz-tim-walz/>.

<sup>61</sup> 42 C.F.R. § 430.35.

<sup>62</sup> Optum State Government Solutions, Minnesota DHS/MNIT Vulnerability Assessment (Jan. 31, 2026), <https://kstp.com/wp-content/uploads/2026/02/MN-PI-RRT-Vulnerability-Assessment-Redacted.pdf>; Optum State Government Solutions, Minnesota DHS/MNIT Addendum to Program Integrity Vulnerability Assessment (Feb. 5, 2026), <https://www.documentcloud.org/documents/26883645-mn-pi-vulnerability-assessment-addendum-2526-redacted-protected/>.

<sup>63</sup> *Id.*

<sup>64</sup> Alyssa Chen, *Report: Poor policy language may have cost \$1B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 16, 2026), <https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicare-services/>.

<sup>65</sup> *Id.*

On May 21, 2026, the U.S. Department of Justice (DOJ) announced the Minnesota Health Care Fraud Takedown, the largest Medicaid fraud take down in the history of the District of Minnesota.<sup>66</sup> As part of this takedown, DOJ charged two individuals in the largest autism fraud case ever charged by DOJ, in which it is alleged that two defendants perpetrated a \$46.6 million scheme to bill for EIDBI services that were not necessary or never rendered.<sup>67</sup> It is alleged that the defendants paid kickbacks to parents to enroll their children in autism therapy, facilitated diagnosing children with autism whether or not they in fact had the condition, and billed Minnesota Medicaid for ABA services that were not rendered.<sup>68</sup>

Other charges in the Takedown included a \$1.4 million fraud scheme to bill the ICS program for services that were not provided to vulnerable patients that need assistance with health and home care to remain in their own homes.<sup>69</sup> In this case, a patient that required 24-hour care for their condition was found dead after not receiving services that were billed to Medicaid.<sup>70</sup> DOJ also filed charges against two Minnesota defendants for their connection to a \$22 million scheme to operate more than 20 separate residences in the IHS program, which is intended to help individuals with disabilities and traumatic brain injuries live independently.<sup>71</sup> Once these disabled residents were living in the defendants' homes, the defendants used the residents' Medicaid beneficiary information to bill for other services that were not rendered.<sup>72</sup> The takedown also included eight defendants charged with perpetrating fraud in the HSS program.<sup>73</sup> This scheme, which totaled more than \$15 million, attracted "fraud tourists" that traveled from out of state to enroll as Medicaid providers and billed for housing consulting services for vulnerable populations that were not rendered.<sup>74</sup>

## 2. California

In California, self-directed personal care services are provided by the In-Home Supportive Services (IHSS) program.<sup>75</sup> The IHSS program, which operates under Medi-Cal (California Medicaid) as an in-home assistance benefit to "eligible aged, blind, and disabled individuals," has experienced 348 percent growth in the last decade.<sup>76</sup> As part of sweeping indictments announced by DOJ in the 2025 National Health Care Fraud Takedown, five

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<sup>66</sup> Press Release, U. S. Dep't of Justice, Minnesota Health Care Fraud Takedown Results in Charges Against 15 Defendants for Over \$90M in Fraud (May 21, 2026), <https://www.justice.gov/opa/pr/minnesota-health-care-fraud-takedown-results-charges-against-15-defendants-over-90m-fraud>.

<sup>67</sup> *Id.*

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*

<sup>71</sup> *Id.*

<sup>72</sup> *Id.*

<sup>73</sup> *Id.*

<sup>74</sup> *Id.*

<sup>75</sup> California Dep't of Social Servs, In-Home Supportive Services (IHSS) Program, <https://www.cdss.ca.gov/in-home-supportive-services> (last visited June 15, 2026).

<sup>76</sup> *Id.*; Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs., to The Hon. Gavin Newsom, Governor, State of California (Jan. 27, 2026), <https://x.com/DrOzCMS/status/2016259818013552852>.

individuals were charged for their role in fraudulent Medi-Cal billing for IHSS services.<sup>77</sup> 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.<sup>78</sup>

As part of the 2025 National Health Care Fraud Takedown, another six individuals, including two physicians, were indicted for their connection to an alleged \$2.7 million Medi-Cal and Medicare hospice fraud scheme.<sup>79</sup> In this scheme, patients—who did not qualify for hospice because they were not terminally ill—were allegedly fraudulently enrolled in hospice with the intent to defraud Medi-Cal and Medicare.<sup>80</sup> Seven additional individuals were recently arrested in connection with \$3 million in Medi-Cal and Medicare hospice fraud in Monterey County and are similarly alleged to have recruited and enrolled patients to hospice who were not eligible due to not having a terminal illness.<sup>81</sup> In 2024, eight individuals were indicted for their alleged participation in a home health scheme that defrauded Medi-Cal of nearly \$60 million between 2016 and 2022.<sup>82</sup> One defendant, Gerardo Santillan, was previously excluded from participation in Medi-Cal due to prior fraud convictions, yet was able to establish other home health agencies and conspire with others to fraudulently bill Medi-Cal.<sup>83</sup>

Recently, a California man, Paul Randall, pleaded guilty to perpetrating nearly \$270 million in fraudulent claims to Medi-Cal for prescription drugs that were costly, medically unnecessary, or in some cases not provided to patients that needed them.<sup>84</sup> In the scheme, Mr. Randall and his co-defendants, a pharmacist and nurse practitioner, conspired to bill Medi-Cal for high-reimbursement medications while providing patients with cheaper, generic alternatives.<sup>85</sup> The medications prescribed in this case were high-cost drugs that normally require prior authorization to be reimbursed by Medi-Cal.<sup>86</sup> This scheme was made possible because, “[i]n early 2022, Medi-Cal suspended its requirement that health care providers obtain prior

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<sup>77</sup> 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 June 22, 2026).

<sup>78</sup> *Id.*

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> Press Release, State of California Dep’t of Justice, Attorney General Bonta Announces Seven Arrests for Hospice Fraud: My Office is On It! (Feb. 5, 2026), <https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-seven-arrests-hospice-fraud-my-office-it>.

<sup>82</sup> Press Release, State of California Dep’t of Justice, Attorney General Bonta Announces Indictment of Southern California Healthcare Provider for Medi-Cal Fraud of Nearly \$60 Million (Sept. 18, 2024), <https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-indictment-southern-california-healthcare>.

<sup>83</sup> *Id.*

<sup>84</sup> Press Release, U. S. Dep’t of Justice, California Man Pleads Guilty to Orchestrating \$270M Medication Reimbursement Fraud Scheme (Apr. 7, 2026), <https://www.justice.gov/opa/pr/california-man-pleads-guilty-orchestrating-270m-medication-reimbursement-fraud-scheme>.

<sup>85</sup> *Id.*

<sup>86</sup> Press Release, U.S. Attorney’s Off., Central District of California, Montclair Pharmacist Charged with Submitting Over \$300 Million in Fraudulent Claims to Medi-Cal in Medication reimbursement Scam (June 27, 2024), <https://www.justice.gov/usao-cdca/pr/montclair-pharmacist-charged-submitting-over-300-million-fraudulent-claims-medi-cal>.

authorization before providing certain health care services or medications as a condition of reimbursement.”<sup>87</sup>

On January 27, 2026, Administrator Oz sent a letter to California Governor Gavin Newsom requesting information on “program integrity, eligibility verification, and provider oversight within the Medi-Cal program.”<sup>88</sup> CMS demanded 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.<sup>89</sup>

Subsequently, on May 13, 2026, Vice President J.D. Vance announced a deferral of \$1.3 billion in questionable or potentially unallowable costs in California’s Medi-Cal program, specifying that, “the state of California has not taken fraud very seriously.”<sup>90</sup> The deferral consists of over \$1.18 billion of claims for costs in the state’s Community First Choice (CFC) Program and PCS programs.<sup>91</sup> CFC is a Section 1915(k) home and community based services (HCBS) waiver program, which provides in-home services for elderly people and those with disabilities that meet the criteria for institutional-level care to remain in their own homes.<sup>92</sup> Specifically, CMS requested detailed claims data from California, which the state failed to submit to CMS in a timely manner.<sup>93</sup> As a result, CMS based its deferral on “the significant growth observed in California’s CFC-PCS claiming, which between federal fiscal year (FFY) 2023 and FFY 2025 exceeded the average growth rate of all other states by 11.23%,” in addition to “significant CFC-PCS-related program integrity risks.”<sup>94</sup>

### 3. New York

Recent fraud investigations and convictions related to New York’s Medicaid programs are concerning. The Community-Driven Personal Assistance Program (CDPAP) delivers self-directed PCS reimbursed by Medicaid.<sup>95</sup> CDPAP, which New York Governor Kathy Hochul has referred to as a “racket,” allows chronically ill and disabled Medicaid patients to hire their own in-home caregivers.<sup>96</sup> CDPAP costs have skyrocketed from \$1.5 billion in 2017 to \$11.2 billion

<sup>87</sup> *Id.*

<sup>88</sup> *Supra*, note 76 (Letter from Administrator Oz).

<sup>89</sup> *Id.*

<sup>90</sup> Sarah Kliff, *Trump Administration will withhold \$1.3 billion in Medicaid payments to California*, N.Y. TIMES (May 13, 2026), <https://www.nytimes.com/2026/05/13/us/politics/vance-medicare-fraud-california.html>.

<sup>91</sup> Letter from Dorothy Ferguson, Director - Division of Financial Operations West, U. S. Centers for Medicare and Medicaid Services, to Tyler Sadwith, State Medicaid Director, California Department of Health Care Services (May 13, 2026), <https://www.dhcs.ca.gov/Program-Integrity/Documents/Deferral-Letter-CA-Q1-2026.pdf>.

<sup>92</sup> Medicaid.gov, Community First Choice (CFC) 1915 (k), <https://www.medicare.gov/medicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k> (last visited June 16, 2026).

<sup>93</sup> *Supra*, note 91.

<sup>94</sup> *Id.* at 5.

<sup>95</sup> New York State Dep’t of Health, Consumer Directed Personal Assistance Program (CDPAP), [https://www.health.ny.gov/health\\_care/medicaid/program/longterm/cdpap/](https://www.health.ny.gov/health_care/medicaid/program/longterm/cdpap/) (last visited June 16, 2026).

<sup>96</sup> Laura Nahmias, *New York City’s biggest job engine has become a ‘racket,’ Hochul says*, BLOOMBERG (July 22, 2024), <https://www.bloomberg.com/news/articles/2024-07-22/ny-s-cdpap-home-health-aide-job-program-has-become-a-racket-hochul?srnd=all&embedded-checkout=true>.

in 2023, and the program has been identified as vulnerable to fraudulent billing for self-reported hourly caregiving.<sup>97</sup> For example, 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.<sup>98</sup> Over several years, Mr. Hossain and ten others were paid to be caregivers for his mother, who resided out of the country.<sup>99</sup> To carry out the scheme, Mr. Hossain's brother posed as the mother during routine site visits.<sup>100</sup>

In January 2026, two individuals pleaded guilty to a seven year \$68 million Medicaid fraud scheme involving two Brooklyn-based adult day cares and a home health company.<sup>101</sup> In this scheme, the two men received kickbacks and bribes as marketers and recruiters for social adult daycares and a home health care fiscal intermediary, billing for induced or not provided Medicaid services.<sup>102</sup> In February 2026, two Queens men who owned social adult daycare centers and a pharmacy were charged with \$120 million in alleged Medicare and Medicaid fraud schemes, including illegal cash kickbacks to Medicaid recipients to fill prescriptions at the defendants' pharmacies and enroll in one of the defendant's adult day cares.<sup>103</sup>

Last year, investigations into New York non-emergency medical transportation (NEMT) companies were initiated for fake billing of transportation services intended to assist Medicaid patients traveling to and from non-emergency medical appointments.<sup>104</sup> New York's MFCU investigated 25 transportation companies, finding evidence that many defrauded Medicaid by billing for fake trips, inflating costs with fraudulent toll charges or extended mileage, and using unlicensed drivers.<sup>105</sup> In January 2026, one transportation company owner was convicted for submitting over \$1 million in fraudulent Medicaid claims for NEMT services that were not

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<sup>97</sup> Public Partnerships LLC, PPL uncovers fraud risks in CDPAP and works with state to safeguard program (Sept. 15, 2025), <https://pplfirst.com/news/ppl-uncovers-fraud-risks-in-cdpap/>; see also Isabel Vincent, *Notoriously fraudulent NY health program lost \$1.2 billion to scammers and middlemen: 'Minnesota multiplied by 10'*, NEW YORK POST (Jan. 8, 2026), <https://nypost.com/2026/01/08/us-news/nys-fraudulent-cdpap-program-lost-1-2-billion-to-scammers-and-mismanagement/>; Grace Ashford, *N. Y. lawmakers press officials about home health program's issues*, NEW YORK TIMES (Aug. 25, 2025), <https://www.nytimes.com/2025/08/21/nyregion/cdpap-new-york.html>.

<sup>98</sup> News Release, Off. 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 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>.

<sup>99</sup> *Id.*

<sup>100</sup> *Id.*

<sup>101</sup> Press Release, U.S. Dep't of Justice, Two Individuals Plead Guilty to \$68M Adult Day Care Fraud Scheme (Jan. 15, 2026), <https://www.justice.gov/opa/pr/two-individuals-plead-guilty-68m-adult-day-care-fraud-scheme>.

<sup>102</sup> *Id.*

<sup>103</sup> Press Release, U.S. Dep't of Justice, Two Queens men charged with \$120M adult day care and pharmacy fraud on Medicare and Medicaid (Feb. 9, 2026), <https://www.justice.gov/opa/pr/two-queens-men-charged-120m-adult-day-care-and-pharmacy-fraud-medicare-and-medicaid>.

<sup>104</sup> Press Release, New York State Attorney General Letitia James, Attorney General James secures more than \$13 million in sweeping takedown of transportation companies for defrauding Medicaid (June 30, 2025), <http://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation>.

<sup>105</sup> *Id.*

rendered.<sup>106</sup> Some of these patients were deceased, incarcerated, or hospitalized at the time these fraudulent claims were submitted.<sup>107</sup>

On March 3, 2026, Administrator Oz sent a letter to New York Governor Kathy Hochul, requesting more information on the state’s Medicaid program integrity efforts.<sup>108</sup> In the letter, Administrator Oz highlighted high levels of Medicaid spending in New York, concerns about accelerated growth in billing for 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.”<sup>109</sup> Administrator Oz requested that New York answer questions about program integrity, provider screening and enrollment, and specific concerns with programs in the state that have “high-risk billing patterns and systemic vulnerabilities.”<sup>110</sup>

On June 16, 2026, DOJ filed a lawsuit against Public Partnerships, LLC (PPL), James McDonald, Commissioner of the New York State Department of Health (DOH) and Amir Bassiri, New York State Medicaid Director.<sup>111</sup> DOJ alleges that the state failed to properly solicit bids in its search for a single fiscal intermediary to manage CDPAP, and did not adequately oversee PPL in its processing of CDPAP claims.<sup>112</sup> As a result, it is alleged that by billing at excessive rates, “PPL has generated millions of dollars of unauthorized profits funded by federal taxpayers.”<sup>113</sup> According to the lawsuit, Medicaid managed care organizations alerted DOH about billing discrepancies by PPL but these complaints were not acted upon.<sup>114</sup>

#### 4. Ohio

Recent media investigations into Ohio home health care providers have uncovered a range of concerning patterns that are indicative of potential fraud.<sup>115</sup> Reporters identified multiple home health companies registered to locations such as empty or windowless office buildings, including one location associated with more than \$66 million in Medicaid billing.<sup>116</sup> A

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<sup>106</sup> Press Release, New York State Attorney General Letitia James, Attorney General James announces conviction and sentencing of Suffolk County transportation company owner for stealing over \$1 million from Medicaid (Jan. 14, 2026), <https://ag.ny.gov/press-release/2026/attorney-general-james-announces-conviction-and-sentencing-suffolk-county>.

<sup>107</sup> *Id.*

<sup>108</sup> Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs., to The Hon. Kathy Hochul, Governor, State of New York, et al. (Mar. 3, 2026), <https://x.com/DrOzCMS/status/2028930123013976543>.

<sup>109</sup> *Id.* at 2.

<sup>110</sup> *Id.* at 6.

<sup>111</sup> Press Release, U.S. Dep’t of Justice, Department of Justice Files Suit to Stop Ongoing Medicaid Fraud Related to New York’s \$10 Billion Home-Care Program (June 16, 2026), <https://www.justice.gov/opa/pr/departement-justice-files-suit-stop-ongoing-medicaid-fraud-related-new-yorks-10-billion-home>.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.*

<sup>114</sup> Complaint at 26-27, *United States v. Public Partnerships, LLC*, No. 1:26-cv-03601 (E.D.N.Y. June 16, 2026), <https://www.justice.gov/opa/media/1446226/dl>.

<sup>115</sup> Luke Rosiak, *DW investigation reveals one of the biggest government waste scandals hiding in plain sight*, DAILY WIRE (May 4, 2026), <https://www.dailywire.com/news/medicaid-millionaires-how-the-feds-pay-immigrants-billions-to-hang-out-with-their-families>.

<sup>116</sup> *Id.*

New Jersey-based real estate group controls several buildings in Columbus, Ohio, where 288 Medicaid providers are registered.<sup>117</sup> Together, those providers with clustered geographical groupings billed the Medicaid program over \$250 million between 2018 and 2024.<sup>118</sup> Investigators also found that some owners of these home health companies had prior criminal convictions, including for fraud and money laundering.<sup>119</sup> These findings raise significant concerns about oversight, accountability, and the potential misuse of Medicaid funds.

In a November 2024 review, Ohio Auditor of State Keith Faber found that the Ohio Department of Medicaid was not requiring electronic visit verification (EVV) for PCS and home health services as mandated by federal law.<sup>120</sup> On June 11, 2026, the Ohio General Assembly passed a comprehensive Medicaid reform package that, among other things, codifies mandatory EVV requirements as a condition for payment for in-home services provided by non-live-in family caregivers.<sup>121</sup>

In May 2026, then-Ohio Attorney General Dave Yost announced that three individuals had been charged in Medicaid fraud schemes.<sup>122</sup> The defendants are alleged to have fabricated home health billing time sheets, billed for services that were not provided, and double billed while working at other jobs.<sup>123</sup> Two of the individuals are alleged to have billed Medicaid for in-home health services that were not possible—one while a client was hospitalized for four months, and another when the provider was on vacation in Jamaica.<sup>124</sup>

During a June 4, 2026 press conference, DOJ announced a \$30 million Medicaid fraud case, known as “Operation Playground Therapy.”<sup>125</sup> The Federal Bureau of Investigation (FBI) alleges that the defendants operated behavioral health services companies that submitted false claims for therapy services for children and young adults.<sup>126</sup> After one therapy provider failed to

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<sup>117</sup> Luke Rosiak, *Inside Ohio’s Home Health Empire: 7 buildings, 288 Medicaid companies, \$250 Million*, DAILY WIRE (May 5, 2026), <https://www.dailywire.com/news/inside-ohios-home-health-empire-7-buildings-288-medicaid-companies-250-million>.

<sup>118</sup> *Id.*

<sup>119</sup> Luke Rosiak, *Meet the convicted fraudster running a million dollar Medicaid business*, DAILY WIRE (May 7, 2026), <https://www.dailywire.com/news/meetthe-convicted-fraudster-running-a-million-dollar-medicaid-business>; Luke Rosiak, *He was convicted for defrauding the government. now Medicaid pays his wife millions*, DAILY WIRE (May 13, 2026), <https://www.dailywire.com/news/he-was-convicted-for-defrauding-the-government-now-medicaid-pays-hiswife-millions>.

<sup>120</sup> Ohio Auditor of State Keith Faber, Ohio Department of Medicaid Electronic Visit Verification Auditor of State Report (Nov. 2024), <https://ohioauditor.gov/auditsearch/detail.aspx?ReportID=c36ab207-710e-4e5a-8841-85ce6990d631>.

<sup>121</sup> Enact the Enhanced Cybersecurity for SNAP Act, S.B. 315, Ohio Gen. Assemb. (June 10, 2026), [https://search-prod.lis.state.oh.us/api/v2/general\\_assembly\\_136/legislation/sb315/05\\_EN/pdf/](https://search-prod.lis.state.oh.us/api/v2/general_assembly_136/legislation/sb315/05_EN/pdf/).

<sup>122</sup> News Release, Off. of Ohio Attorney General Dave Yost, Eight Indicted in Medicaid Fraud, Nursing Home Theft Case (May 20, 2026), <https://www.ohioattorneygeneral.gov/Media/News-Releases/May-2026/Eight-Indicted-in-Medicaid-Fraud-Nursing-Home-Theft>.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> Press Release, U. S. Dep’t of Justice, Fraud Division Announces Federal-State Partnership in Ohio to Prosecute Fraud (June 4, 2026), <https://www.justice.gov/opa/pr/fraud-division-announces-federal-state-partnership-ohio-prosecute-fraud>; Katie Millard, *Attorney General, FBI director address Medicaid fraud in Ohio news conference*, NBC4 (June 4, 2026), <https://www.nbc4i.com/news/local-news/whitehall/attorney-general-fbi-director-address-medicaid-fraud-in-ohio-news-conference/>.

<sup>126</sup> *Id.*

renew its Medicaid credentialing, the defendants allegedly conspired to continue billing Medicaid by routing claims through a separate company.<sup>127</sup> In the course of its investigation, DOJ “seized three bank accounts with \$469K in funds and 14 vehicles worth \$800K.”<sup>128</sup>

At the same press conference, Administrator Oz announced that CMS is suspending 49 home health care companies in Ohio identified as high-risk for fraud.<sup>129</sup> He also stated that CMS approved Ohio’s request for a six-month moratorium on newly enrolling home health and hospices in Ohio, and that Ohio is working closely with CMS to identify Medicaid fraud and refer cases to law enforcement.<sup>130</sup>

The U.S. Attorney for the Southern District of Ohio also announced that DOJ is standing up a Southern District of Ohio Fraud Task Force.<sup>131</sup> In addition, Ohio Secretary of State Frank LaRose announced a new data sharing agreement with DOJ’s National Fraud Enforcement Division, providing the federal government access to state corporate registration data.<sup>132</sup> This information will help state and federal investigators analyze business ownership links in high-risk Medicaid areas—including clinics, laboratories, and billing entities—that can be used to conceal and facilitate Medicaid fraud schemes.<sup>133</sup>

#### **D. Trump Administration Efforts to Hold States Accountable for Medicaid Fraud**

President Trump is surging federal government resources to antifraud efforts, while offering states the opportunity to collaborate with CMS and Administration efforts to improve Medicaid program integrity.<sup>134</sup> On March 16, 2026, President Trump signed Executive Order 14395, “Establishing the Task Force to Eliminate Fraud.”<sup>135</sup> The President’s Fraud Task Force, chaired by Vice President Vance with Federal Trade Commission Chairman Ferguson serving as Vice Chairman, convenes representatives from the entire U.S. government to “fight fraud, close loopholes, enforce eligibility rules, and protect benefits for eligible Americans, while ensuring States administering Federal benefits programs do the same.”<sup>136</sup> The President’s Fraud Task Force has been integral in decisive Medicaid fraud enforcement actions, including criminal charges, provider enrollment moratoriums and terminations, and facilitating information and data sharing between states and the federal government.<sup>137</sup>

On March 17, 2026, Administrator Oz sent a letter to Florida Governor Ron DeSantis requesting more information and documentation about the state’s program integrity efforts given

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<sup>127</sup> *Id.*

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*; Dr. Mehmet Oz (@DrOzCMS), X, (June 4, 2026, 12:42 PM), <https://x.com/DrOzCMS/status/2062575663438074230>.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> See Press Release, The White House, Trump Administration’s Full-Scale War on Fraud (May 26, 2026), <https://www.whitehouse.gov/releases/2026/05/trump-administrations-full-scale-war-on-fraud/>.

<sup>135</sup> Exec. Order No. 14395, 91 C.F.R. 13485 (2026), <https://www.federalregister.gov/documents/2026/03/19/2026-05497/establishing-the-task-force-to-eliminate-fraud>.

<sup>136</sup> *Id.*

<sup>137</sup> See e.g. *supra* note 125.

the “well-documented history of health care fraud affecting both Medicare and the Florida Medicaid program.”<sup>138</sup> CMS requested more information from Florida about high-risk services such as DME, ABA, adult day centers, and PCS.<sup>139</sup> On June 12, 2026, Governor DeSantis announced a statewide antifraud initiative that includes launching a pilot program with identity verification platform SentiLink, imposing enrollment moratoriums for DME and adult daycare providers, conducting statewide Medicaid provider revalidation, and intensifying claims review processing and enforcement actions.<sup>140</sup>

On April 23, 2026, Administrator Oz sent letters to all state governors requesting that each state “undertake a swift revalidation of Medicaid providers of services at high risk of waste, fraud, abuse, and corruption as part of each state’s program integrity obligations under federal law.”<sup>141</sup> Specifically, Administrator Oz highlighted the risk of fraudulent providers, especially those without National Provider Identifiers (NPI), and urged states to closely review such providers.<sup>142</sup> Simultaneously, Administrator Oz sent letters to all state Medicaid directors asking them to submit a two-year provider revalidation strategy.<sup>143</sup> In the letter, Administrator Oz highlighted “a persistent and growing Medicaid threat posed by sophisticated actors knowingly exploiting these complex systems for financial gain.”<sup>144</sup> Additionally, the request encouraged states to increase their oversight of high-risk provider types by revalidating them more frequently than the required minimum of once every five years.<sup>145</sup> CMS also asked that SMAs include a strategy for assessing the enrollment of providers without NPIs.<sup>146</sup>

On May 13, 2026, HHS Inspector General, T. March Bell, sent a letter to all 53 MFCUs, reminding them of the federal requirements tied to the federal funding that supports state fraud-fighting efforts.<sup>147</sup> Inspector General Bell notified the MFCUs that HHS-OIG intends to conduct thorough recertifications of each unit to ensure that they are effectively fighting fraud.<sup>148</sup> On June 4, 2026, Inspector General Bell notified Hawaii Attorney General Anne Lopez and MFCU Director Landon Murata that the Hawaii MFCU had not been recertified and will no longer

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<sup>138</sup> Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs. to The Hon. Ron DeSantis et al., Governor, State of Florida (Mar. 17, 2026), <https://leadingage.org/wp-content/uploads/2026/03/031726-CMS-Florida-Fraud-Letter.pdf>.

<sup>139</sup> *Id.* at 4.

<sup>140</sup> Press Release, Executive Off. of the Governor – Ron DeSantis, Governor Ron DeSantis Announces Medicaid Integrity Initiative to Crack Down on Fraud (June 12, 2026), <https://www.flgov.com/eog/news/press/2026/governor-ron-desantis-announces-medicaid-integrity-initiative-crack-down-fraud>.

<sup>141</sup> *E.g.*, Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs. to The Hon. Kay Ivey, Governor, State of Alabama, <https://leadingage.org/wp-content/uploads/2026/04/042326-HHS-Letter-Alabama-Governor.pdf>.

<sup>142</sup> *Id.*

<sup>143</sup> Letter from Dr. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Servs. to State Medicaid Directors (Apr. 23, 2026), <https://leadingage.org/wp-content/uploads/2026/04/042326-HHS-Letter-Medicaid-Director.pdf>.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *E.g.* Letter from The Hon. T. March Bell, Inspector Gen., U.S. Dep’t of Health and Human Servs., to The Hon. Rob Bonta, Attorney Gen., State of California Dep’t of Justice (May 13, 2026), <https://leadingage.org/wp-content/uploads/2026/05/California-DOJ.pdf>.

<sup>148</sup> *Id.*

receive approximately \$3 million annually in federal funds.<sup>149</sup> In the denial letter, Inspector General Bell stated, “the Hawaii MFCU for many years has not effectively carried out, and is not currently effectively carrying out, its statutory fraud-fighting functions and requirements.”<sup>150</sup> Specifically, Inspector General Bell pointed to the fact that Hawaii did not obtain a single Medicaid fraud conviction between 2022 and 2025, and has only obtained one fraud indictment in the last five years.<sup>151</sup> Moreover, the lack of MFCU activity is concerning given the growth in the state’s Medicaid program over the last six years.<sup>152</sup>

### **E. Prior Committee Activity**

Building upon the Committee’s past oversight work of FWA in Medicaid in prior Congresses, on January 16, 2026, the Committee launched an investigation into Minnesota’s Medicaid program after prosecutions and alarming allegations of widescale fraud were uncovered.<sup>153</sup> The Committee requested documents, communications, and information about Minnesota’s Medicaid program design and efforts it is taking to curb fraud in its programs.<sup>154</sup> Minnesota produced over 9,300 pages of documents and 23 pages of information to the Committee.

In February 2026, the Subcommittee on Oversight and Investigations held a hearing entitled, “Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid.”<sup>155</sup> This hearing featured experts investigating Medicare and Medicaid fraud across the U.S.<sup>156</sup> 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 and programs more vulnerable to fraud.<sup>157</sup> The hearing reinforced that Medicaid fraud is not limited to Minnesota and that Medicaid fraud investigators “see that fraud schemes across state lines far more than they used to.”<sup>158</sup> Expert witnesses

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<sup>149</sup> Letter from The Hon. T. March Bell, Inspector Gen., U.S. Dep’t of Health and Human Servs., to The Hon. Anne E. Lopez, Attorney Gen., State of Hawaii, and Landon M. M. Murata, Dir., Medicaid Fraud Control Unit, State of Hawaii (June 4, 2026), [https://oig.hhs.gov/documents/medicaid-fraud-control-units/11679/Hawaii\\_Denial\\_of\\_Recertification\\_Letter.pdf](https://oig.hhs.gov/documents/medicaid-fraud-control-units/11679/Hawaii_Denial_of_Recertification_Letter.pdf).

<sup>150</sup> *Id.*

<sup>151</sup> *Id.*

<sup>152</sup> *Id.*

<sup>153</sup> 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>; Letter from The Hon. Brett Guthrie, Chairman, Committee on Energy and Commerce, et al., to The Hon. Tim Walz, Governor, State of Minnesota and Shireen Gandhi, Temporary Commissioner, Minnesota Dep’t of Human Servs. (Jan. 16, 2026), [https://d1dth6e84htgma.cloudfront.net/1\\_16\\_2026\\_MN\\_Medicaid\\_Fraud\\_Letter\\_944a806843.pdf](https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf).

<sup>154</sup> *Id.* (Letter from The Hon. Brett Guthrie).

<sup>155</sup> *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>.

<sup>156</sup> *Id.*

<sup>157</sup> *Id.*

<sup>158</sup> *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>.

testified that Medicaid programs experiencing high rates of fraud include ABA services, NEMT, HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.<sup>159</sup>

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.<sup>160</sup> The letter recipients included New York and California.<sup>161</sup> The Committee requested information and documentation about states' efforts to identify, investigate, and mitigate the risk of fraud in their state's Medicaid program.<sup>162</sup> The Committee has reviewed more than 94,000 pages of information provided in response to the Committee's January 16 letter to Minnesota and March 3 letters to ten additional states.

On March 17, 2026, the Subcommittee on Oversight and Investigations held a hearing with CMS Chief Operating Officer and Deputy Administrator Kimberly Brandt.<sup>163</sup> Deputy Administrator Brandt highlighted high-risk programs experiencing high rates of fraud in Medicare and Medicaid, including hospice, home health, DME, ABA services, and personal care services.<sup>164</sup> Deputy Administrator Brandt also discussed the real patient harm that results from Medicare and Medicaid fraud.<sup>165</sup> She also described the extensive work that CMS is doing to combat fraud in Medicare and Medicaid, including moving away from the "pay and chase" model to the "caught and stopped" model, keeping taxpayer dollars from being paid out to fraudsters rather than trying to recoup payments for fraudulent claims after the fact.<sup>166</sup> Additionally, CMS is deploying pre-payment review and payment suspensions powered by data analytics and artificial intelligence.<sup>167</sup> Deputy Administrator Brandt also discussed how CMS is developing a 50-state playbook as a guide to program integrity best practices that states can apply to Medicaid programs.<sup>168</sup>

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<sup>159</sup> 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>.

<sup>160</sup> 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>.

<sup>161</sup> *Id.*

<sup>162</sup> *Id.*

<sup>163</sup> *Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations*, 119th Cong. (Mar. 17, 2026), <https://docs.house.gov/meetings/IF/IF02/20260317/119065/HHRG-119-IF02-Transcript-20260317.pdf>.

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> *Id.*

<sup>167</sup> *Id.*

<sup>168</sup> *Id.*

#### **IV. KEY QUESTIONS**

The hearing may include discussion around the following key questions:

- What is known about the scope and scale of Medicaid fraud?
- What steps are states taking to prevent and detect Medicaid fraud?
- Are states complying with federal program integrity requirements to prevent, detect, and root out Medicaid fraud?
- How are states collaborating with the federal government to improve anti-fraud efforts?
- Are states effectively working with MFCUs and other law enforcement entities to investigate and prosecute fraud?

#### **V. STAFF CONTACTS**

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