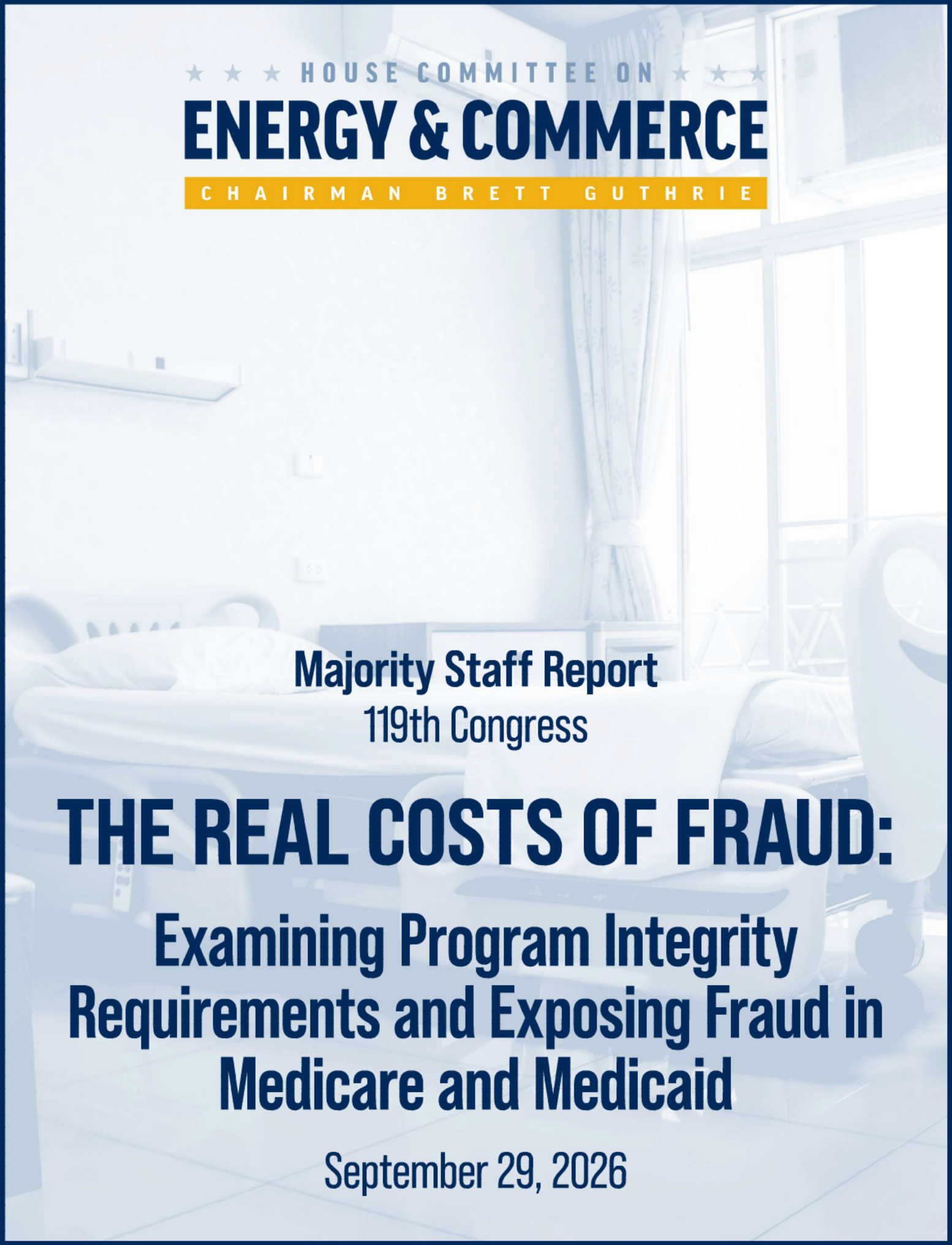
HOUSE COMMITTEE ON

ENERGY & COMMERCE

CHAIRMAN BRETT GUTHRIE



Majority Staff Report
119th Congress

THE REAL COSTS OF FRAUD:

Examining Program Integrity Requirements and Exposing Fraud in Medicare and Medicaid

September 29, 2026

Table of Contents

I. Executive Summary

Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars a year.[1] Fraud is prevalent in all sectors of health care and is especially egregious in taxpayer-funded health care programs that are intended to serve vulnerable populations, including the elderly, disabled, children, and pregnant women.[2] Although different services or programs may be impacted by state or region, the patterns of fraud are the same across the nation. Patients are suffering from identity theft, long waiting lists, substandard health care, and, in some cases, a lack of health care services due to fraudulent claims to Medicare and Medicaid.[3] Efforts to crack down on health care fraud are ongoing, but there is more to be done to reform Medicare and Medicaid to reduce their susceptibility to fraud.[4]

Fraud is a dual victim crime, impacting every single American in one way or another.[5] Beneficiaries of Medicare and Medicaid—more than one third of Americans—may be negatively impacted due to interruptions in care, poor quality or lack of care, and identity theft.[6] Taxpayers that fund benefit programs with federal and state taxpayer dollars are cheated by fraud, inflating health care costs which are passed along to everyone.[7] Every dollar stolen from federal health care programs is a dollar that is not spent on high-quality health care for those that need it most. The purpose of the Committee's oversight is to make sure that every dollar that is spent on Medicare and Medicaid reaches the patients that need this care.

The urgency to address these issues continues to grow as health care fraud schemes are becoming increasingly sophisticated and perpetrated by transnational criminal organizations (TCO).[8] Last year, the U.S. Department of Justice (DOJ) National Health Care Fraud Takedown

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[1] U.S. Centers for Medicare and Medicaid Services, CMS Accomplishments, January 1, 2025 – December 31, 2025 (Aug. 2026), Crushing Fraud, https://www.cms.gov/files/document/cpi-data-dashboard-december-update.pdf.
[2] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (last visited Mar. 5, 2026).
[3] U.S. Dep't of Justice, Federal Bureau of Investigation, Healthcare Fraud, https://www fbi.gov/investigate/white-collar-crime/healthcare-fraud (last visited Aug. 3, 2026); U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, INVESTIGATIVE ADVISORY ON MEDICAID FRAUD AND PATIENT HARM INVOLVING PERSONAL CARE SERVICES (Oct. 3, 2016), https://oig.hhs.gov/documents/additional-reports/1313/OIG-OR-2017-01-Complete%20Report.pdf.
[4] *See, e.g.*, Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with over $14.6 Billion in Alleged Fraud (Jun. 30, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.
[5] White House Task Force to Eliminate Fraud, *Remarks by J.D. Vance, Vice President of the U.S. at a meeting of the White House Task Force to Eliminate Fraud, Washington, D.C.* (Aug. 5, 2026), https://x.com/FoxNews/status/2085010015195148682.
[6] U.S. CENSUS BUREAU, P60-288, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2024, 3 (Sept. 2025), https://www2.census.gov/library/publications/2025/demo/p60-288.pdf.
[7] U.S. Dep't of Justice, Federal Bureau of Investigation, Healthcare Fraud, https://www fbi.gov/investigate/white-collar-crime/healthcare-fraud (last visited Aug. 3, 2026); Jordan Antwi, *Medicaid fraud and its systemic impact on U.S. healthcare access and cost*, 1 AMERICAN JOURNAL OF HEALTHCARE STRATEGY 87 (July 31, 2025), https://ajhcs.org/wp-content/uploads/2025/07/Medicaid-Fraud-and-Its-Systemic-Impact-on-US-Healthcare-Access-and-Cost-1.pdf.
[8] U.S. DEP'T OF THE TREASURY, FINANCIAL CRIMES ENFORCEMENT NETWORK, FIN-2026-A001 FINCEN ADVISORY ON HEALTH CARE FRAUD SCHEMES TARGETING MEDICARE, MEDICAID, AND OTHER FEDERAL AND STATE HEALTH

included charges for 29 individuals involved in TCO fraud schemes.[9] The 2025 Takedown included Operation Gold Rush, which resulted in 11 individuals being charged in "the largest case by loss amount ever charged by the Department of Justice."[10] This scheme involved members of Russian organized crime who purchased 30 small medical supply companies already enrolled in Medicare, billing more than $10.6 billion in fraudulent urinary catheter claims using stolen beneficiary information.[11] In 2026, investigations stemming from the Gold Rush scheme continued with DOJ charging an additional $3.7 billion in fraudulent Medicare billing of urinary catheters and other durable medical equipment, prosthetics, orthotics, and supplies (DME) tied to an individual related to TCOs that had previously evaded law enforcement and fled the U.S.[12]

Under Rule X of the U.S. House of Representatives, the House Committee on Energy and Commerce (Committee) has legislative and oversight jurisdiction over much of the Medicare program and the entirety of the Medicaid program.[13] The Committee has a long-standing history of conducting oversight of Medicare and Medicaid fraud.[14] Recent actions taken by the Committee include legislative reforms, oversight hearings, and investigations into the fraud risks of federal health care programs. During the 118th Congress, the Subcommittee on Oversight and Investigations held a hearing with then- U.S. Department of Health and Human Services (HHS) Inspector General Christi Grimm, in which Republicans and Democrats on the Committee acknowledged the prevalence of fraud in HHS programs and questioned Inspector General Grimm about fraud occurring in programs such as Medicare Advantage.[15]

Over the past year, the Committee has observed several emerging trends in Medicare and Medicaid, along with criminal investigations and prosecutions that highlight emerging program integrity vulnerabilities. These developments include reduced program integrity capacity at the U.S. Centers for Medicare and Medicaid Services (CMS) under the Biden Administration, increased utilization and spending in recent years, continued reliance on reactive program integrity rather than preventative oversight, and limited oversight of waivered Medicaid services.

CARE BENEFIT PROGRAMS (Mar. 30, 2026), https://www fincen.gov/system/files/2026-03/FinCEN-Advisory-Health-Care-Fraud.pdf.

[9] Press Release, National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud (June 30, 2025), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[10] Press Release, U.S. Attorney's Office, Eastern District of New York, 11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice (Jun. 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

[11] *Id.*

[12] Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over $6.5 Billion in Alleged Fraud (June 23, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65.

[13] House of Representatives, Rule X(f) (119th Cong.); 42 U.S.C. §1395 et seq.; 42 U.S.C. §§ 1396 et seq. (The Committee has primary jurisdiction over Medicare Parts B (Supplementary Medical Insurance) and D (prescription drug benefits), and secondary jurisdiction over Medicare Part C (Medicare Advantage)).

[14] *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.

[15] *Insights from the HHS Inspector General on Oversight of Unaccompanied Minors, Grant Management, and CMS: Hearing Before H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 118th Cong. (Apr. 18, 2023), https://www.congress.gov/event/118th-congress/house-event/LC72508/text.

In light of these trends, the Committee examined how well CMS and State Medicaid Agencies (SMA) are equipped to improve program integrity moving forward.

The Committee's investigation of Medicare and Medicaid fraud has been comprehensive, consisting of twelve letters, three Subcommittee on Oversight and Investigations hearings, and the review of over 100,000 pages of documents and information produced to the Committee. The inquiry revealed clear nationwide trends in fraud across Medicare and Medicaid, indicating a need for strengthened oversight of high-risk providers by both CMS and state agencies. Further, the Committee found that states may play a significant role in oversight of Medicare services and confirmed persistent patterns of suspicious hospice activity. The Committee's investigation also uncovered disparities in the oversight and enforcement of the state Medicaid program that put the integrity of the Medicaid program at risk. As a result of insufficient or ineffective program integrity efforts, states are struggling to get fraud under control. Some states are failing to adequately screen Medicaid providers before they enroll and during revalidation, not utilizing audits to their full extent to monitor ongoing fraud, and failing to leverage investigative authorities at their disposal to stop fraud.

The Committee also found that heightened attention to the prevalence and pervasiveness of fraud by Congress and the Trump Administration is paying off.[16] In HHS programs alone, the Trump Administration has already uncovered $96.4 billion in fraud, stopped $46.2 billion of fraud, and recovered $33.1 billion of fraud through enforcement actions since January 2025.[17]

Based on the findings of this report, the Committee is making a series of recommendations to strengthen federal program integrity guidelines, improve states' capacity to prevent fraud before it occurs, more comprehensively share data and information to inform fraud investigations, and employ innovative tools to improve fraud detection capabilities. The Committee's recommendations aim to strengthen federal health care programs to ensure their fiscal sustainability and preserve access to these benefits for the vulnerable patients that need them most. Both federal and state governments have a duty to the American people to ensure the program integrity of Medicare and Medicaid.

[16] *E.g.*, The Hon. Brett Guthrie, *Here's the Truth: The One Big Beautiful Bill Actually Strengthens Medicaid*, COURIER JOURNAL (July 29, 2025), courier-journal.com/story/opinion/contributors/2025/07/29/trump-big-beautiful-bill-medicaid-fraud-abuse-ky-guthrie/85403461007/; U.S. Centers for Medicare and Medicaid Services, CMS Medicaid Fraud War Room Stops More Than $203 Million in Improper Payments During First 88 Days (July 28, 2026), https://www.cms.gov/newsroom/press-releases/cms-medicaid-fraud-war-room-stops-more-203-million-improper-payments-during-first-88-days.

[17] The White House, The Fraud Ledger, https://www.whitehouse.gov/fraud/ (last visited Sept. 25, 2026).

II. Table of Acronyms

Acronym	Description
ABA	Applied Behavior Analysis
ADC	Adult Day Care
AERO	Audit Enforcement and Risk Oversight
AI	Artificial intelligence
CDPAP	Consumer Directed Personal Assistance Program
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CMS	U.S. Centers for Medicare and Medicaid Services
CPI	U.S. Centers for Medicare and Medicaid Services Center for Program Integrity
DOJ	U.S. Department of Justice
DME	Durable medical equipment, prosthetics, orthotics, and supplies
EIDBI	Early Intensive and Developmental Behavioral Intervention
FBI	Federal Bureau of Investigation
FDOC	Fraud Defense Operation Center
FFP	Federal Financial Participation
FFS	Fee-for-service
FMAP	Federal Medical Assistance Percentage
FWA	Fraud, waste, and abuse
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HCBS	Home and Community-Based Services
HHA	Home health agency
HHS	U.S. Department of Health and Human Services
HHS-OIG	U.S. Department of Health and Human Services Office of Inspector General
HQRP	Hospice Quality Reporting Program
HSS	Housing Stabilization Services
ICS	Integrated Community Supports
IHSS	In-Home Supportive Services
L.A.	Los Angeles
LEIE	List of Excluded Individuals/Entities
MAC	Medicare Administrative Contractor
MACPAC	Medicaid and CHIP Payment and Access Commission
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
NEMT	Non-emergency medical transportation
NFDC	National Fraud Detection Center
NPI	National Provider Identifier
PCS	Personal care services
RAC	Recovery Audit Contractor
SMA	State Medicaid Agency
SMRC	Supplemental Medical Review Contractor
SPA	State Plan Amendment

SUD	Substance Use Disorder
TCO	Transnational criminal organization
UPIC	Unified Program Integrity Contractor
U.S.	United States of America
WFTC	Working Families Tax Cuts Law

III. Findings

- Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars per year. Rampant fraud jeopardizes the longevity and purpose of Medicare and Medicaid to deliver necessary health care services to vulnerable patients. Federal health care programs have limited resources, and every dollar spent on fraud is a dollar not going to a beneficiary that needs these critical services.

- Fraud is not a victimless crime. Patients suffer under the care of fraudulent providers. Patients have suffered from stolen identities, long wait lists, substandard health care, and, in some cases, neglect and death.

- There are nationwide trends in fraud that indicate certain services in Medicare and Medicaid are at risk.

    - In Medicare, areas with elevated fraud activity include hospice, home health services, DME, and genetic testing.

    - Medicaid programs experiencing high rates of fraud include Applied Behavior Analysis (ABA) services, non-emergency medical transportation (NEMT), Home and Community-Based Services (HCBS), Adult Day Care (ADC), and substance use disorder (SUD) treatment.

- Medicare and Medicaid fraud have distinct and increasingly sophisticated patterns, with fraud schemes crossing state and international lines more than they have previously. TCOs are perpetrating fraud across the U.S., targeting state and federal health care programs and laundering money through overseas bank accounts.

- Medicaid services are not always designed with program integrity in mind. States have rapidly expanded benefits under HCBS Section 1915(c) waivers, resulting in sky rocketing program costs and leaving Medicaid vulnerable to fraud without proper programmatic safeguards.

- Medicaid provider screening is essential for verifying that providers are legitimate and qualified to deliver health care services. Current preventative program integrity efforts are not sufficient, and requirements for states to conduct provider screening activities are not adequate.

- States are not utilizing Medicaid provider risk levels as an essential program integrity tool and some states are not meeting current federal requirements. By not using available program integrity tools, states may be using federal standards as a loophole to avoid being held to further provider screening requirements.

- States are not using audit and investigative authorities to their fullest potential to prevent Medicaid fraud from occurring. States vary in auditing capacity and are generally not focusing on high-risk providers in their state.

- States are not taking fraud into account in their Medicaid auditing activities, dismissing the prevalence of fraud and its risks to program integrity and beneficiaries.

- Concerning patterns of fraud have also been identified hospice services, such as instances of networks of individuals associated with multiple hospice agencies and several hospices registered to the same address.

- SMAs often have information on fraud occurring in Medicare services and must play an important oversight role in detecting fraudulent billing through state licensing and routine auditing of Medicaid claims submitted by these providers.

- Heightened attention to fraud pays off. Federal efforts to combat health care fraud return $12.70 for every $1 spent, demonstrating that oversight pays for itself. Preventative "detect and prevent" program integrity strategies outperform traditional "pay and chase" approaches, reducing losses by identifying improper payments before they occur rather than trying to recover them after the fact.

- Recent efforts by the Trump Administration are making significant progress in increasing accountability for states that fail to root out fraud. Many of these efforts must be continued or codified to ensure that program integrity remains a priority of the U.S. Government.

IV. Background

CMS, a subagency of HHS, administers Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[18] The CMS Center for Program 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."[19] In 2025, CMS referred 343 fraud cases to law enforcement, totaling $3.4 billion in fraudulent billing.[20] CMS recently achieved its highest return on investment ever—$22.30 saved for every $1 spent on program integrity in the Medicare program—with total Medicare program integrity savings reaching $41.9 billion last year.[21] In the first half of 2026, CMS identified $1.8 billion in Medicare overpayments, suspended 1,095 Medicare providers and suppliers, and revoked 1,625 Medicare providers.[22]

Fraud in Medicare and Medicaid is a serious problem that is costing taxpayers billions of dollars a year.[23] According to the U.S. Department of the Treasury, "[f]raud, including health care fraud and government benefits fraud, […] continues to be one of the largest sources of illicit proceeds in the United States."[24] Although no precise estimate of annual fraud rates in Medicare or Medicaid exists, the U.S. Government Accountability Office (GAO) recently estimated that $233 billion to $521 billion, approximately 3 percent to 7 percent of federal outlays, are lost annually to fraud.[25] For context, the National Health Care Anti-Fraud Association estimates that 3 to 10 percent of all health care expenditures are lost to fraud.[26]

While there are reliable estimates of Medicare and Medicaid improper payment rates, not all improper payments constitute fraud: improper payments only capture some fraud and also

[18] U.S. Centers for Medicare and Medicaid Services, About Us, https://www.cms.gov/about-cms (last visited Aug. 20, 2026).
[19] U.S. Centers for Medicare and Medicaid Services, Center for Program Integrity, https://www.cms.gov/about-cms/leadership/center-program-integrity (last visited July 27, 2026); *see* 42 C.F.R. §§ 430.32, 431.16, 433.32, 455.12, 456.
[20] U.S. Centers for Medicare and Medicaid Services, CMS Accomplishments, January 1, 2025 – December 31, 2025, Crushing Fraud, https://www.cms.gov/files/document/cpi-data-dashboard-december-update.pdf.
[21] U.S. Centers for Medicare and Medicaid Services, CMS Reports Highest Program Integrity ROI Ever Recorded (May 2026), https://www.cms.gov/files/document/cpi-roi-fy25-pdf.pdf.
[22] U.S. Centers for Medicare and Medicaid Services, Crushing Fraud 2026, January 1, 2026 – June 30, 2026 (Aug. 2026), https://www.cms.gov/files/document/cpi-quarterly-dashboard.pdf.
[23] U.S. Centers for Medicare and Medicaid Services, CMS Accomplishments, January 1, 2025 – December 31, 2025, Crushing Fraud, https://www.cms.gov/files/document/cpi-data-dashboard-december-update.pdf.
[24] U.S. DEP'T OF THE TREASURY, FINANCIAL CRIMES ENFORCEMENT NETWORK, FIN-2026-A001 FINCEN ADVISORY ON HEALTH CARE FRAUD SCHEMES TARGETING MEDICARE, MEDICAID, AND OTHER FEDERAL AND STATE HEALTH CARE BENEFIT PROGRAMS, 2 (Mar. 30, 2026), https://www.fincen.gov/system/files/2026-03/FinCEN-Advisory-Health-Care-Fraud.pdf.
[25] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-26-109100, COMBATTING FRAUD: MANAGING RISKS IN FEDERALLY FUNDED, STATE-ADMINISTERED PROGRAMS, 1 (July 23, 2026), https://www.gao.gov/assets/gao-26-109100.pdf.
[26] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (last visited Jan. 25, 2026).

include payment errors, insufficient documentation, or administrative processing failures.[27] Despite the limitations in measuring the total universe of Medicare and Medicaid fraud, the Committee's investigation showed that there are likely billions of dollars lost to fraud annually that constitute less than the overall estimate of improper payments but more than the aggregate recoveries from criminal cases.

A. Overview of the Medicaid Program

Medicaid is a jointly administered federal and state health insurance program for means-eligible vulnerable groups, including children, pregnant women, seniors, and individuals with disabilities.[28] Since the passage of the Patient Protection and Affordable Care Act, 41 states and the District of Columbia have expanded Medicaid to include adults with incomes up to 138 percent of the federal poverty level.[29] In fiscal year (FY) 2024, the Medicaid program spent over $957 billion.[30]

As a shared federal-state program, each state, district, and territory must operate its Medicaid program within federal guidelines and contribute a portion to its operation that is matched by the federal government via the Federal Medical Assistance Percentage (FMAP).[31] FMAP is determined by a state's per capita income, with a statutory floor of 50 percent.[32] Medicaid adult expansion populations receive an enhanced FMAP of 90 percent.[33]

As a requirement of receiving federal financial participation (FFP), the SMA must enter into a state plan agreement (SPA) with CMS that specifies the policies and procedures of the Medicaid program.[34] SPAs include details such as commitments to operate within federal rules; guidelines for optional eligibility tiers and services; state-specific eligibility standards and provider reimbursement; and other administrative procedures.[35] In addition to approving state plans and providing federal funds, CMS is responsible for providing states guidance and approving state plan amendments, waivers, and demonstrations.[36] Through these pathways, states

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[27] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-24-105833, FRAUD RISK MANAGEMENT: 2018-2022 DATA SHOW FEDERAL GOVERNMENT LOSES AN ESTIMATED $233 BILLION TO $521 BILLION ANNUALLY TO FRAUD, BASED ON VARIOUS RISK ASSESSMENTS (Apr. 16, 2024), https://www.gao.gov/products/gao-24-105833.
[28] U.S. Centers for Medicare and Medicaid Services, Medicaid Eligibility Policy, https://www medicaid.gov/medicaid/eligibility-policy (last visited July 29, 2026).
[29] Patient Protection and Affordable Care Act, Pub. L. No. 111-148; KFF, Status of State Medicaid Expansion Decisions (Aug. 21, 2026), https://www kff.org/medicaid/status-of-state-medicaid-expansion-decisions/.
[30] Medicaid and CHIP Payment and Access Commission, Exhibit 16. Medicaid Spending by State, Category, and Source of Funds, FY 2024 (Feb. 2026), https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf.
[31] Medicaid and CHIP Payment and Access Commission, Administration, https://www macpac.gov/medicaid-101/administration/ (last visited Mar. 5, 2026).
[32] *Id.*
[33] Medicaid and CHIP Payment and Access Commission, Federal Match Rate Exceptions, https://www macpac.gov/federal-match-rate-exceptions/ (last visited Sept. 2, 2026).
[34] 42 C.F.R. § 431.10.
[35] Medicaid and CHIP Payment and Access Commission, State Plan (Aug. 14, 2019), https://www macpac.gov/subtopic/state-plan/.
[36] Medicaid and CHIP Payment and Access Commission, Administration, https://www macpac.gov/medicaid-101/administration/ (last visited Sept. 2, 2026).

may modify their Medicaid program to fit specific needs in their state or implement new ways to deliver health care services.[37]

Both the federal government and states share responsibility for program integrity measures to reduce fraud, waste, and abuse (FWA) in the Medicaid program.[38] For SMAs, 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.[39]

CMS assists states with program integrity efforts through State Program Integrity Reviews, which target high-risk service areas for focused examination of a state's capacity for case tracking and referrals, managed care, statutory and regulatory compliance, overpayment identification and recovery, personal care services (PCS), pre-payment and post-payment review, surveillance and utilization systems, and territory oversight operations.[40] Recent focused program integrity reviews of PCS have been completed in Ohio, Maine, Montana, Arkansas, and Tennessee.[41] Another way that CMS provides SMAs with program integrity resources is through the CMS Medicaid Integrity Institute, offering 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."[42]

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.[43] Three formal CMS processes for holding states accountable and preventing the payment of improper or fraudulent claims are deferrals, disallowances, and withholding of FFP.[44] A deferral temporarily delays payment while CMS reviews questioned costs.[45] A disallowance is made to deny federal payment after a state fails to provide necessary documentation substantiating a claim or when CMS determines that a claim is not allowable under federal requirements.[46] Lastly, CMS may withhold future FFP when a state fails to comply with federal requirements or implement a prescribed corrective action plan.[47] CMS may continue withholding FFP until the state comes

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[37] U.S. Centers for Medicare and Medicaid Services, About Section 1115 Demonstrations, https://www medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations (last visited Sept. 2, 2026).
[38] Medicaid and CHIP Payment and Access Commission, Administration, https://www macpac.gov/medicaid-101/administration/ (last visited Sept. 2, 2026).
[39] U.S. Centers for Medicare and Medicaid Services, Center for Program Integrity, https://www.cms.gov/about-cms/leadership/center-program-integrity (last visited Sept. 2, 2026).
[40] U.S. Centers for Medicare and Medicaid Services, State Program Integrity Reviews, https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/stateprogramintegrityreviews (last visited Sept. 2, 2026).
[41] U.S. Centers for Medicare and Medicaid Services, Focused Program Integrity Reviews by State or Territory, https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/focused-program-integrity-review-reports-state-or-territory (last visited Aug. 4, 2026).
[42] *Id.* at 38; U. S. Centers for Medicare and Medicaid Services, Medicaid Integrity Institute (MII), https://www.cms.gov/medicaid-chip/medicare-coordination/integrity-institute (last visited Sept. 2, 2026).
[43] 42 C.F.R. § 430 et seq.
[44] *Id.*
[45] 42 C.F.R. § 430.40.
[46] 42 C.F.R. § 430.42.
[47] 42 C.F.R. § 430.35.

into compliance.[48] These mechanisms give CMS the leverage needed to enforce program standards, promote fiscal responsibility, and ensure that federal Medicaid dollars are used appropriately.

SMAs are the first line of defense against Medicaid fraud.[49] 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."[50] Federal regulations require SMAs to have fraud detection and investigation programs in place and suspend payments if there is a credible allegation of fraud.[51] States must investigate all 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.[52]

Federal regulations require SMAs to refer all cases of suspected Medicaid provider fraud to the Medicaid Fraud Control Unit (MFCU) and cooperate with MFCU investigations.[53] All 50 states (except for Hawaii and New York), 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.[54] MFCUs investigate and prosecute Medicaid fraud, in addition to patient abuse and neglect.[55] Certified MFCUs receive 75 percent of their operating funds from the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), which oversees this award by annually assessing performance and compliance with federal regulations.[56]

Federal law requires states to establish Medicaid Recovery Audit Contractor (RAC) programs, which identify and correct improper payments on fee-for-service (FFS) Medicaid

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[48] *Id.*
[49] *See* 42 C.F.R. § 455 Subpart A.
[50] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, 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.
[51] 42 C.F.R. § 455 subpart A.
[52] 42 C.F.R. § 455.13 et seq.
[53] 42 C.F.R. § 455.21.
[54] U.S. Dep't of Health and Human Services Office of Inspector General, Medicaid Fraud Control Units, https://oig hhs.gov/fraud/medicaid-fraud-control-units-mfcu/ (last visited July 30, 2026); *see* Letter from The Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services, to The Hon. Anne E. Lopez, Attorney General, State of Hawaii, and Landon M. M. Murata, Director, 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; *see* Letter from The. Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services, to The Hon. Letitia A. James, Attorney General, State of New York, and Amy Held, Director, Medicaid Fraud Control Unit, State of New York (June 30, 2026), https://oig hhs.gov/documents/medicaid-fraud-control-units/11727/NY_MFCU.pdf (on June 4, 2026, HHS-OIG decertified the Hawaii MFCU and on June 30, 2026, HHS-OIG decertified the New York MFCU, citing ineffective case outcomes for Medicaid fraud enforcement actions in both units).
[55] *Id.*
[56] U.S. Dep't of Health and Human Services Office of Inspector General, Medicaid Fraud Control Units, General Terms and Conditions, https://oig hhs.gov/fraud/medicaid-fraud-control-units-mfcu/terms-conditions/ (last visited Sept. 18, 2026).

claims.[57] States may seek full 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."[58] 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 about their findings.[59]

B. Overview of the Medicare Program

Medicare is a federal health insurance program for qualifying seniors aged 65 and older, in addition to certain groups eligible due to disability or disease.[60] Medicare provides comprehensive hospital insurance (Part A) with several optional benefits for supplementary coverage of medical services and supplies, including physicians' services, laboratory services, DME, and some home health services (Part B), and prescription drug benefits (Part D).[61] Beneficiaries can also opt to receive comprehensive coverage under Medicare Advantage (Part C) as an alternative to traditional Medicare.[62]

CMS, with the assistance of contractors, is responsible for Medicare program integrity. This includes certifying provider and supplier enrollment and revalidation, claims review, identifying and recovering improper payments, identifying fraud, and referring credible allegations of fraud to law enforcement.[63] CMS program integrity contractors consist of Unified Program Integrity Contractors (UPIC), Supplemental Medical Review Contractors (SMRC), and Medicare Administrative Contractors (MAC).[64] According to the CMS Medicare Program Integrity Manual:

> The focus of the UPICs, SMRCs and MACs shall be to ensure compliance with Medicare regulations, refer suspected fraud and abuse to our Law Enforcement (LE) partners, and/or recommend revocation of providers that are non-compliant with Medicare regulation and policies.[65]

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[57] Social Security Act, Pub. L. No. 74-271 § 1902(a)(42), as amended, 49 Stat. 620 (1935); U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, REPORT TO CONGRESS – MEDICARE AND MEDICAID INTEGRITY PROGRAMS FOR FISCAL YEAR (FY) 2024, 28 (Sept. 2025), https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf.
[58] *Id.*
[59] 42 C.F.R. § 455.508(h).
[60] U.S. Dep't of Health and Human Services, Who's eligible for Medicare?, https://www hhs.gov/answers/medicare-and-medicaid/who-is-eligible-for-medicare/index html (last visited July 29, 2026).
[61] Paulette C. Morgan and Phoenix Voorhies, CONG. RESEARCH SERV., IF10885, MEDICARE OVERVIEW, 1 (last updated July 8, 2024), https://www.congress.gov/crs-product/IF10885.
[62] U.S. Centers for Medicare and Medicaid Services, Compare Original Medicare & Medicare Advantage, https://www medicare.gov/basics/get-started-with-medicare/get-more-coverage/your-coverage-options/compare-original-medicare-medicare-advantage (last visited Sept. 23, 2026).
[63] U.S. Centers for Medicare and Medicaid Services, Pub. 100-08- Medicare Program Integrity Manual, https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms-items/cms019033.
[64] *Id.* at Chapter 4.
[65] *Id.* at Chapter 4.1.

Similarly, Medicare provider and supplier enrollment, revalidation, and change of ownership applications are screened by MACs.[66] Federal regulations prescribe the provider risk levels of Medicare providers based on CMS' assessment of their risk.[67] State Medicaid programs must follow the screening requirements established by Medicare for providers that also operate in the Medicaid program.[68] For limited risk providers, the MAC: [69]

- Verifies that a provider or supplier meets all applicable Federal regulations and State requirements for the provider or supplier type prior to making an enrollment determination.
- Conducts license verifications, including licensure verifications across State lines for physicians or nonphysician practitioners and providers and suppliers that obtain or maintain Medicare billing privileges as a result of State licensure, including State licensure in States other than where the provider or supplier is enrolling.
- Conducts database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type.

For moderate level providers, the MAC follows the limited risk screening requirements in addition to conducting an on-site visit.[70] For high risk providers, the MAC follows the limited and moderate risk requirements, but the MAC also:[71]

- Requires the submission of a set of fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier; and
- Conducts a fingerprint-based criminal history record check of the Federal Bureau of Investigation's Integrated Automated Fingerprint Identification System on all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier.

[66] *Id.* at Chapter 10; 42 C.F.R. §§ 424.518, 489.18.
[67] 42 C.F.R. § 424.518.
[68] *Id.*; U.S. Centers for Medicare and Medicaid Services, Medicaid Provider Enrollment Compendium, 19 (last updated Nov. 17, 2025), https://www medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf.
[69] 42 C.F.R. § 424.518(a)(2).
[70] 42 C.F.R. § 424.518(b)(2).
[71] 42 C.F.R. § 424.518(c)(2)(ii)

CMS adjusts an individual provider's risk level from limited or moderate to high in several circumstances, including if a provider has been excluded from any federal health care program in the past.[72]

Despite Medicare being federally administered, states play an important role in overseeing Medicare providers by granting licenses and surveying or certifying certain providers as a requirement for enrollment in Medicare.[73] SMAs may audit state Medicaid providers that are also enrolled as Medicare providers and uncover findings relevant to the entities' compliance with Medicare requirements.[74]

Additionally, a state Attorney General and the MFCU may investigate fraud by Medicaid providers that also operate in the Medicare program.[75] As referenced in the screening requirements for limited risk providers, state licenses and requirements are verified before a provider can be enrolled in Medicare.[76] For example, hospice providers operating in California must first be licensed by the California Department of Public Health.[77] A March 2022 California State Auditor Report found "cases in which [the California Department of] Public Health became aware of possible fraud during the [hospice] licensing process and instead of denying the licenses, it granted licenses to these hospice agencies."[78] Adequate state inspection upon Medicare provider licensure and renewal of licensure can potentially make a substantial impact on identification of fraudulent providers.

C. Types of Health Care Fraud

There are numerous ways that Medicare and Medicaid fraud schemes are commonly carried out.[79] The Federal Bureau of Investigation (FBI) and CMS have identified certain types of health care fraud schemes that are commonly committed against both public and private payers.[80] Overarching types of health care fraud schemes in Medicare and Medicaid include medical identity theft (patients and physicians), billing for unnecessary services or items, billing for services not rendered or furnished, upcoding, unbundling, and kickbacks.[81]

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[72] 42 C.F.R. § 424.518(c)(3).
[73] 42 C.F.R. § 424.510(d)(2)(iii); 42 C.F.R. Part 488.
[74] Documents on file with the Comm.
[75] 42 C.F.R. § 455 Subpart A; 42 C.F.R. § 1007 Subpart B.
[76] 42 C.F.R. § 424.518(a)(2)(i-ii).
[77] California Dep't of Public Health, Hospice Agency Initial Application Packet, https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AppPacket/Hospice-Initial.aspx# (last visited Aug. 25, 2026); AUDITOR OF THE STATE OF CALIFORNIA, REPORT 2021-123, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, 10 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf.
[78] AUDITOR OF THE STATE OF CALIFORNIA, REPORT 2021-123, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, 2 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf.
[79] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf.
[80] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf; U.S. Dep't of Justice, Federal Bureau of Investigation, Health Care Fraud, https://www.fbi.gov/investigate/white-collar-crime/health-care-fraud (last visited July 29, 2026).
[81] *Id.*

Public health care programs are vulnerable to fraud because of their size, complexity, and FFS payment models that pay providers by claim volume.[82] In addition to financial losses by payers and the government, Medicare and Medicaid beneficiaries are exploited in fraud schemes through identity theft or loss of services.[83] In Medicare and Medicaid, fraud enforcement is traditionally undertaken after a fraudulent claim is paid.[84] This is known as the "pay and chase" model, which results in reliance on law enforcement bodies to investigate, prosecute, and recoup fraudulent claims after payment.[85]

Provider fraud is perpetrated via billing, coding, or payment schemes. One common method is a provider submitting multiple claims for the same service, known as double billing.[86] Providers may also perpetrate phantom billing, where they bill services for patients that they may have never seen, or medical supplies that a patient never received.[87] Phantom billing can be extremely profitable for fraudsters to bill a high volume of claims for inexpensive DME or services and avoid scrutiny.[88] Unbundling is another common scheme where providers fragment billing for tests or procedures, that are required to be billed together to reduce costs, into separate components to increase reimbursement rates.[89] Providers may also participate in upcoding by billing a patient for a more complex or expensive service than they actually received.[90]

In addition, providers may participate in illegal kickback schemes, defined as:

> [O]ffering, soliciting, paying, or receiving remuneration (in kind or in cash) to induce, or in return for[,] referral of patients or the generation of business involving any item or service for which payment may be made under federal health care program[s].[91]

Finally, legitimate providers may themselves become victims of fraud if their billing credentials are used by fraudsters to facilitate schemes that require a physician's authorization.[92]

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[82] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/ (last visited July 29, 2026).
[83] *Id.*
[84] University of Utah Marriner S. Eccles Institute for Economics and Quantitative Analysis, Regulate Before or Litigate After? How to Combat Medicare Fraud, https://marriner.eccles.utah.edu/regulate-before-or-litigate-after-how-to-combat-medicare-fraud/ (last visited July 29, 2026).
[85] *Id.*
[86] U.S. Dep't of Justice, Federal Bureau of Investigation, Health Care Fraud, https://www fbi.gov/investigate/white-collar-crime/health-care-fraud (last visited July 29, 2026).
[87] *Id.*
[88] *See* Dan Diamond and Lauren Weber, *Inside Operation Gold Rush, largest health care fraud bust in U.S. history*, THE WASH. POST (Jun. 30, 2025), https://www.washingtonpost.com/health/2025/06/30/health-care-fraud-bust-largest-in-us-history/.
[89] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf.
[90] U.S. Dep't of Justice, Federal Bureau of Investigation, Health Care Fraud, https://www fbi.gov/investigate/white-collar-crime/health-care-fraud (last visited July 29, 2026).
[91] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf.
[92] U.S. Centers for Medicare and Medicaid Services, Center for Program Integrity, Victimized Provider Project, https://www.cms.gov/about-cms/components/cpi/victimizedproviderproject (last visited Aug. 6, 2026).

Some types of health care fraud schemes disproportionately harm program beneficiaries. One method of fraud against patients is misleading marketing that may involve kickbacks and patient referrals.[93] This involves deceptive tactics that may influence a beneficiary to select a specific health plan, provider, or service that does not meet the beneficiary's medical needs.[94] In these schemes, criminals may take advantage of a beneficiary's need for assistance in navigating the complicated health care system for their own self-interest.[95] In identity theft-enabled schemes, criminals obtain a beneficiary's personally identifiable information or beneficiary number and bill for goods or services that were never provided.[96]

D. Federal Health Care Fraud Statutes

Several federal statutes govern health care fraud enforcement under Medicare and Medicaid. Federal law establishes civil monetary penalties for individuals that commit fraud, submit false claims, or commit other unlawful acts against Medicare or Medicaid.[97] Under the federal health care fraud statute, fraud is defined as:

> Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice to defraud a health care benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services [...].[98]

1. False Claims Act

Health care fraud may be prosecuted under the False Claims Act, which enacted civil liability for certain acts, including any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" and "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim."[99] In addition to the government, private citizens with knowledge of fraud may file *qui tam* suits on behalf of the government against those that have perpetrated fraud in government programs.[100] Private citizens bringing successful *qui tam* suits may receive a percentage of the recovered funds collected by the government.[101]

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[93] U.S. Dep't of Health and Human Services Office of Inspector General, Special Fraud Alert: Suspect Payments in Marketing Arrangements Related to Medicare Advantage and Providers (Dec 11, 2024), https://oig hhs.gov/documents/special-fraud-alerts/10092/Special%20Fraud%20Alert:%20Suspect%20Payments%20in%20Marketing%20Arrangements%20Related%20to%20Medicare%20Advantage%20and%20P.pdf.
[94] *Id.*
[95] *Id.*
[96] U.S. Centers for Medicare and Medicaid Services, Common Types of Health Care Fraud (July 2016), https://www.cms.gov/files/document/overviewfwacommonfraudtypesfactsheet072616pdf.
[97] 42 C.F.R. § 1320a-7a.
[98] 18 U.S.C. § 1347.
[99] 31 U.S.C. § 3729.
[100] U.S. Dep't of Justice, Civil Division, The False Claims Act, https://www.justice.gov/civil/false-claims-act (last visited Aug. 6, 2026).
[101] *Id.*

Currently, 29 states have state-level False Claims Acts, with Louisiana, Michigan, New Hampshire, Texas, and Washington having "Medicaid only" False Claims Acts.[102] HHS-OIG grants states with False Claims Act laws that meet certain qualifications a financial incentive of a 10-percentage point increase in their share of amounts recovered under the laws.[103] Not all states with False Claims Acts have been granted a financial incentive by HHS-OIG.[104]

For HHS-OIG to grant the financial incentive, a state False Claims Act must do the following:

- Establish liability to the State for false or fraudulent claims, as described in the Federal False Claims Act (FCA), with respect to Medicaid spending;
- Contain provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described in the FCA;
- Contain a requirement for filing an action under seal for 60 days with review by the State Attorney General; and
- Contain a civil penalty that is not less than the amount of the civil penalty authorized under the FCA.[105]

2. Anti-Kickback Statute

The Anti-Kickback Statute prohibits receiving any "renumerations" or payment of anything of value, in exchange for patient referrals or generating business in any service payable by a federal health care program, such as Medicare or Medicaid.[106] The Physician Self-Referral Law (also known as the Stark Law) limits doctors from referring patients to certain designated health services payable by Medicare and Medicaid, including clinical laboratory services, DME, home health services, and outpatient prescription drugs, if they are entities in which the doctor or an immediate family member has a financial stake.[107]

3. Exclusion Authority

HHS-OIG has mandatory exclusion authority, meaning it can exclude an individual or entity from participation in federal health care programs when there has been a conviction of certain crimes including Medicare or Medicaid fraud or other convictions for health care

[102] The Anti-Fraud Coalition, State False Claims Acts, https://www.taf.org/resources/state-false-claims-acts/ (last visited Aug. 7, 2026).
[103] 42 U.S.C. § 1396h; U.S. Dep't of Health and Human Services Office of Inspector General, State False Claims Act Reviews, https://oig hhs.gov/fraud/state-false-claims-act-reviews/ (last visited Aug. 7, 2026).
[104] *Id.*
[105] *Id.*
[106] 42 U.S.C. § 1302a-7b(b).
[107] 42 U.S.C. § 1395nn.

fraud.[108] HHS-OIG has discretion over permissive exclusions, which can be related to misdemeanor convictions, fraud convictions in non-health care government-funded programs, submitting false or fraudulent claims to Medicare or Medicaid, or participation in kickback schemes.[109] The List of Excluded Individuals/Entities (LEIE), maintained by HHS-OIG, is publicly accessible and provides information on the individuals and organizations excluded from participating in federally funded healthcare programs.[110]

[108] 42 U.S.C. § 1320a-7.
[109] U.S. Dep't of Health and Human Services Office of Inspector General, Background Information & Exclusion Authorities, https://oig hhs.gov/exclusions/background-information-exclusion-authorities/ (last visited Aug. 7, 2026).
[110] *Id.*

V. Committee Investigation

A. Predicate for Investigation

The Committee has a well-established role in overseeing federal health care program integrity. Recent actions include comprehensive program integrity reform, oversight hearings, and investigations into fraud risks within Medicare and Medicaid.[111] This Congress, the Committee has noted emerging trends in Medicare and Medicaid, along with criminal investigations and prosecutions that reveal the urgency of addressing program integrity vulnerabilities. The Committee has observed and ascertained information regarding several overarching trends: reduced program integrity capacity at CMS under the Biden Administration, rising utilization and spending, continued reliance on reactive rather than proactive program integrity, and limited oversight of waivered Medicaid services. Together, these findings underscore the need for strengthened program integrity across federal health care programs.

1. Reduced Capacity at CMS during the Biden Administration

HHS Secretary Robert F. Kennedy Jr., recently described the concerning state of CMS' program integrity capabilities when he entered the agency in January 2025.[112] According to Secretary Kennedy, the Biden Administration and former HHS Secretary Xavier Becerra reduced Medicare and Medicaid program integrity staff from 80 to 6 personnel between January 2021 and January 2025.[113]

[111] *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.; *See, e.g.,* An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, 139 Stat. 77 (2025).
[112] U.S. Dep't of Health and Human Services, *Remarks by Secretary Robert F. Kennedy, Jr., Secretary, at news conference on combatting fraud at the U.S. Dep't of Health and Human Services, Washington, D.C.* (July 21, 2026), https://www.c-span.org/program/news-conference/hhs-secy-kennedy-dr-oz-and-others-news-conference-on-combating-fraud/683173.
[113] *Id.*; *see also The Fiscal Year 2027 Department of Health and Human Services Budget: Hearing Before H. Comm. on Energy and Commerce, Subcomm. on Health*, 119th Cong. at 25-26 (Apr. 21, 2026) (statement by Hon. Robert F. Kennedy, Jr., Secretary, U.S. Dep't of Health and Human Services), https://docs.house.gov/meetings/IF/IF14/20260421/119213/HHRG-119-IF14-Transcript-20260421.pdf.

At the Committee's April 21, 2026, hearing with Secretary Kennedy before the Subcommittee on Health, Chairman of the Energy and Commerce Committee Brett Guthrie asked Secretary Kennedy about program integrity, to which Secretary Kennedy testified: [114]

> **Q. Now that we are seeing waste, fraud, and abuse in Minneapolis, other places, not just in Medicaid but home health and others, in California, what has surprised you about what you have seen in the waste, fraud, and abuse? And what more do we need to be doing to deal with it? [...] What is the most shocking thing you have seen?**
>
> **A. Yeah. I mean, the most shocking thing to me was the Biden Administration opening the door to waste, fraud, and abuse. They implemented a new program called "pay and chase" where we have to pay people—we have ended this—we pay claims that we know to be fraudulent—and that is what they did during the Biden administration—and then go and try to claw back that money, which never happens.**
>
> **Another thing they did was, we had a program integrity office. There were 80 people in it, which was not enough to cover 50 states and six territories. They fired immediately all but six of them. So we have no program integrity department.**
>
> **They instructed people in my office that they should not be doing program integrity, that they could only validate enrollments, the legitimacy of enrollments, once a year [...] and that there was no pre-validation to them signing up. So they were just inviting people onto the rolls.**

As a result, CMS was not equipped to oversee Medicare and Medicaid program integrity because it was not operating at full capacity. Secretary Kennedy points to the reduced capacity at CMS as one of the reasons for the recent trends in Medicare and Medicaid fraud.[115]

2. Increased Program Spending

Increased spending has raised concerns about the extent to which fraud is inflating health care costs. Medicare spending continues to grow, magnifying the scrutiny of the projected

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[114] *The Fiscal Year 2027 Department of Health and Human Services Budget: Hearing Before H. Comm. on Energy and Commerce, Subcomm. on Health*, 119th Cong. at 25-26 (Apr. 21, 2026) (statement by Hon. Robert F. Kennedy, Jr., Secretary, U.S. Dep't of Health and Human Services), https://docs.house.gov/meetings/IF/IF14/20260421/119213/HHRG-119-IF14-Transcript-20260421.pdf.

[115] U.S. Dep't of Health and Human Services, *Remarks by Secretary Robert F. Kennedy, Jr., Secretary, at news conference on combatting fraud at the U.S. Dep't of Health and Human Services, Washington, D.C.* (July 21, 2026), https://www.c-span.org/program/news-conference/hhs-secy-kennedy-dr-oz-and-others-news-conference-on-combating-fraud/683173.

insolvency of the Medicare Hospital Insurance Trust Fund in 2033.[116] Medicaid spending is also rising and now represents the largest category of total state expenditures, accounting for an average of 30.7 percent of state budgets.[117] In 2024, national Medicaid spending increased 6.6 percent, with per enrollee costs increasing by 16.6 percent, even as enrollment declined by 8.6 percent following the conclusion of post-pandemic eligibility unwinding.[118]

Certain states are experiencing noticeable spikes in Medicaid spending. California, for example, is expected to increase its annual Medi-Cal spending from $83 billion a year in 2014 to $219.7 billion a year in 2027, nearly tripling program costs within 13 years.[119] New York is projected to spend 11 percent more on Medicaid from all funding sources in 2027—a total of $124 billion.[120] With limited options for tightening program budgets due to mandated eligibility and benefits, states must invest in program integrity efforts to ensure that payments for Medicaid services are made appropriately.

3. Increased Spending on Certain Services

Between 2021 and 2025, Medicaid spending on ABA services for children with autism grew six times faster than the number of children receiving the service, increasing 421 percent from $2 billion to over $10 billion per year nationally.[121]

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[116] BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS, 2026 ANNUAL REPORT, 8 (June 9, 2026), https://www.cms.gov/oact/tr/2026#page=64.
[117] National Association of State Budget Officers, 2025 State Expenditure Report: Fiscal Years 2023-2025, 41, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2025_SER/2025_NASBO_State_Expenditure_Report_S.pdf.
[118] U.S. Centers for Medicare and Medicaid Services, National Health Expenditures 2024 Highlights, https://www.cms.gov/files/document/nhe-infographic.pdf (last visited Aug. 3, 2026).
[119] Sally C. Pipes, *Too Big, Too Broken: Restoring Integrity to Medi-Cal*, PACIFIC RESEARCH INSTITUTE, 5 (July 2026), https://www.pacificresearch.org/wp-content/uploads/2026/07/MediCal_IssueBrief_July2026_F_web.pdf.
[120] Bill Hammond, *Healthcare Revelations in the Enacted Budget Financial Plan*, EMPIRE CENTER (June 26, 2026), https://www.empirecenter.org/publications/healthcare-revelations-in-the-enacted-budget-financial-plan/.
[121] U.S. Dep't of Justice and U.S. Dep't of Health and Human Services, *Remarks by Dan Brillman, Director of Medicaid and CHIP, U.S. Centers for Medicare and Medicaid Services, at news conference on combatting Medicaid fraud in Pennsylvania, Philadelphia, PA* (Aug. 4, 2026), https://www.c-span.org/program/news-conference/officials-holds-news-conference-on-combating-medicaid-fraud-in-pennsylvania/683668; U.S. Centers for Medicare and Medicaid Services, Autism Services, Autism Spectrum Disorder and Applied Behavior Analysis Data Book, August 2026, https://www medicaid.gov/medicaid/benefits/autism-services (last visited Aug. 18, 2026).

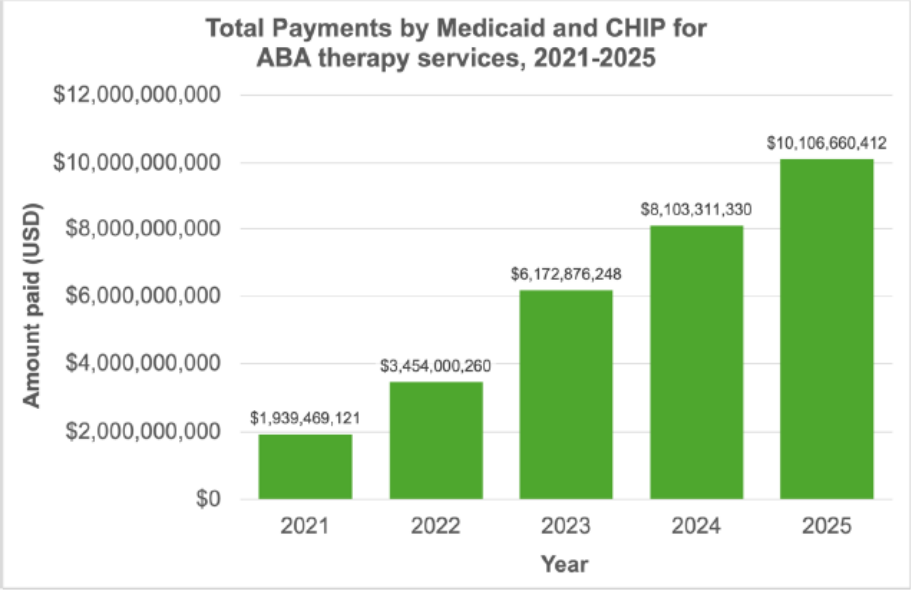

Figure 1: Total Payments by Medicaid and CHIP for ABA services from 2021 to 2025.[122]

Medicaid HCBS program expenditures have surged from $97.1 billion in 2019 to $145.91 billion in 2023, a 50 percent increase, while enrollment only grew 13.5 percent during that period.[123] In Medicare, DME expenditures have skyrocketed from $8.8 billion in 2018 to $18.5 billion in 2024.[124] Medicare payments for wound care allografts, medical supplies that are commonly known as skin substitutes, grew from $200 million in 2019 to $14.4 billion in 2025.[125]

4. Reactive Program Integrity

As described in Section IV, the "pay and chase" model refers to the traditional approach used by federal and state governments in which claims are paid first and the improper or fraudulent payment recovery is pursued afterward.[126] Recovering funds once they have been paid is difficult, and only a small share is typically recouped.[127] Under this investigative model, fraud

[122] U.S. Centers for Medicare and Medicaid Services, Autism Services, Autism Spectrum Disorder and Applied Behavior Analysis Data Book, August 2026, 10, https://www medicaid.gov/medicaid/benefits/autism-services (last visited Aug. 18, 2026).
[123] Alexandra Carpenter et al., Medicaid Long-Term Services and Supports Users and Expenditures by Service Category, 2023, Mathematica, 8 (Oct. 17, 2025), https://www medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-users-expenditures-category-brief-2023.pdf.
[124] U.S. Centers for Medicare and Medicaid Services, National Health Expenditure Data, National Health Expenditures by Type of Service and Source of Funds, CY 1960-2024, https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical.
[125] U.S. Dep't of Justice, 2026 National Health Care Fraud Takedown, Medicare Claims for Allografts | 2019-2026, https://www.justice.gov/criminal/criminal-fraud/2026-national-health-care-fraud-takedown (last visited Aug. 7, 2026).
[126] Pietje Kobus-McAllister, *Pay and Chase Construct is Tempting for Medicaid Fraudsters, Expert Says*, HCI Innovation Group (Aug. 18, 2025), https://www hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/news/55310573/pay-and-chase-construct-is-tempting-for-medicaid-fraudsters-expert-says.
[127] *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. at 27 (Mar. 17, 2026) (statement of Kimberly Brandt, Deputy Administrator and Chief Administrative Officer,

cannot be prevented before it occurs, allowing limited taxpayer dollars to be paid out to fraudsters with no guarantee that the funds can be recovered.

5. Limited Oversight of Home and Community-Based Service Programs

HCBS programs, which states can apply for under CMS Section 1915(c) waivers, include in-home PCS, which are intended to "meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting."[128] Some HCBS providers have low barriers to entry and less rigorous billing requirements than traditional health care providers, such as not having required National Provider Identifiers (NPI) if they do not meet the federal definition of a health care provider.[129] CMS, however, has identified providers without NPIs as being a higher fraud risk.[130] Self-directed caregiving, in which a patient employs an in-home caregiver that may be a relative or friend, has little oversight as it takes place in a patient's home and typically without other providers or patients around to witness.[131]

A. The Committee's Work in the 119th Congress

1. The Working Families Tax Cuts Law

In July 2025, Congress passed the Working Families Tax Cuts law (WFTC) and President Trump signed it into law, codifying needed reforms to target FWA in federal health care programs.[132] The WFTC Medicaid integrity provisions include:

- A moratorium on the implementation of rules relating to eligibility and enrollment in the Medicare Savings Program, thus allowing states to prevent improper enrollments and disenroll individuals who are ineligible for Medicaid.[133]

- Reducing duplicate enrollment under Medicaid and CHIP by requiring CMS to establish a system to prevent individuals from being simultaneously enrolled in multiple state Medicaid programs.[134] Since this provision was enacted, CMS has

U.S. Centers for Medicare and Medicaid Services), https://docs.house.gov/meetings/IF/IF02/20260317/119065/HHRG-119-IF02-Transcript-20260317.pdf.

[128] 42 C.F.R. § 441 Subpart G; U.S. Centers for Medicare and Medicaid Services, Home & Community-Based Services 1915(c), https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c (last visited Aug. 5, 2026).

[129] 45 C.F.R. § 160.103.

[130] Letter from The Hon. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Kay Ivey, Governor, State of Alabama, (Apr. 23, 2026), https://leadingage.org/wp-content/uploads/2026/04/042326-HHS-Letter-Alabama-Governor.pdf.

[131] *Id.*

[132] An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, 139 Stat. 77 (2025).

[133] *Id.*, § 71101.

[134] *Id.*, § 71103.

already eliminated 2.8 million duplicative enrollments across Medicaid, saving an estimated $14 billion.[135]

- Ensuring deceased individuals do not remain enrolled in Medicaid by requiring states to regularly review the Social Security Administration's Death Master File.[136]

- Ensuring deceased providers do not remain enrolled in Medicaid by requiring states to regularly review the Social Security Administration's Death Master File.[137]

- Payment reduction of federal financial participation in Medicaid related to certain erroneous excess payments.[138]

- Eligibility redeterminations for expansion population adults every six months.[139]

- Preventing new or increased abuses of provider taxes.[140]

- Establishing limits on State Directed Payments made through Medicaid managed care.[141]

- Requiring able-bodied adult Medicaid beneficiaries to meet 80-hours per month of qualifying activities, such as employment, community service, participation in certain work programs, or enrollment in educational programs.[142]

Similarly, the WFTC reformed the Medicare program, including limiting Medicare coverage to U.S. citizens, permanent lawful residents, and certain immigrants with temporary protected status, refugees, or asylum seekers.[143]

2. Committee Inquiries and Hearings

i. Inquiry About Hospice and Home Health Fraud in Los Angeles County, California

On January 9, 2026, the Committee, alongside the House Committee on Ways and Means, sent a letter to HHS Inspector General T. March Bell about concerning evidence and

[135] Centers for Medicare and Medicaid Services, CMS Finds 2.8 Million Americans Potentially Enrolled in Two or More Medicaid/ACA Exchange Plans (July 17, 2025), https://www.cms.gov/newsroom/press-releases/cms-finds-28-million-americans-potentially-enrolled-two-or-more-medicaid/aca-exchange-plans.
[136] An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, § 71104, 139 Stat. 77 (2025).
[137] *Id.*, § 71105.
[138] *Id.*, § 71106.
[139] *Id.*, § 71107.
[140] *Id.*, § 71115.
[141] *Id.*, § 71116.
[142] *Id.*, § 71119.
[143] *Id.*, § 71201.

trends in home health and hospice fraud in Los Angeles (L.A.) County, California.[144] The Committees shared information with Inspector General Bell about an influx of home health agencies (HHA) and hospices in L.A. County that indicate fraudulent billing practices and potential ties to transnational criminal organizations.[145] The Committees were concerned about data from a March 2022 California State Auditor's Report and HHS hospice ownership data, showing that L.A. County had more than 31 percent of the hospice agencies in the U.S. in 2022.[146] Despite a statewide freeze on new hospice licenses by the California Department of Public Health that has been in place since January 1, 2022, 15 new hospices located in a building in L.A. County flagged as suspicious still received Medicare certification in 2023.[147]

The same day the Committees wrote to Inspector General Bell, CMS Administrator Mehmet Oz, along with the top-ranking prosecutor in the U.S. Attorney's Office in L.A., announced that CMS and DOJ were cracking down on HHA and hospice fraud in L.A. County where billing rates reached $3.5 billion for these two health care sectors.[148] According to CMS, "[r]ecent CMS action, undertaken in coordination with Vice President JD Vance's Anti-Fraud Task Force, has included the suspension of payments to approximately 800 hospices and HHAs suspected of fraud in L.A. alone that were responsible for $1.4 billion in Medicare spending last year, with $70 million in suspended funds thus far."[149]

ii. Inquiry about Medicaid Fraud in Minnesota

On January 16, 2026, the Committee launched an investigation into Minnesota's Medicaid program after prosecutions and alarming allegations of wide-scale fraud were uncovered in the state's Medicaid program.[150] Numerous individuals have been charged and convicted in various Medicaid fraud schemes, including Housing Stabilization Services (HSS),

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[144] Letter from The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., to The Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services (Jan. 9, 2026), https://d1dth6e84htgma.cloudfront.net/1_9_2026_HHS_OIG_Letter_1_4ad020643d.pdf.

[145] *Id.*

[146] AUDITOR OF THE STATE OF CALIFORNIA, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, REPORT 2021-123, 25 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf; U.S. Dep't of Health and Human Services Assistant Secretary for Planning and Evaluation, Hospice Agency Changes of Ownership: An Analysis of Publicly Available Ownership Data, Issue Brief (Jan. 10, 2025), https://aspe.hhs.gov/sites/default/files/documents/d5de5b564c2eb67de9c65900ffffca6f/hospice-agency-changesownership.pdf.

[147] Cal. S.B. 664, 2021–2022 Reg. Sess. (2021) (codified at Cal. Health & Safety Code §§ 1747–1747.16); Cal. Assemb. B. 177, 2023–2024 Reg. Sess. § 1 (Cal. 2024); Ava Kofman, *Medicare Certifies Hospices in California Despite State Ban on New Licenses,* PROPUBLICA (Jan. 25, 2024), https://www.propublica.org/article/medicare-californiahospice-care-fraud-southwest.

[148] Sonja Sharp, *Dr. Oz touts federal crackdown on healthcare fraud by 'foreign influences' in L.A.,* LOS ANGELES TIMES (Jan. 9, 2026), https://www.latimes.com/california/story/2026-01-09/dr-oz-healthcare-fraud-crackdown.

[149] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice and Home Health Agency Enrollment Moratoria (May 13, 2026), https://www.cms.gov/newsroom/press-releases/cms-announces-aggressive-nationwide-crackdown-fraud-six-month-hospice-home-health-agency-enrollment.

[150] 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 Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

Early Intensive Developmental and Behavioral Intervention (EIDBI), Integrated Community Supports (ICS), and in-home PCS programs.[151] According to the U.S. Attorney's Office for the District of Minnesota, some of these programs had "low barriers to entry and minimal records requirements for reimbursement," allowing criminals to perpetrate fraud, in some cases across state lines.[152] The Committee requested documents, communications, and information regarding Minnesota's Medicaid program and the efforts it is taking to eliminate fraud.[153] Committee staff reviewed over 9,300 pages of documents and information that were produced by Minnesota in response to the Committee's request.

iii. Oversight and Investigations Subcommittee Hearing Featuring Health Care Fraud Experts

FINDING: Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars per year. Rampant fraud jeopardizes the longevity and purpose of Medicare and Medicaid to deliver necessary health care services to vulnerable patients. Federal health care programs have limited resources, and every dollar spent on fraud is a dollar not going to a beneficiary that needs these critical services.

On February 3, 2026, the Subcommittee on Oversight and Investigations held a hearing titled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid" where health care fraud expert witnesses explored the prevalence of Medicare and Medicaid fraud schemes occurring nationwide.[154] Fraud experts discussed the common schemes fraudsters use to perpetrate Medicare and Medicaid fraud across the U.S., how fraud schemes have changed over time, and aspects of program design that make certain provider types more vulnerable to fraud.[155]

With respect to Medicare, the Subcommittee examined the role of transnational criminal actors in recent Medicare fraud schemes targeting DME, the vulnerability of hospice, genetic testing, clinical laboratory services, and skin substitutes, along with FWA and the harm to beneficiaries from medical identity theft.[156] The hearing also reinforced the fact that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators nationally are

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[151] *Id.*
[152] Press Release, U.S. Attorney's Office, District of Minnesota, Six Additional Defendants Charged, One Defendant Pleads Guilty in Ongoing Fraud Schemes (Dec. 18, 2025), https://www.justice.gov/usao-mn/pr/six-additional-defendants-charged-one-defendant-pleads-guilty-ongoing-fraud-schemes; Press Release, U.S. Dep't of Justice, Fraud Tourists Plead Guilty to Minneapolis Medicaid Fraud (Feb. 10, 2026), https://www.justice.gov/opa/pr/fraud-tourists-plead-guilty-minneapolis-medicaid-fraud.
[153] 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 Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[154] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong., (Feb. 3, 2026), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Transcript-20260203.pdf.
[155] *Id.*
[156] *Id.*

observing "fraud schemes across state lines far more than they used to."[157] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services, NEMT, HCBS, laboratory services, SUD treatment, and hospice.[158]

iv. Inquiries to Ten Additional States about Medicaid Program Integrity

On March 3, 2026, as part of the Committee's ongoing oversight and investigative work, the Committee sent letters to a sample of ten additional states across the country, requesting documents and information on state Medicaid programs and program integrity efforts.[159] The Committee requested documents and information from California, Colorado, Massachusetts, Maine, Nebraska, New York, Oregon, Pennsylvania, Vermont, and Washington.[160] The Committee picked a sample of states after looking at a variety of publicly available reports and data, including Medicaid and CHIP Payment and Access Commission (MACPAC) spending and enrollment data;[161] recent cases of Medicaid fraud occurring in certain services;[162] and recent audits and reports that identified certain Medicaid programs of concern.[163] Committee staff reviewed over 96,000 pages of documents and information provided by the ten states relating to states' identification and auditing of fraud risks, processes for making criminal referrals, provider screening and revalidation processes, use of data analytics, improper payment and recovery efforts, and oversight of fiscal intermediaries.[164]

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[157] *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.

[158] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and 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 and Commerce, Subcomm. on Oversight and 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.

[159] 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.

[160] *Id.*

[161] Medicaid and Chip Payment and Access Commission, MACStats (Feb. 2026), https://www macpac.gov/macstats/.

[162] *See, e.g.*, Press Release, U.S. Attorney's Office, District of Minnesota, Six Additional Defendants Charged, One Defendant Pleads Guilty in Ongoing Fraud Schemes (Dec. 18, 2025), https://www.justice.gov/usao-mn/pr/six-additional-defendants-charged-one-defendant-pleads-guilty-ongoing-fraud-schemes; Press Release, U.S. Dep't of Justice, Fraud Tourists Plead Guilty to Minneapolis Medicaid Fraud (Feb. 10, 2026), https://www.justice.gov/opa/pr/fraud-tourists-plead-guilty-minneapolis-medicaid-fraud.

[163] *See, e.g.*, U.S. Dep't of Health and Human Services Office of Inspector General, SRS-A-25-029, Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/ (last updated Feb. 25, 2026).

[164] 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.

v. Oversight and Investigations Subcommittee Hearing Featuring CMS Deputy Administrator and Chief Operating Officer Kimberly Brandt

On March 17, 2026, the Subcommittee on Oversight and Investigations held a hearing with CMS Deputy Administrator and Chief Operating Officer Kimberly Brandt entitled "Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud."[165] Deputy Administrator Brandt highlighted high-risk programs experiencing high rates of fraud in Medicare and Medicaid, including hospice, home health, DME, ABA, and PCS.[166] Deputy Administrator Brandt also discussed the real patient harm that results from Medicare and Medicaid fraud.[167]

In addition to discussing the scope of the fraud CMS is seeing in Medicare and Medicaid, Deputy Administrator Brandt described the extensive work that CMS is doing to combat fraud in these programs, including moving away from the "pay and chase" model to pre-payment analytics, keeping taxpayer dollars from being paid out to fraudsters rather than relying on payment recovery of fraudulent claims after the fact.[168] Additionally, Deputy Administrator Brandt described how CMS is deploying pre-payment review and payment suspensions powered by data analytics and artificial intelligence (AI).[169] Lastly, Deputy Administrator Brandt discussed how CMS is developing a 50-state playbook as a guide to program integrity best practices that states can apply to Medicaid programs.[170]

vi. Oversight and Investigations Subcommittee Hearing Featuring State Medicaid Directors

On June 25, 2026, the Subcommittee on Oversight and Investigations held a hearing titled "State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies," featuring the State Medicaid Directors of Minnesota, California, New York, and Ohio.[171] At the hearing, Members of the Committee raised concerns about state Medicaid program integrity nationwide, as well as what actions are being taken in the four states to address and root out fraud amid recent allegations.[172]

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[165] *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.
[166] *Id.*
[167] *Id.*
[168] *Id.*
[169] *Id.*
[170] *Id.*
[171] *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong. (June 25, 2026), https://docs.house.gov/meetings/IF/IF02/20260625/119405/HHRG-119-IF02-Transcript-20260625.pdf.
[172] *Id.*

Chairman Guthrie questioned Amir Bassiri, the New York State Medicaid Director, about the state's failure to provide certain information to the Committee in the course of its investigation: [173]

> **Q. New York has failed to provide certain information in response to our – to the Committee's letter. For example, you have not provided simple information such as all the state's designated risk levels for Medicaid-only providers – types. I would also note that you only provided the basic information that was requested about the frequency of on-site visits in yearly improper payment and recovery efforts the day before. Why have you been unable to provide that information to the Committee?**
>
> **A. Thank you for the question, Chairman. We have been as responsive as we can. We're handling many inquiries from both the committee, the Center for Medicare and Medicaid Services, and HHS-OIG, but I'm happy to take that back, and we will –**
>
> **Q. We brought this up to you on March the 3rd. It's now June 25th. If your agency doesn't have this information readily accessible, that is a problem in itself. But the committee and the American people deserve to have transparency of how New York and all states are operating in their program. And will you commit to providing that information to this committee that we have requested?**
>
> **A. Thank you for the follow-up. We agree that transparency is paramount. I can't commit to that here, but I'm happy to take that back and get back to you as soon as possible.**
>
> **Q. You can't commit to providing this information I just laid out?**
>
> **A. I think we've been – I'm happy to take that back and get back to you.**

New York later provided the requested information to the Committee, which is discussed in more detail in Section VII. Director Bassiri also discussed New York's current efforts to shore up program integrity, stating, "[w]e completely agree that the front door to the program is [a] very important safeguard."[174] However, when asked about at what point the state suspends payments due to suspected fraud, Director Bassiri stated, "it's very important for us to prioritize continuity of care or ensure that access can be provided if an instance like that is reached."[175]

[173] *Id.* at 47-48 (statement of Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce).
[174] *Id.* at 78 (statement of Amir Bassiri, State Medicaid Director, New York Dep't of Health).
[175] *Id.* at 89 (statement of Amir Bassiri, State Medicaid Director, New York Dep't of Health).

Chairman Guthrie questioned California State Medicaid Director Tyler Sadwith regarding California's failure to provide requested Medicaid provider audits to the Committee: [176]

> **Q. The Committee requested documents and information from your agency on March 3, including 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. I think that is about the time you said the licensing was ceased. I think I said – I might have said in home; I think it was hospice care when I was referring earlier. Based on the information that has been provided to the Committee, we know that California has conducted such audits, but the committee did not receive a single audit document from California until 7:00 p.m. last night.**
>
> **Do you believe that providing more than 1,300 pages of documents on the eve of a hearing is fair to this committee?**
>
> **A. Thank you, Chairman, and I acknowledge the frustration. We have been working with Committee staff to produce information and address the questions, including the list of 26,000 audits and investigations that we have conducted over the past 5 years. Last night we provided some audits related to transportation and mental health that the committee had indicated were –**
>
> **Q. There were also others that we have requested. Do you commit to providing that – what we have requested to this Committee in a timely manner?**
>
> **A. Thank you, Chairman. There are ongoing law enforcement investigations that would be impacted by those specific audits that were requested. We're happy to provide the appropriate information at the appropriate time.**
>
> **Q. Well, I would say it just seems unfair to us to prepare for a hearing that you send everything at 7:00 p.m. last night. It almost seems like that was intentional. It appears that way.**

California subsequently provided most of the requested audits to the Committee, examined further in Section VII.

[176] *Id.* at 49-50 (statement of Tyler Sadwith, State Medicaid Director, California Dep't of Health Care Services).

Subcommittee on Oversight and Investigations Chairman John Joyce, M.D., asked Director Sadwith about California's decision to classify all Medicaid-only provider types as limited risk: [177]

> **Do all of California's Medicaid providers being considered as limited risk really reflect what you are seeing in these programs?**
>
> **[…]**
>
> **By classifying all Medicaid-only programs as limited risk, are you saying that all of these programs really show that – limited risk as far as fraud goes?**
>
> **A. Thank you for the question. So, the risk classification, categorical risk level classification, is one of many tools that we use to assess program risk.**
>
> **Q. Is this adequate? When you paint with one brush all of those as limited risk, which requires less oversight, are you missing fraud?**
>
> **A. We employ a number of safeguards to prevent bad actors from entering the program for in-home supportive services, specifically. We do conduct fingerprint and criminal background checks, which is one of the features of a high risk categorical level designation. So even though –**
>
> **Q. But is that – that is high risk, but we are talking about limited risk which you ascribed to all Medicaid-only providers. Does that catch all the fraudsters, or should this be more of an individualized approach, and not painting just with one brush? Is there an opportunity to really […] weed out the fraud at its beginning stages?**
>
> **A. Absolutely, I share your focus on –**
>
> **Q. Have you previously designated any Medicaid-only provider types that were classified as moderate or high risk?**
>
> **A. To my knowledge, we have not classified any Medicaid-only provider types.**

Minnesota Temporary Commissioner of Human Services and State Medicaid Director, John Connolly, acknowledged ABA fraud in his state and pointed to the benefit of elevating a

[177] *Id.* at 40-41 (statement of Tyler Sadwith, State Medicaid Director, California Dep't of Health Care Services).

service to the high risk category, which "comes with enhanced fingerprint background checks, unannounced site visits, and more frequent revalidation."[178] When questioned about the characteristics of the 14 programs in Minnesota that have recently experienced fraud vulnerabilities, Temporary Commissioner Connolly admitted that "it starts with the design and the policy around the program."[179]

Lastly, Scott Partika, Ohio State Medicaid Director, highlighted the benefits of the WFTC on strengthening Ohio's Medicaid program and discussed the positive impact of improved data sharing on the state's ability to prevent Medicaid fraud.[180] Director Partika also discussed Medicaid fraud trends in Ohio: [181]

> **Q. So my question to you, Director, is I know that your administration has already been working. Can you go through some of the fraud that you already discovered? And more importantly than that, can you go through the fraud that you think you might find?**
>
> **A. Congressman, thank you for the question, and we share – Medicaid – your sentiment towards the meaningful intent of many of these programs, which is why we fight anyone defrauding them, insulting – and needing address so that we could provide that long-term stability.**
>
> **As we've talked about in the home health safety space, we've identified abnormal trends in different parts of our state, abnormal billing patterns that we are now working to address. We, as – have identified – and it's been in the news, the $42 million finding on the behavioral health services provided in our community that we have been working on making policy changes including prior authorizations, reviewing our enrollment process, and identifying high risk providers in each of those areas.**

The Committee's hearing underscored the persistent vulnerabilities in Medicaid program integrity across multiple states and highlighted the need for stronger safeguards and more transparent oversight. The New York Medicaid Director Amir Bassiri's lack of transparency—and his admission that New York prioritizes access over program integrity—reflects many of the ongoing fraud challenges in the state. Similarly, during the hearing, California Medicaid Director Tyler Sadwith did not provide requested information to the Committee about state audits or the rationale for refraining from elevating any provider risk levels. It was only after the hearing that

[178] *Id.* at 51 (statement of John Connolly, Temporary Commissioner and State Medicaid Director, Minnesota Dep't of Human Services).
[179] *Id.* at 102 (statement of John Connolly, Temporary Commissioner and State Medicaid Director, Minnesota Dep't of Human Services).
[180] *Id.* at 35-37 (statement of Scott Partika, Director, Ohio Dep't of Medicaid).
[181] *Id.* at 94-95 (statement of Scott Partika, Director, Ohio Dep't of Medicaid).

both New York and California provided the requested documents and information to the Committee. Testimony from Minnesota's Medicaid Director emphasized the importance of safeguards, such as provider risk designations and program design. Ohio's Medicaid Director highlighted the value of data sharing and described proactive steps the state is taking in response to emerging fraud trends. The witnesses' testimony made clear that robust preventative and investigative controls are essential to protecting beneficiaries and taxpayer resources.

VI. Trends in Recent Fraud Schemes

A. Common Schemes

FINDING: There are nationwide trends in fraud that indicate certain services in Medicare and Medicaid are at risk.

- **In Medicare, areas with elevated fraud activity include hospice, home health services, DME, and genetic testing.**
- **Medicaid programs experiencing high rates of fraud include ABA services, NEMT, HCBS, ADC, and SUD treatment.**

FINDING: Medicaid services are not always designed with program integrity in mind. States have rapidly expanded benefits under HCBS Section 1915(c) waivers, resulting in sky rocketing program costs, and leaving Medicaid vulnerable to fraud without proper programmatic safeguards.

The Committee's investigation identified overarching patterns in common fraud schemes that persist nationwide, impacting both Medicare and Medicaid. Fraudsters are using sophisticated methods to commit fraud, such as using AI to fabricate documents to support false claims.[182] The U.S. Department of the Treasury recently reported a staggering $17.5 billion in suspicious financial activity potentially linked to health care fraud in federal, state, and private health insurance programs.[183] HHAs accounted for about 20 percent of the suspected fraud flagged by U.S. financial institutions, with additional recurrent reports involving hospice companies, behavioral health and SUD treatment providers, DME suppliers, and ADCs.[184]

Just this year, DOJ, in partnership with HHS-OIG and state Attorneys General, have announced criminal charges against defendants including major Medicaid fraud charges in Minnesota, Ohio, and Pennsylvania for HCBS.[185] The 2026 Health Care Fraud Takedown was wide ranging, charging 455 defendants with over $6.5 billion in alleged fraud across 45 states

[182] *See* Press Release, U.S. Dep't of Justice, Four Men Plead Guilty to $2M Minnesota Medicaid Fraud (July 24, 2026), https://www.justice.gov/opa/pr/four-men-plead-guilty-2m-minnesota-medicaid-fraud.
[183] Press Release, U.S. Dep't of the Treasury, Treasury Uncovers $17.5 Billion in Suspected Health Care Fraud (Sept. 9, 2026), https://home.treasury.gov/news/press-releases/sb0625.
[184] *Id.*
[185] 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; 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; News Release, Ohio Attorney General, Six Medicaid Providers Indicted on Fraud Charges (Aug. 13, 2026), https://www.ohioattorneygeneral.gov/Media/News-Releases/August-2026/Six-Medicaid-Providers-Indicted-on-Fraud-Charges; Press Release, U.S. Attorney's Office, Eastern District of Pennsylvania, Dozens Charged With Health Care Fraud in Federal and State Cases Involving $5.76 Million in Billings to Pennsylvania's Medicaid Program (Aug. 4, 2026), https://www.justice.gov/usao-edpa/pr/dozens-charged-health-care-fraud-federal-and-state-cases-involving-576-million.

and territories.[186] The 2026 Takedown included fraudulent claims for wound care skin substitutes, SUD treatment centers, ADC, prescription opioid trafficking, telemedicine, and genetic testing.[187] State and federal law enforcement efforts to prevent and detect fraud in Medicare and Medicaid must match the sophistication of the modern tactics fraudsters use to line their pockets with taxpayer money.

1. Medicare Schemes

Medicare benefits commonly targeted by fraudsters include, but are not limited to, DME, genetic and clinical laboratory testing, and hospice.[188] The cases highlighted below are a few examples of Medicare provider categories that experience high rates of fraud. These cases are only a snapshot of fraud in these programs as Medicare fraud is not isolated to certain states.

i. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

In DME fraud schemes, criminals acquire Medicare beneficiary and physician information (in some cases, in concert with beneficiaries or physicians in exchange for kickbacks) to fraudulently bill for medically unnecessary or not provided medical equipment such as urinary catheters, continuous glucose monitors, surgical dressings, orthotic braces, or positive airway pressure devices and supplies.[189] According to HHS-OIG, "each year, bad actors defraud Medicare and taxpayers of millions of dollars by billing for durable medical equipment that enrollees do not need or never receive."[190] DME fraud schemes are made possible when bad actors evade enrollment safeguards, such as using straw owners to hide the true owner's identity, falsifying or paying for physician credentials to authorize fraudulent claims, or obtaining stolen Medicare identification numbers to submit false claims.[191]

Last year, the DME fraud takedown Operation Gold Rush, discussed further in this section, involved members of Russian organized crime who purchased dozens of small medical

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[186] Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over $6.5 Billion in Alleged Fraud (June 23, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65.
[187] *Id.*
[188] Senior Medicare Patrol, Fraud Schemes, https://smpresource.org/medicare-fraud/fraud-schemes/ (last visited Mar. 5, 2026); *see* U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-02-24-00311, WHITE PAPER: THE NATION'S CHALLENGE TO COMBAT DURABLE MEDICAL EQUIPMENT FRAUD IN MEDICARE, 1 (Aug. 2026), https://oig hhs.gov/documents/evaluation/11855/OEI-02-24-00311.pdf; *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 Mar. 5, 2026); Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 7 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf; U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.
[189] *Id.*; Erin Rutzler, *FWA Insights: How to catch a DME scheme,* COTIVITI, https://resources.cotiviti.com/fraud-waste-and-abuse/dme-scheme (last visited Mar. 6, 2026).
[190] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-02-24-00311, WHITE PAPER: THE NATION'S CHALLENGE TO COMBAT DURABLE MEDICAL EQUIPMENT FRAUD IN MEDICARE, 1 (Aug. 2026), https://oig hhs.gov/documents/evaluation/11855/OEI-02-24-00311.pdf.
[191] *Id.*

supply companies and billed Medicare more than $10.6 billion for fraudulent urinary catheter claims. [192] Another scheme uncovered in 2019, Operation Brace Yourself, involved overseas call centers that advertised free orthotic braces to Medicare beneficiaries, resulting in more than $1 billion in false Medicare billing for unnecessary back, shoulder, wrist, and knee braces.[193] The FBI charged 24 people for their role in the five-year fraudulent prescribing and billing scheme, and more than 100 DME companies were cut off from Medicare payments for their involvement.[194]

In February 2026, a Russian citizen, Nika Machutadze, was charged for his role in an alleged $3.4 billion money laundering scheme involving two DME companies based in Texas and Florida, that fraudulently billed Medicare for identical medical products and backdated claims for equipment allegedly prescribed to deceased beneficiaries.[195] Mr. Machutadze's first company allegedly billed Medicare for $3.3 billion in claims, in which over half were processed ($1.78 billion) before Medicare suspended reimbursements.[196] Mr. Machutadze's second company purportedly billed $134 million in the course of one month in 2025, with Medicare paying over $90 million of the claims before halting reimbursements.[197] Medicare beneficiaries noticed the claims and reported that they did not receive the medical equipment or that it was not medically necessary, while some physicians reported they were listed as the authorizing physician on claims despite having no knowledge of the referrals or companies involved.[198] In March 2026, DOJ announced charges against another Russian citizen, Nikolai Buzolin, accusing him of laundering $1.2 million of proceeds from a fraudulent DME scheme targeting Medicare Advantage plans.[199]

In March 2026, Patrick Cassells was sentenced to prison for his role in a $59.9 million DME fraud scheme.[200] Mr. Cassells operated three DME companies in Texas, including one he

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[192] Press Release, U.S. Attorney's Office, Eastern District of New York, 11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice (Jun. 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

[193] U.S. Dep't of Justice, Federal Bureau of Investigation, Billion-Dollar Medicare Fraud Bust – FBI Announces Results of Operation Brace Yourself (Apr. 9, 2019), https://www fbi.gov/news/stories/billion-dollar-medicare-fraud-bust-040919.

[194] *Id.*

[195] Dalton Huey, *Feds allege $3.4 billion Medicare fraud scheme tied to Russian citizen living in Austin*, KXAN (Feb. 2, 2026), https://www kxan.com/investigations/feds-allege-3-4-billion-medicare-fraud-scheme-tied-to-russian-citizen-living-in-austin/; Brian New, *Russian-run Texas medical supplier at center of massive Medicare billing scheme, feds say*, CBS NEWS (Feb. 24, 2026), https://www.cbsnews.com/texas/news/russian-run-texas-medical-supplier-massive-medicare-billing-scheme-feds-say/.

[196] Dalton Huey, *Feds allege $3.4 billion Medicare fraud scheme tied to Russian citizen living in Austin*, KXAN (Feb. 2, 2026), https://www kxan.com/investigations/feds-allege-3-4-billion-medicare-fraud-scheme-tied-to-russian-citizen-living-in-austin/.

[197] *Id.*

[198] *Id.*

[199] Press Release, U.S. Dep't of Justice, Russian citizen charged with laundering over $1.2M connected to $400M in fraudulent Medicare claims (Mar. 5, 2026), https://www.justice.gov/opa/pr/russian-citizen-charged-laundering-over-12m-connected-400m-fraudulent-medicare-claims.

[200] Press Release, U.S. Dep't of Justice, Owner of durable medical equipment company sentenced for $59M Medicare fraud (Mar. 9, 2026), https://www.justice.gov/opa/pr/owner-durable-medical-equipment-company-sentenced-59m-medicare-fraud.

falsely represented as being owned by another individual.[201] He also paid illegal kickbacks to co-conspirators who supplied him with signed physicians' orders and paperwork, which he then used to fraudulently bill Medicare for orthotic braces without any provider examining or treating the patients.[202]

In May 2026, Brett Blackman was convicted in the Southern District of Florida for orchestrating a large-scale Medicare fraud scheme through his software platform.[203] Using his software and in coordination with pharmacies, telemedicine providers, and DME suppliers accepting kickbacks and bribes, Mr. Blackman generated falsified physicians' orders and prescriptions for DME, resulting in more than $1 billion in false claims to Medicare.[204]

i. Genetic and Clinical Laboratory Testing

Genetic and clinical laboratory testing claims have been identified as a high-risk category in Medicare due to the number and variability of laboratories; the high-volume, low-dollar nature of laboratory services; and technical complexity of laboratory services.[205] In February 2026, a former National Football League player, Keith J. Gray, was convicted for orchestrating a $328 million genetic testing fraud scheme.[206] In this fraud scheme, Mr. Gray billed Medicare for medically unnecessary tests and offered and paid kickbacks to marketers to obtain "Medicare beneficiaries' DNA samples, personally identifiable information (including Medicare numbers) and signed test orders."[207] Patient marketers, at the behest of Mr. Gray, contacted Medicare beneficiaries through telemarketing and "doctor chased" by contacting beneficiaries' physicians to pressure the authorization of medically unnecessary tests.[208]

Similar to genetic testing fraud, clinical laboratory fraud schemes may involve medically unnecessary testing and billing practices to inflate costs.[209] In a recent criminal case, a California man was convicted of billing Medicare over $4 million in fraudulent claims for urine drug testing for patients under pain management treatment.[210] In this scheme, urine testing, which has

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[201] *Id.*
[202] *Id.*
[203] Press Release, U.S. Dep't of Justice, Owner of Health Care Software Company Convicted of 1 Billion Dollar Medicare Fraud Conspiracy (May 14, 2026), https://www.justice.gov/opa/pr/owner-health-care-software-company-convicted-1-billion-dollar-medicare-fraud-conspiracy.
[204] *Id.*
[205] U.S. Dep't of Health and Human Services Office of Inspector General, Nationwide Genetic Testing Fraud, https://oig hhs.gov/newsroom/media-materials/media-materials-nationwide-genetic-testing-fraud/ (last visited Mar. 9, 2026); Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 6 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf.
[206] Press Release, U.S. Dep't of Justice, Former NFL Player and Laboratory Owner Convicted in $328M Genetic Testing Fraud Scheme (Feb. 20, 2026), https://www.justice.gov/opa/pr/former-nfl-player-and-laboratory-owner-convicted-328m-genetic-testing-fraud-scheme.
[207] *Id.*
[208] *Id.*
[209] Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 9-12 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf.
[210] Press Release, U.S. Dep't of Justice, Lab operator convicted of $4M Medicare fraud scheme (Feb. 25, 2025), https://www.justice.gov/opa/pr/lab-operator-convicted-4m-medicare-fraud-scheme.

a high Medicare reimbursement rate, was fraudulently ordered by paying patient marketers kickbacks to conspire with physician office staff to forward testing orders that a doctor did not authorize for their patients.[211]

ii. Hospice

Amid the rising utilization of hospice benefits, CMS has designated hospice as a high risk provider type.[212] CMS has observed patients remaining in hospice too long, unusually high concentrations of hospice agencies in certain geographic locations, and high rates of patients discharged from hospice alive.[213] Investigations uncovered illegal patient marketers who enroll unknowing Medicare beneficiaries—without a terminal illness— in hospice care.[214] Additional red flags include a surge in newly licensed providers, clusters of agencies operating in the same building, and agencies with unusually low patient counts.[215]

Due to these concerning patterns, CMS implemented additional oversight of hospice in July 2023, through the Provisional Period of Enhanced Oversight, applying it to all newly enrolling or newly acquired hospices in Arizona, California, Nevada, and Texas.[216] Hospice fraud is not only a financial crime, but it also imposes serious harm to patients.[217] When a Medicare beneficiary is improperly enrolled in hospice, their ability to receive care for serious health conditions becomes restricted under Medicare rules, leading to potentially delayed or denied care.[218]

In April 2026, five individuals were arrested in California for their involvement in millions of dollars of alleged hospice fraud.[219] Last year, a California man pleaded guilty to more than $17 million in Medicare hospice and home health fraud.[220] In this scheme, the man and his

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[211] *Id.*
[212] U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.
[213] *Id.*
[214] Colin May, *Safeguarding hospice care: Addressing fraud and upholding patient trust,* Association of Certified Fraud Examiners (Jan. 2026), https://www.acfe.com/acfe-insights-blog/blog-detail?s=safeguarding-hospice-care-fraud.
[215] AUDITOR OF THE STATE OF CALIFORNIA, REPORT 2021-123, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, 15 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf; Rachel Gold et al., *We visited "ground zero" for hospice fraud: Los Angeles, California*, CBS NEWS (Mar. 10, 2026), https://www.cbsnews.com/projects/2026/hospice-fraud/.
[216] *Id.*
[217] William La Jeunesse, *Los Angeles hospice fraud reaches billions as Medicare providers scam federal system with fake companies*, FOX NEWS (Jan. 30, 2026), https://www.foxnews.com/us/los-angeles-hospice-fraud-reaches-billions-medicare-providers-scam-federal-system-fake-companies.
[218] *Id.*
[219] Press Release, U.S. Attorney's Office, Central District of California, 8 Arrested in Health Care Fraud Taekdown, Including Owners of Hospices that Billed Millions of Dollars to Serve the 'Dying' (Apr. 2, 2026), https://www.justice.gov/usao-cdca/pr/8-arrested-health-care-fraud-takedown-including-owners-hospices-billed-taxpayers.
[220] Press Release, U.S. Dep't of Justice, Man pleads guilty in connection with $17M Medicare hospice fraud and home health care fraud schemes (Feb. 3, 2025), https://www.justice.gov/opa/pr/man-pleads-guilty-connection-17m-medicare-hospice-fraud-and-home-health-care-fraud-schemes.

co-conspirators fraudulently enrolled in Medicare as hospice providers using sham provider credentials and subsequently submitted fraudulent claims for hospice services that were medically unnecessary and not provided.[221] In addition to the hospice scheme, the defendant was found to have fraudulently used physician information to falsely certify Medicare beneficiaries for home health care services that were not authorized.[222] This conviction followed $2.8 million and $9 million Medicare hospice fraud cases in California that were resolved the previous year.[223]

2. Medicaid Schemes

While Medicaid services vary state-by-state, there are Medicaid programs operating in many states that have been identified as high-risk. These include, but are not limited to, ABA services, PCS, NEMT, and ADC.[224] The cases highlighted below are a few examples of Medicaid provider categories that experience high rates of fraud. These cases are only a snapshot of fraud in these programs as Medicaid fraud is not isolated to certain states.

i. *Applied Behavior Analysis and Related Services*

Medicaid covers ABA therapy and services for eligible children with autism that can significantly improve cognitive and behavioral outcomes.[225] However, ABA programs and other services for children with autism have been identified to have "questionable billing patterns […] as well as Federal and State payments for providers for unallowable services."[226] An August 2026 review by CMS of Medicaid ABA billing and utilization shows both the rapid growth in

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[221] *Id.*
[222] *Id.*
[223] Press Release, U.S. Dep't of Justice, Doctor convicted of $2.8M Medicare fraud scheme (Feb. 16, 2024), https://www.justice.gov/archives/opa/pr/doctor-convicted-28m-medicare-fraud-scheme; Press Release, U.S. Dep't of Justice, Two men sentenced for role in $9M hospice fraud scheme (Mar. 29, 2024), https://www.justice.gov/archives/opa/pr/two-men-sentenced-role-9m-hospice-fraud-scheme.
[224] *See* Isaac Asamoah Amponsah, *Ethics at Risk: Addressing Fraudulent Behavior in ABA Therapy,* Association of Certified Fraud Examiners (July 2024), https://www.acfe.com/acfe-insights-blog/blog-detail?s=ethics-risk-addressing-fraudulent-behavior-aba-therapy; *see also* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; Erin Rutzler, *FWA insights: Spotting red flags in adult day care claims*, COTIVITI, https://resources.cotiviti.com/fraud-waste-and-abuse/fwa-insights-spotting-red-flags-in-adult-day-care-claims (last visited Mar. 6, 2026); U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation: Medicaid Non-Emergency Medical Transportation Booklet for Providers, 7 (Apr. 2016), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf; Laura Geller et al., *In One NYC Neighborhood, Dozens of Adult Daycares Bill Millions to Taxpayers. Now the Feds have Questions*, CBS NEWS (July 1, 2026), https://www.cbsnews.com/news/adult-daycare-centers-dr-oz-potential-fraud/.
[225] *See* U.S. Centers for Medicare and Medicaid Services, Division of Quality and Health Outcomes, 2024 Medicaid & CHIP beneficiaries at a glance: Autism (July 2024), https://www medicaid.gov/medicaid/benefits/downloads/2024-autism-infographic.pdf.
[226] U.S. Dep't of Health and Human Services Office of Inspector General, Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/ (last visited Aug. 17, 2026).

utilization of these services, as well as spending that vastly outpaces utilization.[227] CMS' review found that while the number of individuals receiving ABA therapy increased 200 percent between 2021 to 2025, ABA Medicaid spending increased by 421 percent in that same period.[228]

As part of an ongoing review, HHS-OIG is auditing select states' ABA payments to assess compliance with federal and state requirements.[229] In reviews completed so far in Indiana, Wisconsin, Maine, and Colorado, HHS-OIG identified patterns in improper payments that reveal ABA providers billing for services that are not covered under the ABA benefit, are not properly documented to show that services are being provided in compliance with federal requirements, and in some instances by providers who do not have the proper credentials to perform reimbursable therapy.[230] While not all improper payments are fraud, the billing patterns found in HHS-OIG's reviews indicate that without proper documentation, millions of dollars in payments for ABA services cannot be properly substantiated to rule out FWA.[231] According to CMS, ABA-specific indicators of improper or fraudulent billing activity can include: high service hours per beneficiary, high technician-to-supervisor ratios, rapid onset of billing upon provider enrollment, unusual clustering of billing codes, providers billing for high volumes of services with limited credentialed supervisory staff, and excessive use of telehealth services.[232]

In 2025, Minnesota had the highest per beneficiary per month payments for ABA services, topping out at $7,673 per beneficiary per month.[233] Ongoing criminal investigations

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[227] U.S. Centers for Medicare and Medicaid Services, Autism Services, Autism Spectrum Disorder and Applied Behavior Analysis Data Book, August 2026, https://www medicaid.gov/medicaid/benefits/autism-services (last visited Aug. 18, 2026).
[228] *Id.* at *iii*.
[229] U.S. Dep't of Health and Human Services Office of Inspector General, Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/ (last visited Aug. 17, 2026).
[230] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-09-22-02002, INDIANA MADE AT LEAST $56 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (Dec. 16, 2024), https://oig hhs.gov/documents/audit/10123/A-09-22-02002.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-06-23-01002, WISCONSIN MADE AT LEAST $18.5 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (July 10, 2025), https://oig hhs.gov/documents/audit/10497/A-06-23-01002.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-01-24-00006, MAINE MADE AT LEAST $45.6 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR REHABILITATIVE AND COMMUNITY SUPPORT SERVICES PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (Jan. 16, 2026), https://oig.hhs.gov/documents/audit/11447/A-01-24-00006.pdf; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-09-24-02004, COLORADO MADE AT LEAST $77.8 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN (Feb. 25, 2026), https://oig.hhs.gov/documents/audit/11493/A-09-24-02004.pdf.
[231] *See* U.S. Centers for Medicare and Medicaid Services, Fiscal Year 2025 Improper Payments Fact Sheet (Jan. 15, 2026), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet; *see also* The Editorial Board, *The Medicaid Autism Racket*, WALL ST. JOURNAL (Mar. 8, 2026), https://www.wsj.com/opinion/the-medicaid-autism-racket-a9d20f30?mod=hp_opin_pos_1.
[232] U.S. Centers for Medicare and Medicaid Services, State Medicaid & Children's Health Insurance Program Applied Behavior Analysis Toolkit (Aug. 2026), 120-121, https://www medicaid.gov/medicaid/downloads/autism-services-aba-toolkit.pdf.
[233] U.S. Centers for Medicare and Medicaid Services, Autism Services, Autism Spectrum Disorder and Applied Behavior Analysis Data Book, August 2026, iii, https://www.medicaid.gov/medicaid/benefits/autism-services (last visited Aug. 18, 2026).

into Minnesota's EIDBI program, which provides Medicaid ABA services, show patterns of documentation inconsistencies, kickback schemes, and unqualified providers.[234] Late last year, Abdinajib Hassan Yussuf pleaded guilty to allegations that he perpetrated $6 million in fraud against Minnesota's Medicaid program as an EIDBI provider.[235] 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 autism diagnoses to qualify for the services.[236] In his plea hearing, Mr. Yussuf admitted that he did not know anyone with autism and worked with his co-conspirators to recruit children who could be diagnosed for the purposes of qualifying for EIDBI.[237] Another individual, Asha Farhan Hassan, who recently pleaded guilty for her role in a $14 million ABA services fraud scheme in Minnesota, had previously been charged in the Feeding Our Future fraud scheme.[238]

ii. *Personal Care Services*

PCS, which provide eligible individuals assistance with daily living needs within their own home, have been identified as high-risk for fraud due to a "high rate of utilization," potential for "collusion among multiple people," and cases of "billing for services that were never rendered or billing for services supposedly rendered."[239] Under Section 1915(c) HCBS waivers, many states offer self-directed PCS programs that allow patients to hire their own caregiver to provide services in their home.[240] CMS regulations require that state "written plan[s] must prevent the provision of unnecessary or inappropriate services and supports" in PCS.[241]

In New York, the Community-Driven Personal Assistance Program (CDPAP) delivers self-directed PCS reimbursed by Medicaid.[242] 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.[243] Over several years, Mr. Hossain and ten others were paid to be

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[234] 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.
[235] Press Release, U.S. Attorney's Office, District of Minnesota, Six Additional Defendants Charged, One Defendant Pleads Guilty in Ongoing Fraud Schemes (Dec. 18, 2025), https://www.justice.gov/usao-mn/pr/six-additional-defendants-charged-one-defendant-pleads-guilty-ongoing-fraud-schemes.
[236] *Id.*; 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.
[237] *Id.*
[238] *Id.*
[239] U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf.
[240] *Id.* at 7.
[241] *Id.* at 12.
[242] New York State Department of Health, Consumer Directed Personal Assistance Program (CDPAP), https://www health ny.gov/health_care/medicaid/program/longterm/cdpap/ (last visited Sept. 2, 2026).
[243] News Release, Office of the New York State Welfare Inspector General, Catherine Leahy Scott, Manhattan man sentenced to prison and pays restitution for his $600,000 theft of welfare and unemployment insurance benefits 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.

caregivers for his mother, who resided out of the country.[244] To carry out the scheme, Mr. Hossain's brother posed as the mother during routine site visits.[245]

California spends the most of any state on PCS, totaling $25.18 billion in 2025.[246] California self-directed PCS are provided through the Medicaid In-Home Supportive Services (IHSS) program.[247] As part of sweeping indictments announced by DOJ in the 2025 National Health Care Fraud Takedown, five individuals were charged for their role in fraudulent Medi-Cal billing for IHSS services.[248] 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.[249]

iii. *Non-Emergency Medical Transportation*

NEMT services are a critical Medicaid benefit providing no-cost transportation to eligible patients needing assistance getting to non-emergency medical appointments.[250] NEMT "can pose a significant risk of fraud, waste, and abuse in Medicaid," and last year HHS-OIG announced it is conducting a targeted review to reduce FWA in Medicaid NEMT.[251]

In February 2026, the U.S. Attorney for the District of Colorado and the Colorado Attorney General's Office announced charges against two individuals for defrauding Health First Colorado's NEMT program.[252] 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.[253] Ms. Stevens also billed "ghost rides," meaning trips that did not occur or rides that did not involve a medical destination, in addition to over $450,000 for rides that exceeded 400 miles per beneficiary to destinations that were substantially closer.[254] The second defendant, Wesam Yassin, billed Health First Colorado for $3.3 million in NEMT rides, including $283,000

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[244] *Id.*
[245] *Id.*
[246] U.S. Centers for Medicare and Medicaid Services, Medicaid Service Area Heat Map, Personal Care Services, https://www.cms.gov/files/document/crushing-fraud-pcs-heat-map.pdf.
[247] California Dep't of Social Services, In-Home Supportive Services (IHSS) Program, https://www.cdss.ca.gov/in-home-supportive-services (last visited Sept. 2, 2026).
[248] 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 Sept. 2, 2026).
[249] *Id.*
[250] U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation, https://www.cms.gov/medicare/medicaid-coordination/states/non-emergency-medical-transportation (last visited Sept. 14, 2026).
[251] U.S. Dep't of Health and Human Services, Office of Inspector General, Use of Targeted Reviews to Reduce Fraud, Waste, and Abuse in Medicaid Nonemergency Medical Transportation, OEI-02-25-00360, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/using-targeted-reviews-to-reduce-fraud-waste-and-abuse-in-medicaid-nonemergency-medical-transportation/ (last visited Sept. 14, 2026).
[252] 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.
[253] *Id.*
[254] *Id.*

for 64 rides for a single beneficiary, $165,000 of which occurred after the beneficiary had died.[255] Ms. Yassin similarly billed ghost rides and beneficiary rides that were not associated with a medical destination.[256]

iv. *Adult Day Care*

ADC, a benefit typically offered under HCBS, is intended to serve elderly adult populations by providing activities, exercise, meals, personal care, and basic health services.[257] CMS has identified ADC as a high-risk service area and recent investigations into suspicious billing and rapid growth in ADCs warrant enhanced oversight.[258] Last year, Minnesota paused licensing of new ADCs until 2028, citing an increase in ADCs that exceeds the demand for services by nearly 3,000.[259]

In 2025, New York paid $753.92 million for ADC, the highest amount of any state that year.[260] In the year prior, 17 percent of nationwide Medicaid spending went to ADCs in New York.[261] Within New York City, there is a cluster of 64 ADC facilities within a one-mile radius in Flushing, Queens, and the growth of ADCs in this area is outpacing the Medicaid-eligible population there.[262] The New York State Comptroller has warned that ADCs pose a heightened fraud risk to the Medicaid program due to a pattern of questionable and improper payments, and other notable concerns such as ADCs operating with supposed patient populations that are above the building's occupational capacity.[263]

In January 2026, two individuals pleaded guilty to a seven-year $68 million Medicaid fraud scheme involving two Brooklyn-based ADCs and a home health company.[264] In this scheme, the two men received kickbacks and bribes as marketers and recruiters for ADCs and a home health care fiscal intermediary, billing for induced or not provided Medicaid services.[265] In February, two Queens men who owned ADCs and a pharmacy were charged with $120 million in

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[255] *Id.*
[256] *Id.*
[257] U.S. Centers for Medicare and Medicaid Services, Medicaid Service Area Heat Map, Adult Day Care (Aug. 2026), https://www.cms.gov/files/document/crushing-fraud-adc-heat-map.pdf.
[258] U.S. Centers for Medicare and Medicaid Services, Crushing Fraud, Waste, and Abuse, https://www.cms.gov/fraud (last visited Sept. 25, 2026); Laura Geller et al., *In One NYC Neighborhood, Dozens of Adult Daycares Bill Millions to Taxpayers. Now the Feds have Questions*, CBS NEWS (July 1, 2026), https://www.cbsnews.com/news/adult-daycare-centers-dr-oz-potential-fraud/.
[259] Matt Sepic, *State Pauses New Adult Day Care Licenses Amid Fraud Concerns*, MPR NEWS (Dec. 16, 2025), https://www mprnews.org/story/2025/12/16/minnesota-pauses-new-adult-day-care-licenses-amid-fraud-concerns.
[260] U.S. Centers for Medicare and Medicaid Services, Medicaid Service Area Heat Map, Adult Day Care (Aug. 2026), https://www.cms.gov/files/document/crushing-fraud-adc-heat-map.pdf.
[261] Laura Geller et al., *In One NYC Neighborhood, Dozens of Adult Daycares Bill Millions to Taxpayers. Now the Feds have Questions*, CBS NEWS (July 1, 2026), https://www.cbsnews.com/news/adult-daycare-centers-dr-oz-potential-fraud/.
[262] *Id.*
[263] Office of the New York State Comptroller Thomas P. DiNapoli, Department of Health, Medicaid Program: Oversight of Social Adult Day Care Programs, Report 2023-S-21 (Feb. 2026), https://www.osc ny.gov/files/state-agencies/audits/pdf/sga-2026-23s21.pdf.
[264] 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.
[265] *Id.*

alleged Medicaid and Medicare fraud, including illegal cash kickbacks to Medicaid recipients to fill prescriptions at their pharmacies and enroll in their ADC.[266] In July 2026, Eric Zhu, the owner of an ADC in Brooklyn, was sentenced to 57 months in prison for a $3.2 million Medicaid fraud and kickback scheme, in which his ADC was paying Medicaid recipients illegal kickbacks and bribes to enroll, and patients did not receive the services that were billed.[267]

B. Patient Harm

FINDING: Fraud is not a victimless crime. Patients suffer under the care of fraudulent providers. Patients have suffered from stolen identities, long wait lists, substandard health care, and in some cases neglect and death.

1. Adverse Outcomes

Fraud can cause significant patient harm, and in some cases hospitalizations and deaths—particularly among vulnerable patient populations.[268] Services for certain populations such as children, disabled individuals, and elderly patients carry heightened patient harm risks when fraud is occurring. A 2019 study by researchers at the Johns Hopkins Bloomberg School of Public Health found that Medicare providers excluded for fraud and abuse were more likely to treat dual-eligible Medicaid-Medicare beneficiaries, minorities, and disabled patients.[269] Some individuals in these groups may have a limited ability to communicate about the care they are receiving—or are not receiving—from a therapist or caregiver.[270] In caregiver settings such as PCS, HHS-OIG has warned that fraud poses an increased risk of patient harm because care is typically provided in a patient's home without supervision from other providers.[271] In a 2016 report, HHS-OIG recommended that CMS "establish minimum Federal qualifications and screening standards for PCS workers, including background checks."[272] This recommendation has not been implemented by CMS.

In Minnesota, Ahmed Kadar is currently under federal indictment for three counts of health care fraud and two counts of money laundering related to his home health company,

[266] 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.
[267] Press Release, U.S. Dep't of Justice, Brooklyn Adult Daycare Owner Sentenced to 57 Months for Medicaid Fraud Scheme (July 20, 2026), https://www.justice.gov/opa/pr/brooklyn-adult-daycare-owner-sentenced-57-months-medicaid-fraud-scheme.
[268] *See, e.g.*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, INVESTIGATIVE ADVISORY ON MEDICAID FRAUD AND PATIENT HARM INVOLVING PERSONAL CARE SERVICES (Oct. 3, 2016), https://oig hhs.gov/documents/additional-reports/1313/OIG-OR-2017-01-Complete%20Report.pdf.
[269] Lauren Hersch Nicolas et al., *Medicare Beneficiaries' Exposure to Fraud and Abuse Perpetrators*, 38 HEALTH AFFAIRS 5 (May 2019), https://www healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05149.
[270] *Id.* at 5.
[271] *Id.*
[272] Lauren Hersch Nicolas et al., *Medicare Beneficiaries' Exposure to Fraud and Abuse Perpetrators*, 38 HEALTH AFFAIRS 5, 7 (May 2019), https://www healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05149.

Ultimate Home Health LLC.[273] According to the indictment, Mr. Kadar fraudulently billed Medicaid for $1.4 million in Integrated Community Supports (ICS) services, which are intended to help people with disabilities live independently in their home.[274] Disturbingly, because Mr. Kadar allegedly billed Medicaid for services that were not rendered, patients reportedly went without heat during the winter, and in one case, a man died while he was purportedly receiving 24-hour a day in-home care from Ultimate Home Health.[275]

2. Identity Theft and Scams

Health care scams are on the rise. Earlier this year, the Federal Communications Commission released a consumer alert, providing a warning to seniors that may be targeted for scams using Medicare information to commit medical identity theft or facilitate fraudulent billing schemes.[276] Medical identity theft can facilitate fraud schemes including the ordering of DME or enrollment in services that are not medically necessary.[277] Patient marketers may target elderly beneficiaries by asking them to sign up for "free" medical supplies or services, grocery delivery, or even housekeeping services.[278] In some cases, fraudulent Medicare billing for products or services that a beneficiary does not need may disqualify a patient for coverage of services they do need, or medical equipment they are purported to have already received.[279]

A recent disturbing case in St. Paul, Minnesota, demonstrates the patient harm and reverberating impacts of criminal Medicaid schemes.[280] Salman Ahmed Elmi, a previous recipient of the Minnesota Department of Human Services' "Outstanding Refugee Award for Entrepreneurship," alongside three co-defendants, is accused of running four companies providing home health, ABA services, housing assistance, and assisted living, that billed Minnesota Medicaid for more than $4.5 million since 2023.[281] Mr. Elmi's scheme was facilitated by enlisting vulnerable women, who were often homeless, impoverished, or struggling with substance use disorder, into prostitution rings, and used these trafficked women to steal victims' identities and facilitate fraudulent Medicaid billing.[282]

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[273] U.S. Dep't of Justice, Case Summaries, 2026 Minnesota Medicaid and Benefits Fraud Takedown (last updated July 29, 2026), https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit/2026-minnesota-hcf-case-summaries.
[274] *Id.*
[275] *Id.*
[276] Federal Communications Commission, Older Americans and Medicare Call Scams, https://www fcc.gov/older-americans-and-medicare-scams (last updated June 5, 2026).
[277] U.S. Dep't of Health and Human Services Office of Inspector General, Medical Identity Theft & Medicare Fraud, https://oig hhs.gov/documents/root/235/OIG_Med_Id_Theft_Brochure.pdf (last visited Aug. 3, 2026).
[278] The Senior Medicare Patrol National Resource Center, Medical Identity Theft Tip Sheet, https://smpresource.org/medicare-fraud/fraud-schemes/medical-identity-theft/ (last visited Aug. 3, 2026).
[279] *Id.*
[280] Adam Duxter and Frankie McLister, *St. Paul man charged in Medicaid fraud scheme tied to people accused of running sex trafficking ring,* CBS NEWS (Aug. 18, 2026), https://www.cbsnews.com/minnesota/news/medicaid-fraud-sex-trafficking-twin-cities/.
[281] *Id.*
[282] *Id.*

C. Transnational Criminal Organizations

FINDING: Medicare and Medicaid fraud have distinct and increasingly sophisticated patterns, with fraud schemes crossing state and international lines more than they have previously. TCOs are perpetrating fraud across the U.S., targeting state and federal health care programs and laundering money through overseas bank accounts.

TCOs are increasingly facilitating false and fraudulent claims to Medicare and Medicaid.[283] In 2024, reports emerged of large-scale, years-long Medicare fraud schemes involving an estimated $2 billion to $3 billion in fraudulent urinary catheter billing against more than 450,000 Medicare beneficiaries.[284] In June 2025, a clearer picture of this scheme was revealed after a two-year investigation by DOJ called "Operation Gold Rush."[285] Operation Gold Rush resulted in 15 individuals being charged in "the largest case by loss amount ever charged by the Department of Justice."[286] This scheme involved members of Russian organized crime who purchased 30 small medical supply companies already enrolled in Medicare and billed more than $10.6 billion for fraudulent urinary catheter DME claims using stolen beneficiary information.[287] The claims were flagged as suspicious by CMS, and the government was able to prevent more than 99 percent of the payments from ultimately being paid to the criminal organization.[288]

[283] U.S. DEP'T OF THE TREASURY, FINANCIAL CRIMES ENFORCEMENT NETWORK, FIN-2026-A001 FINCEN ADVISORY ON HEALTH CARE FRAUD SCHEMES TARGETING MEDICARE, MEDICAID, AND OTHER FEDERAL AND STATE HEALTH CARE BENEFIT PROGRAMS, 1 (Mar. 30, 2026), https://www.fincen.gov/system/files/2026-03/FinCEN-Advisory-Health-Care-Fraud.pdf; *see, e.g.*, Press Release, U.S. Dep't of Justice, Ohio Man Pleads Guilty to Laundering Health Care Fraud Proceeds for Transnational Criminal Organization (Aug. 14, 2026), https://www.justice.gov/opa/pr/ohio-man-pleads-guilty-laundering-health-care-fraud-proceeds-transnational-criminal.

[284] Letter from The Hon. Cathy McMorris Rodgers, Chair, H. Comm. on Energy and Commerce, et al., to The Hon. Christi Grimm, Inspector General, U.S. Dep't of Health and Human Services and Hon. Chiquita Brooks-LaSure, Administrator, Centers for Medicare and Medicaid Services (Mar. 6, 2024), https://d1dth6e84htgma.cloudfront.net/03_06_24_Letter_to_HHS_OIG_re_2_billion_Catheter_Fraud_7c45aebd9b.pdf.

[285] Press Release, U.S. Attorney's Office, Eastern District of New York, 11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice (Jun. 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

[286] *Id.*

[287] *Id.*

[288] Dan Diamond and Lauren Weber, *Inside Operation Gold Rush, largest health care fraud bust in U.S. history*, THE WASH. POST (Jun. 30, 2025), https://www.washingtonpost.com/health/2025/06/30/health-care-fraud-bust-largest-in-us-history/.

Figure 2: The Movement of TCO Funds during Operation Gold Rush[289]

Schemes uncovered in the 2026 National Health Care Fraud Takedown also implicated TCOs operating DME fraud schemes in Russia, Estonia, Georgia, Pakistan, Hong Kong, and elsewhere, totaling $3.76 billion in alleged fraud.[290] Ibrahim Hilmi was arrested in Northern Cyprus and charged with fraudulently billing Medicare, Medicaid, and private insurers for DME and wound dressings that were never provided.[291] Mr. Hilmi used fraudulent proceeds from this scheme to wire money to a foreign bank account in Hong Kong.[292] Due to proactive efforts by CMS to monitor suspicious billing activity, Mr. Hilmi was only paid $5.7 million of the $3.76 billion that he claimed from Medicare.[293] In September 2026, Erekle Gugava, a Georgian national, was indicted for conspiracy to launder $1.3 billion in health care fraud proceeds stemming from Operation Gold Rush.[294] Mr. Gugava is alleged to have owned a DME company for a five-month span from February to July 2025, during which he submitted $1.3 billion in

[289] U.S. Dep't of Justice, 2025 National Health Care Fraud Takedown, Operation Gold Rush – The Scheme, https://www.justice.gov/criminal/criminal-fraud/2025-national-health-care-fraud-takedown (last visited Aug. 7, 2026).
[290] Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over $6.5 Billion in Alleged Fraud (June 23, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-455-defendants-charged-connection-over-65.
[291] Brian New, *How a Texas-linked network fueled an alleged $3 billion Medicare fraud scheme*, CBS NEWS (June 25, 2026), https://www.cbsnews.com/texas/news/medicare-billing-fraud-bust-texas-i-team/; U.S. Dep't of Justice, Case Summaries, 2026 National Health Care Fraud Takedown, https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit/2026-national-hcf-case-summaries (last visited Aug. 4, 2026).
[292] *Id.*
[293] *Id.*
[294] Press Release, U.S. Attorney's Office, District of Massachusetts, Georgian National Charged for Conspiracy to Launder Proceeds of $1.3 Billion Health Care Fraud Scheme (Sept. 4, 2026), https://www.justice.gov/usao-ma/pr/georgian-national-charged-conspiracy-launder-proceeds-13-billion-health-care-fraud.

claims to Medicare and Medicare supplemental insurers, in addition to private health insurers.[295] The scheme relied upon stolen Medicare beneficiary identification numbers, and the fraudulent proceeds were deposited in foreign bank accounts controlled by a TCO in Russia and elsewhere.[296]

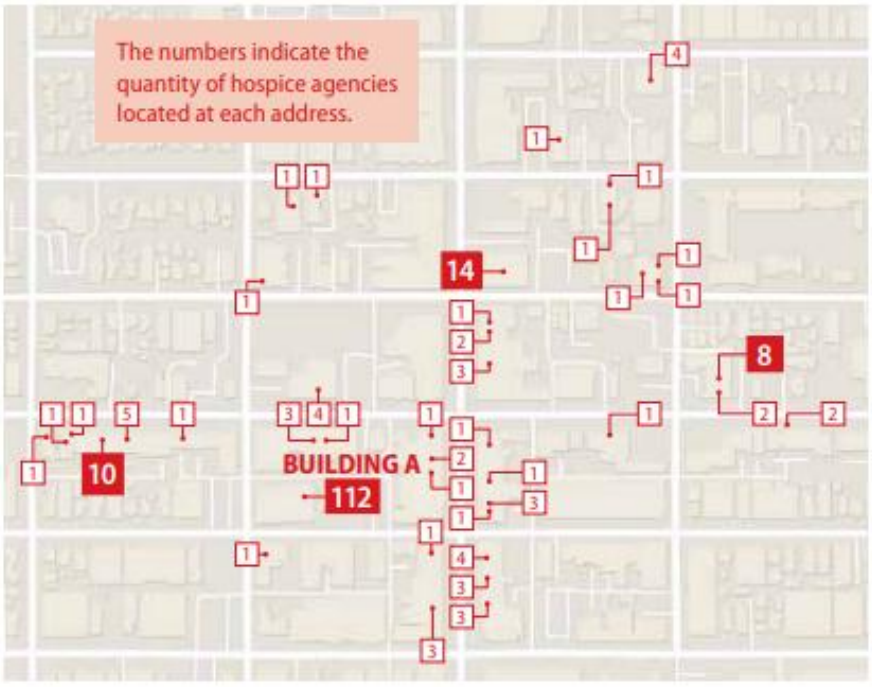
Figure 3: International Enforcement Actions Taken during 2026 National Health Care Fraud Takedown[297]

D. Geographic Concentration

A large number of providers operating within a concentrated area may indicate fraudulent activity, particularly when the number of providers exceeds the needs of the local population.[298] Both the California State Auditor and an independent *CBS News* investigation noted an unusually dense clustering of hospice agencies in L.A. County, California.[299] In 2022, the California State Auditor found that L.A. County has experienced "a significant and disproportionate amount" of growth in hospice agencies that outpaces the expected needs of terminally ill patients.[300] The State Auditor noted that there are concentrations of hospice agencies within L.A. County,

[295] *Id.*
[296] *Id.*
[297] U.S. Dep't of Justice, 2026 National Health Care Fraud Takedown, Medicare Claims for Allografts | 2019-2026, https://www.justice.gov/criminal/criminal-fraud/2026-national-health-care-fraud-takedown (last visited Aug. 7, 2026).
[298] AUDITOR OF THE STATE OF CALIFORNIA, REPORT 2021-123, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, 15 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf
[299] *Id.* at 17-22; Rachel Gold et al., *We visited "ground zero" for hospice fraud: Los Angeles, California*, CBS NEWS (Mar. 10, 2026), https://www.cbsnews.com/projects/2026/hospice-fraud/.
[300] AUDITOR OF THE STATE OF CALIFORNIA, REPORT 2021-123, CALIFORNIA HOSPICE LICENSURE AND OVERSIGHT: THE STATE'S WEAK OVERSIGHT OF HOSPICE AGENCIES HAS CREATED OPPORTUNITIES FOR LARGE-SCALE FRAUD AND ABUSE, 18 (Mar. 2022), https://information.auditor.ca.gov/pdfs/reports/2021-123.pdf.

focusing on clusters of hospices within one mile of one another in Van Nuys, and further noted that there were not similar clusters in large metropolitan areas such as Sacramento and San Diego.[301] Beyond geographic concentration, physical aspects of these businesses raise suspicion, including the absence of public-facing signage and insufficient capacity within the buildings to support the number of hospices registered to those locations.[302]



There are business offices for 210 active hospice agencies located within 1 mile of each other in Van Nuys in Los Angeles County. We found similar clusters in the cities and communities of Glendale, Burbank, and North Hollywood in Los Angeles County. We reviewed data for the Sacramento area, the San Diego area, and the Bay Area and did not identify similar clusters of hospice agencies at a single address.

Source: Public Health's licensing data.

Figure 4: Geographic clustering in active registered hospice agencies in Van Nuys, California, identified by the California State Auditor[303]

A more recent analysis of Medicare hospice records by *CBS News* found that the geographic concentration of hospices operating in L.A. County persists.[304] Investigators observed nearly 500 hospices operating in a three-mile radius in L.A. County, 137 hospices operating on Van Nuys Boulevard alone, and 89 companies registered to a single address in Van Nuys.[305]

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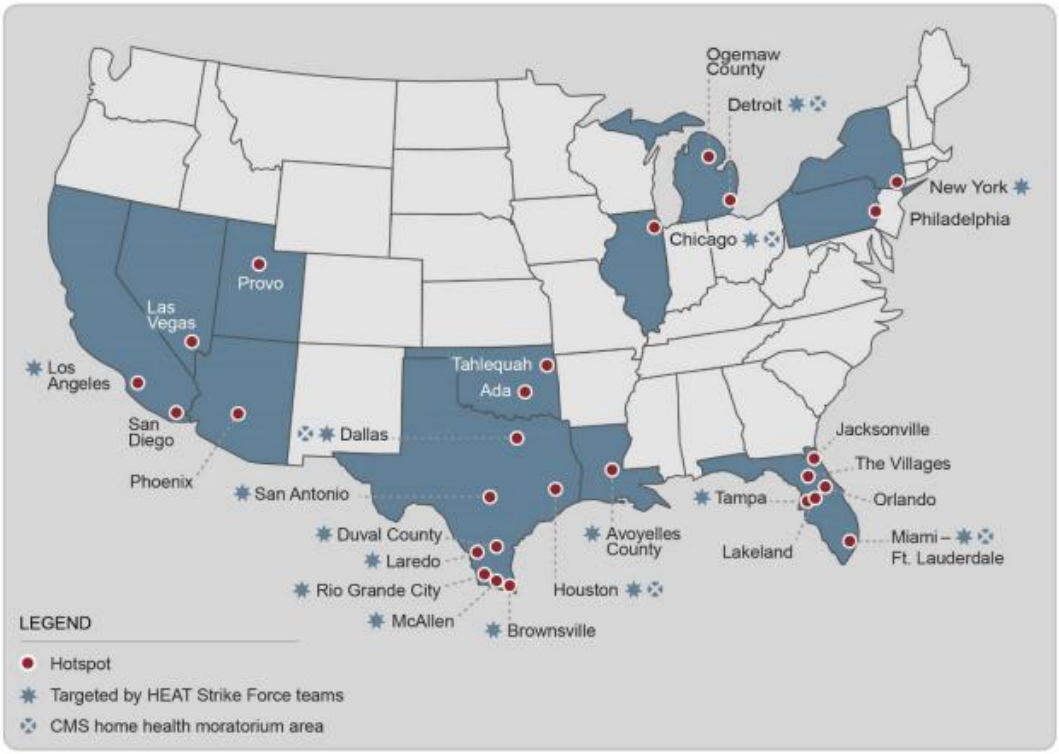
[301] *Id.* at 21.
[302] *Id.*
[303] *Id.*
[304] Rachel Gold et al., *We visited "ground zero" for hospice fraud: Los Angeles, California*, CBS NEWS (Mar. 10, 2026), https://www.cbsnews.com/projects/2026/hospice-fraud/.
[305] *Id.*

Like hospices, HHAs have regional operating areas and may warrant further scrutiny when there is a large concentration within a geographic area.[306] A 2016 HHS-OIG analysis of suspected HHA fraud cases identified 27 geographic hotspots in 12 states, including Arizona, California, Florida, Illinois, Louisiana, Michigan, Nevada, New York, Oklahoma, Pennsylvania, Texas, and Utah, where a large number of home health providers were participating in unusual Medicare billing.[307] Recently, the Ohio Department of Medicaid suspended payments to 47 home health care providers under investigation in the Columbus area, many of which were concentrated along just two major roads.[308]



Source: OIG analysis of Medicare claims data, 2016.

Figure 5: Hotspots for HHA fraud identified by HHS-OIG[309]

[306] *Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud: Hearing Before H. Comm. on Ways and Means*, 119th Cong., 3 (Apr. 21, 2026) (written testimony of Sheila Clark, President and CEO, California Hospice and Palliative Care Association), https://waysandmeans house.gov/wp-content/uploads/2026/04/Clark-Testimony.pdf.

[307] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-05-16-00031, NATIONWIDE ANALYSIS OF COMMON CHARACTERISTICS IN OIG HOME HEALTH FRAUD CASES, 7 (June 2016), https://oig hhs.gov/documents/evaluation/2924/OEI-05-16-00031-Complete%20Report.pdf.

[308] Isabel Cleary, *State suspends dozens of central Ohio Medicaid providers after fraud event*, NBC4 (June 5, 2026), https://www nbc4i.com/news/local-news/columbus/state-suspends-dozens-of-central-ohio-medicaid-providers-after-fraud-event/.

[309] *Id.*

VII. Deficiencies Identified in State Medicaid Program Integrity

A. Insufficiency of Provider Risk Assessments

FINDING: States are not utilizing Medicaid provider risk levels as an essential program integrity tool and some states are not meeting current federal requirements. By not using available program integrity tools, states may be using federal standards as a loophole to avoid being held to further provider screening requirements.

FINDING: Medicaid provider screening is essential for verifying that providers are legitimate and qualified to deliver health care services. Current preventative program integrity efforts are not sufficient and requirements for states to conduct provider screening activities are not adequate.

The Committee's letters to Minnesota and ten additional states posed several questions about SMA procedures for screening, enrolling, and revalidating Medicaid providers.[310] Medicaid provider screening is a critical step in ensuring Medicaid providers are legitimate and qualified to deliver health care services before enrolling in Medicaid and on an ongoing basis during mandatory revalidation periods. According to CMS, "state non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments."[311] There are several requirements in federal law governing SMA provider screening and enrollment processes.[312] CMS provides sub-regulatory guidance and technical assistance to states on provider enrollment in the Medicaid Provider Enrollment Compendium.[313]

SMAs are primarily responsible for facilitating provider screening, enrollment, and revalidation processes as outlined by applicable laws and regulations.[314] Accordingly, SMAs must assign and screen Medicaid providers according to three designated risk categories: "high," "moderate," and "limited" risk.[315] 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.[316] Additionally, states may share data and information with other SMAs or CHIP

[310] Press Release, H. Comm. on Energy and Commerce, E&C Leaders Launch Investigation into Ongoing Medicaid Fraud in Minnesota (Jan. 20, 2026), https://energycommerce.house.gov/posts/e-and-c-leaders-launch-investigation-into-ongoing-medicaid-fraud-in-minnesota; 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.
[311] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES, REPORT TO CONGRESS – MEDICARE AND MEDICAID INTEGRITY PROGRAMS FOR FISCAL YEAR (FY) 2024, 37 (Sept. 2025), https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf.
[312] 42 C.F.R. § 455 Subpart E.
[313] U.S. Centers for Medicare and Medicaid Services, Medicaid Provider Enrollment Compendium (last updated Nov. 17, 2025), https://www medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf.
[314] 42 C.F.R. § 455 Subpart E.
[315] 42 C.F.R. § 455.450.
[316] 42 C.F.R. § 455.410.

agencies to expedite screening of providers with active registration in other states.[317] Examples of providers that exist in both Medicare and Medicaid include DME, home health, and hospice, while Medicaid-only providers include NEMT, ABA, and PCS.

According to federal regulations for limited risk providers, SMAs must designate all Medicaid providers by one of the three categorical risk levels and, at a minimum: [318]

- **Verify that a provider meets any applicable Federal regulations, or State requirements for the provider type prior to making an enrollment determination.**
- **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.**
- **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.**

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.[319] High risk providers must be verified by the limited and moderate screening methods, in addition to criminal background checks and fingerprinting.[320] 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.[321]

[317] *Id.*; U.S. DEP'T OF HEALTH AND HUMAN SERVICES, U.S. CENTERS FOR MEDICARE AND MEDICAID SERVICES, REPORT TO CONGRESS – MEDICARE AND MEDICAID INTEGRITY PROGRAMS FOR FISCAL YEAR (FY) 2024, 37 (Sept. 2025), https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf.
[318] 42 C.F.R. § 455.450(a).
[319] 42 C.F.R. § 455.450(b).
[320] 42 C.F.R. § 455.450(c).
[321] 42 C.F.R. § 455.450(e).

Table 1 portrays the Committee's findings on provider risk designations for 11 states for NEMT, ADC, PCS, and ABA services.[322]

Table 1: Sampled State Provider Risk Levels for Certain Services

State	NEMT Risk Level	ADC Risk Level	PCS Risk Level	ABA* Risk Level
CA	Limited	Limited	Limited	Limited
CO	High	Moderate	High	Moderate
MA	Limited	Limited	Limited	Limited
ME	Limited	Limited	Moderate	Limited
MN	High	High	High	High
NE	Limited	Limited	High	Limited/Moderate**
NY	High	High	High	High
OR	Limited	Low†	Limited	Limited
PA	Limited	Limited	Limited	Limited
VT	Limited	Limited	Moderate	Limited
WA	Limited	Limited	Limited	Limited

† Oregon described Adult Day Services as "low risk" rather than "limited risk."
* Or equivalent provider type due to ABA service programs being named differently in some states.
** Nebraska separately classifies Board Certified Behavioral Analyst as "moderate risk," and Board-Certified Associate Behavior Analyst and Registered Behavioral Technicians as "limited risk."

As described in Section VI, NEMT, ADC, PCS, and ABA are Medicaid-only services currently under scrutiny due to increased fraud risks. Since these services are only offered by Medicaid, SMAs are responsible for assigning the risk level of each provider type—limited, moderate, or high— and determining whether a provider will be subject to enhanced screening requirements established by federal regulations.[323] Notably, many of the states investigated by the Committee do not classify NEMT, ADC, PCS, and ABA providers as needing further oversight through enhanced risk designation, despite recent patterns of fraud within these programs, including in these states.[324]

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[322] Documents on file with the Comm.
[323] 42 C.F.R. § 455 Subpart E.
[324] *See* U.S. Dep't of Health and Human Services, Office of Inspector General, Use of Targeted Reviews to Reduce Fraud, Waste, and Abuse in Medicaid Nonemergency Medical Transportation, OEI-02-25-00360, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/using-targeted-reviews-to-reduce-fraud-waste-and-abuse-in-medicaid-nonemergency-medical-transportation/ (last visited Sept. 14, 2026); U.S. Centers for Medicare and Medicaid Services, Crushing Fraud, Waste, and Abuse, https://www.cms.gov/fraud (last visited Aug. 18, 2026); Laura Geller et al., *In One NYC Neighborhood, Dozens of Adult Daycares Bill Millions to Taxpayers. Now the Feds have Questions*, CBS NEWS (July 1, 2026), https://www.cbsnews.com/news/adult-daycare-centers-dr-oz-potential-fraud/; U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; U.S. Dep't of Health and Human Services Office of Inspector General, Series: Audits of Medicaid Applied Behavior Analysis for Children Diagnosed with Autism, https://oig hhs.gov/reports/work-plan/browse-work-plan-projects/srs-a-25-029/ (last visited Aug. 17, 2026).

1. New York

Based on the information obtained by the Committee, New York is not complying with federal law by designating provider risk levels under 42 C.F.R. § 455 Subpart E.[325] Several months following the Committee's March 3, 2026, request letter, New York was unable to provide the Committee with the designated categorical risk levels of all Medicaid-only providers.[326] At the June 25, 2026, Subcommittee on Oversight and Investigations hearing about state Medicaid program integrity, New York Medicaid Director, Amir Bassiri testified before the Subcommittee on Oversight and Investigations.[327] When questioned by Chairman Guthrie about the status of New York's production to the Committee, Mr. Bassiri was unwilling to commit to provide the outstanding information on provider risk levels, stating on two occasions that he was "happy to take that back and get back to you."[328] New York's counsel later disclosed to the Committee that it does not designate categorical risk levels of all Medicaid-only providers.[329] With the exception of ABA, HCBS 1915(c) waiver services, and licensed home care agencies, New York "doesn't separately distinguish Medicaid-only categories of providers by risk level."[330] Only recently did New York begin the process of elevating the three provider types that it does designate by risk level to the high risk category.[331] It is deeply concerning that the nation's second largest Medicaid program, which spent nearly $98.2 billion in FY 2024 and $12,528 per enrollee per year in FY 2023, is not complying with federal regulations.[332] Minimum standards for Medicaid provider risk levels give states minimum, clear guidelines for Medicaid provider screening and can protect Medicaid beneficiaries from fraud.

Since the Committee began its investigation and CMS began probing into New York's Medicaid program integrity efforts, the state Medicaid Director announced a six-month

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[325] Email from Ben Conery, Counsel to the New York Executive Chamber and New York Dep't of Health, to H. Comm. on Energy and Commerce Majority staff (July 2, 2026) (On file with the Comm.).
[326] Letter from The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, to The Hon. Kathy Hochul, Governor, State of New York, and James V. McDonald, Commissioner, New York State Dep't of Health (Mar. 3, 2026), https://d1dth6e84htgma.cloudfront.net/3_3_2026_Letter_to_NY_on_Medicaid_Fraud_07720efcf3.pdf.
[327] *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong. (June 25, 2026) (statement of Amir Bassiri, State Medicaid Director, New York Dep't of Health), https://docs.house.gov/meetings/IF/IF02/20260625/119405/HHRG-119-IF02-Transcript-20260625.pdf.
[328] *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong. at 48 (June 25, 2026) (statement of Amir Bassiri, State Medicaid Director, New York Dep't of Health), https://docs.house.gov/meetings/IF/IF02/20260625/119405/HHRG-119-IF02-Transcript-20260625.pdf.
[329] Email from Ben Conery, Counsel to the New York Executive Chamber and New York Dep't of Health, to H. Comm. on Energy and Commerce Majority staff (July 2, 2026) (On file with the Comm.).
[330] *Id.*
[331] Email from Ben Conery, Counsel to the New York Executive Chamber and New York Dep't of Health, to H. Comm. on Energy and Commerce Majority staff (July 1, 2026) (On file with the Comm.).
[332] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 22, Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2023, 58, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-22.-Medicaid-Benefit-Spending-Per-Full-Year-Equivalent-FYE-Enrollee-by-State-and-Eligibility-Group-FY-2023.pdf; (FY 2024 is the most recent MACPAC data available for state Medicaid spending and FY 2023 is the most recent data available for per enrollee state Medicaid spending).

enrollment moratorium in July 2026 on certain providers, including licensed home care agencies, ADCs, DME, ABA, laboratories, and pharmacies.[333] In light of the Committee's findings about the state's failure to comply with federal regulations for Medicaid provider risk level designations, it is encouraging that New York is taking this step to freeze provider enrollments in these sectors and give the SMA time to investigate fraud that may be occurring. New York, however, could be doing more to shore up program integrity by complying with federal regulations and assigning provider risk levels to all Medicaid-only provider types. This action would help New York better prevent and detect fraudulent providers as it would increase already required oversight of the state's Medicaid providers on a regular basis.

2. California and Oregon

The Committee's investigation uncovered that California and Oregon are doing the bare minimum to comply with federal requirements to screen Medicaid providers under 42 C.F.R. § 455 Subpart E. In response to the Committee's request for more information about the states' Medicaid provider risk level designations and screening process, California and Oregon shared that their SMAs designate all Medicaid-only providers as limited risk.[334] By assigning wholesale limited risk provider designations, the SMA exempts itself from federal requirements for additional rigorous screenings such as on-site visits and fingerprint-based criminal background checks.[335] Concerningly, Oregon's response to the Committee stated, "[f]or OHA [Oregon Health Authority], there is no formal process to re-evaluate provider type risk levels."[336] Even if a state, such as California, claims to conduct extra screening activities going "above and beyond […] the federally-designated risk [levels]," states should consider elevating the risk levels of certain Medicaid-only providers when appropriate and regularly evaluate regional and national fraud trends, to hold itself accountable to federally mandated enrollment and revalidation benchmarks.[337]

3. Additional State Responses

i. Minnesota

In the wake of widespread fraud impacting Minnesota's Medicaid program over the course of 2025, the SMA elevated 14 programs to high risk, shut down one of these programs, and began an immediate enrollment freeze and off-cycle revalidation process for all providers in

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[333] Maya Kaufman, *New York temporarily freezes Medicaid enrollments for high-risk providers*, POLITICOPRO (July 30, 2026), https://subscriber.politicopro.com/article/2026/07/new-york-temporarily-freezes-medicaid-enrollments-for-high-risk-providers-01017872.

[334] Letter from Judith Recchio, Deputy Director and Chief Counsel, California Dep't of Health Care Services, to Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., 4 (Apr. 24, 2026) (On file with the Comm.); Letter from Sejal Hathi, Director, Oregon Health Authority, to The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., 12 (Mar. 17, 2026) (Document on file with the Comm.).

[335] 42 C.F.R. § 455.450.

[336] Letter from Sejal Hathi, Director, Oregon Health Authority, to The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., 13 (Mar. 17, 2026) (Document on file with the Comm.).

[337] *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong., 40-41 (June 25, 2026) (statement of Tyler Sadwith, State Medicaid Director, California Dep't of Health Care Services), https://docs.house.gov/meetings/IF/IF02/20260625/119405/HHRG-119-IF02-Transcript-20260625.pdf.

the remaining 13 programs.[338] While it is promising that Minnesota took this action to focus on anti-fraud efforts, it came about too little, too late.[339] It is clear that Minnesota's SMA did not design the HSS program with program integrity in mind, and as a result had to shut the program down entirely.[340] By elevating the risk level of 13 Medicaid services, freezing enrollment, and systematically revalidating all Medicaid providers, Minnesota has demonstrated the value of provider risk level designations and how they can be used as a tool to address program integrity concerns both in response to ongoing fraud, but also as a way to prevent fraud from occurring. As a result of this system-wide revalidation, Minnesota has terminated hundreds of providers in high risk services.[341]

ii. Colorado

Colorado—after experiencing alarmingly high spending rates in its NEMT program and a "surge in NEMT fraud," according to the Colorado State Auditor—elevated the risk level of NEMT from moderate to high risk.[342] This is an important step in acknowledging the vulnerabilities of certain provider types amid ongoing FWA schemes, and the power of enhanced screening and more frequent provider revalidation.

iii. Maine

As Maine has faced program integrity challenges in personal care and behavioral health services, the state has gone beyond federal requirements to develop "state review queues" for certain providers of HCBS and behavioral health services, including substance use disorder and

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[338] Program Integrity, Minnesota Dep't of Human Services, https://mn.gov/dhs/program-integrity/ (last visited Sept. 2, 2026); *see also* Letter from Shireen Gandhi, Temporary Commissioner, Minnesota Dep't of Human Services, to Caprice Knapp, Acting Director, Center for Medicaid and CHIP Services, U.S. Centers for Medicare and Medicaid Services (Oct. 27, 2025), https://content.govdelivery.com/attachments/MNGOV/2025/10/29/file_attachments/3440543/2025_10_27%20MN%20DHS%20Program%20Integrity%20Letter%20to%20CMS%20FINAL.pdf.

[339] *See* U.S. Dep't of Justice, Case Summaries – 2026 Minnesota Medicaid and Benefits Fraud Takedown (last visited Aug. 26, 2026), https://www.justice.gov/criminal/criminal-fraud/health-care-fraud-unit/2026-minnesota-hcf-case-summaries.

[340] *Minnesota Moves to End Housing Stabilization Program After Reports of Possible Fraud,* MPR NEWS (Aug. 1, 2025), https://www.mprnews.org/story/2025/08/01/minnesota-to-halt-housing-assistance-program-amid-fraud-probe.

[341] Program Integrity, Minnesota Dep't of Human Services, https://mn.gov/dhs/program-integrity/ (last visited Sept. 2, 2026).

[342] COLORADO OFFICE OF THE STATE AUDITOR, 2301F, STATEWIDE SINGLE AUDIT FISCAL YEAR ENDED JUNE 30, 2023, III-50 (Feb. 2024), https://content.leg.colorado.gov/sites/default/files/documents/audits/2301f_statewide_single_audit_fy23.pdf; 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; Letter from Ralph Choate, Chief Operating Officer, Colorado Department of Health Care Policy and Financing, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 24 (Mar. 17, 2026) (On file with the Comm.).

children's behavioral health providers.[343] The queues are reviewed during enrollment, revalidation, and change of ownership as an added layer of "qualitative review of a provider's ability to deliver services appropriately and in line with state requirements."[344]

iv. Nebraska

Nebraska observed a sharp uptick in provider enrollment and spending in its ABA services and responded by adjusting payment rates to be on par with national and regional averages.[345] The state also recently elevated the risk level of ABA Behavioral Analysts from limited to moderate risk.[346] Additionally, other policy changes were made in ABA services, such as limiting telehealth encounters, improving evidence-based support for services, and capping daily assessment hours.[347] In its response to the Committee, Nebraska also highlighted its initiative to recently reassign "any service that does personal care to be high risk," noting that, "caring for individuals who are isolated and vulnerable to exploitation by others is also considered for the risk level of the service."[348] By acknowledging that PCS is a high-risk service area—due to both potential patient harm and the risk of billing fraud—Nebraska has demonstrated its commitment to stronger due diligence and safeguards for vulnerable patients beyond what is required by federal rules.

4. Conclusion

The Committee's findings indicate a significant vulnerability in states' Medicaid provider risk assessments: SMAs are not utilizing Medicaid provider risk levels as a program integrity tool. New York, for example, has not designated risk levels for all Medicaid providers as required by 42 C.F.R. § 455 Subpart E. Other states are not incorporating state or nationwide fraud trends into their evaluations, nor are they regularly reassessing the risk levels of Medicaid provider types in their states. As a result, some state practices effectively allow them to use federal regulations as a loophole to avoid more rigorous oversight of moderate and high risk providers upon enrollment and revalidation.[349] When all providers are designated as limited risk, SMAs are only required to verify applicable federal regulations or state requirements for that provider type, confirm state licensure, and conduct routine federal database checks such as the LEIE.[350] Defaulting to limited risk designations reduces oversight and increases the likelihood that fraudulent providers enter and remain in Medicaid undetected.

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[343] Letter from Sara Gagné-Holmes, Commissioner, Maine Department of Health and Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 20 (Mar. 17, 2026) (Document on file with the Comm.).
[344] *Id.*
[345] Attachment to Letter from Steve Corsi, Chief Executive Officer, Nebraska Dep't of Health and Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 8 (Mar. 17, 2026) (Document on file with the Comm.); Nebraska Department of Health and Human Services, Nebraska Program Integrity (Mar. 16, 2026) (Document on file with the Comm.).
[346] *Id.*
[347] *Id.*
[348] Attachment to Letter from Steve Corsi, Chief Executive Officer, Nebraska Dep't of Health and Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 7 (Mar. 17, 2026) (Document on file with the Comm.).
[349] 42 C.F.R. § 455.450.
[350] *Id.*

Elevating provider risk levels, when appropriate, can prevent fraud from occurring at the outset and protects patients from harm caused by fraudulent providers. Nonetheless, many states acknowledged adjusting Medicaid provider risk levels in the last five years only when CMS has required them to do so pursuant to Medicare regulations.[351] For example, Pennsylvania's response to the Committee only addresses mandatory risk level changes required by CMS, and states, "[w]e have the ability to make changes independent of CMS, but this is not a regular occurrence."[352] States would benefit from monitoring emerging fraud trends and regularly re-evaluating provider risk levels as a fraud prevention strategy, in addition to any changes in risk level designations required by CMS.[353]

B. Utilization of Audits

FINDING: States are not using audit and investigative authorities to their fullest potential to prevent Medicaid fraud from occurring. States vary in auditing capacity and are not focusing on high-risk providers in their state.

FINDING: States are not taking fraud into account in their Medicaid auditing activities, dismissing the prevalence of fraud and its risks to program integrity and beneficiaries.

The Committee requested that states produce audits related to FWA in the Medicaid program.[354] State responses varied significantly in their ability to produce audits and the volume of documentation provided, highlighting the challenges of overseeing program integrity. For example, New York produced more than 36,000 pages of audit materials from its Office of Medicaid Inspector General, while Colorado only produced 248 pages, 193 of which were already publicly available.[355]

As the Committee sought to understand how states ensure program integrity through routine claims and provider reviews, the Committee found that states' Medicaid audit capabilities vary greatly. Some states, such as Minnesota, rely on contracted third-party claims reviewers for certain services, while others like New York have dedicated entities, such as an inspector general,

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[351] *See, e.g.*, Enclosure to Letter from Valerie Arkoosh, Secretary, Pennsylvania Department of Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 12 (Mar. 18, 2026) (Document on file with the Comm.); Letter from Sejal Hathi, Director, Oregon Health Authority, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 12 (Mar. 17, 2026) (Document on file with the Comm.).
[352] *See, e.g.*, Enclosure to Letter from Valerie Arkoosh, Secretary, Pennsylvania Department of Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 12 (Mar. 18, 2026) (Document on file with the Comm.).
[353] *See* 42 C.F.R § 424.518.
[354] Letter from The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., to The Hon. Tim Walz, Governor, State of Minnesota, and Shireen Gandhi, Temporary Commissioner, Minnesota Department of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf; *e.g.*, Letter from The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., to The Hon. Jared Polis, Governor, State of Colorado, and Kim Bimestefer, Executive Director, Colorado Department of Health Care Policy and Financing (Mar. 3, 2026), https://d1dth6e84htgma.cloudfront.net/3_3_2026_Letter_to_CO_on_Medicaid_Fraud_62fa04e92a.pdf.
[355] Documents on file with the Comm.

that conduct regular Medicaid audits. Other states, such as Colorado rely on federally required oversight mechanisms, such as audits by CMS, HHS-OIG, Single Audits, and RAC and UPIC reviews. The Committee found the variability in audit capacity concerning.

1. Minnesota

Amidst reports of widespread fraud emerging in Minnesota in late 2025, the state elevated the risk levels of 14 of its Medicaid provider types to high risk, froze pending payments to existing providers, and conducted a comprehensive off-cycle revalidation of all providers under the high risk criteria.[356] Subsequently, CMS directed Minnesota to freeze provider enrollment in these services.[357] To further understand how the state was monitoring program integrity in these services, the Committee's January 16, 2026, letter to Minnesota Governor Tim Walz requested that the state:

> Provide all audits related to the 14 Medicaid programs identified by DHS [Minnesota Department of Human Services] as "high-risk provider types," including audits completed by third-party contract auditors:
>
> a. Adult Companion Services,
> b. Adult Day Services,
> c. Adult Rehabilitative Mental Health Services,
> d. Assertive Community Treatment,
> e. Community First Services and Supports,
> f. Early Intensive Developmental and Behavioral Intervention,
> g. Housing Stabilization Services,
> h. Individualized Home Supports,
> i. Integrated Community Supports,
> j. Intensive Residential Treatment Services,
> k. Night Supervision Services,
> l. Nonemergency Medical Transportation Services,
> m. Recovery Peer Support, and
> n. Recuperative Care.[358]

The 14 high risk provider types include many services that have emerged as high risk for fraud across the U.S. throughout the Committee's investigation, including waivered HCBS, PCS,

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[356] Letter from Shireen Gandhi, Temporary Commissioner, Minnesota Dep't of Human Services, to Caprice Knapp, Acting Director, Center for Medicaid and CHIP Services, U.S. Centers for Medicare and Medicaid Services (Oct. 27, 2025), https://content.govdelivery.com/attachments/MNGOV/2025/10/29/file_attachments/3440543/2025_10_27%20MN%20DHS%20Program%20Integrity%20Letter%20to%20CMS%20FINAL.pdf; News Release, Office of Governor Tim Walz and Lieutenant Governor Peggy Flanagan, Governor Walz Orders a Third-Party Audit of Medicaid Billing at DHS (Oct. 29, 2025), https://mn.gov/governor/newsroom/press-releases/index.jsp?id=1055-711001.

[357] News Release, Minnesota Department of Human Services (Jan. 8, 2026), https://mn.gov/dhs/about-us/legislative-media/media/news/?id=1053-719094.

[358] 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 Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

ADC, ABA, and NEMT services. In August 2025, Minnesota announced it would shut down the HSS program after being advised that the program was rife with fraud.[359]

In response to the Committee's request, Minnesota provided audit documents, including status reports from its third-party contract auditor, Myers and Stauffer LC.[360] From 2020 to 2022 and in 2025, Minnesota contracted with Myers and Stauffer "to conduct reviews of non-emergency medical transportation (NEMT) services for the Minnesota Health Care Programs."[361] Notably, the Myers and Stauffer documentation spans from January 2020 to December 2022 and audit services were not provided again by the contractor, or any other contractor to the Committee's knowledge, until Myers and Stauffer was re-engaged beginning January 2025.[362] The provided NEMT documentation included monthly status reports and some annual reports, but does not contain detailed information or allegations about investigations, providers, improper payments, or fraud.[363] It is not clear to the Committee why Myers and Stauffer was not contracted for NEMT services in FY 2023 and FY 2024.[364] A July 2022 Myers and Stauffer Monthly Status Report states:

> On July 21, 2022, Myers and Stauffer received revised/updated guidance from DHS [Minnesota Department of Human Services] and surveillance and Integrity Review Section, Office of Inspector General (SIRS OIG) clarifying how findings should be determined and cited for NEMT reviews going forward. Findings were determined to be categorized as "Health and Safety" and "Administrative." Review of "Health and Safety" findings was approved to continue, and DHS intends to move forward on cases with these findings. DHS does not intend to take action on "Administrative" findings until after the 2023 legislative session. At this time, "Administrative" findings are considered out of the scope of review. On July 26, 2022, DHS advised Myers and Stauffer that the focus of the remainder of this contract period will be on completion of pending work with no new audits anticipated.[365]

Myers and Stauffer's resumption of review services for Minnesota Department of Human Services in January 2025 is notable given the subsequent actions that took place that year with CMS and the state observing concerning evidence of fraud, and the subsequent criminal investigations that came to a head in the fall of 2025.[366]

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[359] Aki Nace and Ubah Ali, *Minnesota DHS moves to terminate housing stability program amid fraud investigation*, CBS NEWS (Aug. 1, 2025), https://www.cbsnews.com/minnesota/news/minnesota-dhs-requests-to-terminate-housing-stabilization-services/.
[360] DHS005310 - DHS005678 (Documents on file with the Comm.).
[361] Myers & Stauffer, Minnesota Department of Human Services, Non-Emergency Medical Transportation Services https://myersandstauffer.com/provider-resources/minnesota/ (last visited Aug. 27, 2026).
[362] DHS005050 - DHS005061; DHS005207 - DHS005309 (Documents on file with the Comm.).
[363] *Id.*
[364] DHS005535 (Document on file with the Comm.).
[365] DHS005572 (Document on file with the Comm.).
[366] *See 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., 2-3 (Mar. 17, 2026) (response to questions for the record by Kimberly Brandt, Deputy Administrator

Minnesota did not share any documentation with the Committee that indicated it was actively auditing the other 13 high risk Medicaid programs prior to actions it took in 2025 to engage Optum for pre-payment review and analysis of billing irregularities in Medicaid.[367] If such documentation exists, it was within the scope of the Committee's request and should have been produced.

2. Colorado

Colorado initially produced a 22-page list of ongoing and completed Department of Health Care Policy and Financing Audits to the Committee, of which it was subsequently only able to produce Statewide Single Audits from 2021 to 2025, and 55 pages of provider-level closing summaries from its UPIC Qlarant.[368] Colorado was unable to produce any further complete audit documents to the Committee due to the stated fact that the Colorado Department of Health Care Policy and Financing:

> Does not maintain uniform or GAO-style audit reports or summaries that would be feasible to produce and usable for the committee. It is not simply a function of reviews being ongoing, but rather the way in which Colorado conducts audits and maintains audit documentation.[369]

Subsequently, Colorado's counsel clarified that internal Department of Health Care Financing audits were not producible to the Committee, in part because audits are stored as case files and "there are no formal reports published, or closing summaries."[370] Colorado provided a sample of partial HCBS audit files to the Committee, which were associated with overpayments and not fraud.[371]

Colorado has not invested in auditing Medicaid provider types broadly or on a programmatic level, which is concerning given its history of challenges with managing both fraud and improper payments in NEMT.[372] The Committee encourages Colorado to improve its Medicaid auditing process to accommodate third-party oversight of the Medicaid program, and focus on fraud investigations based on programmatic trends.

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and Chief Operating Officer, U.S. Centers for Medicare and Medicaid Services), https://docs.house.gov/meetings/IF/IF02/20260317/119065/HHRG-119-IF02-20260317-QFR001.pdf.

[367] Press Release, Office of Governor Tim Walz and Lieutenant Governor Peggy Flanagan, Governor Walz Orders Third Party Audit of Medicaid Billing at DHS (Oct. 29, 2025), https://mn.gov/governor/newsroom/press-releases/?id=1055-711001.

[368] Attachment 1 to Letter from Ralph Choate, Chief Operating Officer, Colorado Department of Health Care Policy and Financing, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 24 (Mar. 17, 2026) (On file with the Comm.); Attachments 1 and 2 from Colorado supplemental production (May 18, 2026) (On file with the Comm.).

[369] Email from Tara Ganapathy, Counsel to the State of Colorado, to Comm. Staff (Aug. 11, 2026) (On file with the Comm.).

[370] Email from Tara Ganapathy, Counsel to the State of Colorado, to Comm. Staff (Sept. 8, 2026) (On file with the Comm.).

[371] *Id.*

[372] COLORADO OFFICE OF THE STATE AUDITOR, 2301F, STATEWIDE SINGLE AUDIT FISCAL YEAR ENDED JUNE 30, 2023, III-46-III-52 (Feb. 2024), https://content.leg.colorado.gov/sites/default/files/documents/audits/2301f_statewide_single_audit_fy23.pdf.

3. Maine

In its response to the Committee, Maine shared that it does not conduct program integrity audits specifically for the purpose of identifying fraud, nor does it acknowledge that fraud is a serious concern.[373] In response to the Committee's request that Maine provide all audits related to FWA in the state's Medicaid program, Maine's Commissioner of Health and Human Services wrote:

> DHHS [Maine Department of Health and Human Services] conducts program integrity audits that review all potential forms of improper payment, which may in turn generate leads about potential FWA; DHHS does not conduct (or participate in) audits aimed specifically at identifying fraud or abuse, which account for a relatively small proportion of overall improper payments.[374]

The Committee recognizes that Medicaid improper payments should be a point of focus, with GAO estimating $37 billion in nationwide Medicaid improper payments in FY 2025.[375] Improper payments, however, are not always related to fraud, and audits focused solely on improper payments may not detect fraud.[376] GAO's Managing Improper Payments Framework recommends that federal agencies regularly identify and assess program improper payment risks, including those related to fraud.[377]

Maine's response to the Committee indicates that the state does not consider fraud to be a significant threat to program integrity and may not prioritize anti-fraud activities.[378] No amount of fraud is acceptable, as every dollar spent on a fraudulent claim is a dollar unavailable to provide beneficiaries with the health care they need.

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[373] Letter from Sara Gagné-Holmes, Commissioner, Maine Department of Health and Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 6 (Mar. 17, 2026) (Document on file with the Comm.).
[374] *Id.*
[375] U.S. Government Accountability Office, $186 Billion Was Lost to Improper Payments Last Year. How Can We Prevent Them in the Future? (June 4, 2026), https://www.gao.gov/blog/186-billion-was-lost-improper-payments-last-year-how-can-we-prevent-them-future.
[376] U.S. GOVERNMENT ACCOUNTABILITY OFFICE, GAO-24-106608, IMPROPER PAYMENTS AND FRAUD: HOW THEY ARE RELATED BUT DIFFERENT (Dec. 7, 2023), https://www.gao.gov/assets/d24106608.pdf.
[377] *Id.* at 9.
[378] Letter from Sara Gagné-Holmes, Commissioner, Maine Department of Health and Human Services, to The Hon. Brett Guthrie et al., Chairman, H. Comm. on Energy and Commerce, 6 (Mar. 17, 2026) (Document on file with the Comm.).

4. California

FINDING: Hospices have concerning patterns of fraud, such as instances of networks of individuals associated with multiple hospice agencies and several hospices registered to the same address.

FINDING: SMAs may have information about fraud occurring in Medicare services and play an important oversight role in detecting fraudulent billing through state licensing and routine auditing of Medicaid claims submitted by these providers.

California produced a limited number of audit documents in response to the Committee's request for materials related to closed and ongoing Medicaid hospice investigations. Even so, the Medi-Cal hospice audits that were provided confirm concerning patterns of hospice provider networks in the L.A. area, including instances of individuals associated with multiple hospice agencies and several hospices registered to the same address.[379] Many of these cases resulted in referrals for credible allegations of fraud to law enforcement.

Several hospices under investigation by the California Department of Health Care Services also appear to be currently registered with CMS as Medicare providers.[380] Some were penalized by CMS for non-compliance with the Hospice Quality Reporting Program (HQRP) Annual Payment Update in FY 2026.[381] To be compliant with the HQRP, hospices must submit the Hospice Outcomes, and/or Patient Evaluation and the Consumer Assessment of Healthcare Providers and Systems Hospice survey on time.[382] Failure to do so results in a four percent reduction in their Annual Payment Update.[383] Although noncompliance with HQRP is not itself indicative of fraud, it confirms that these hospices are still registered Medicare providers and signals that the impacted hospices are not submitting timely documentation to CMS.

These audits demonstrate that even when a service bills primarily to Medicare, states still play an important oversight role and may possess valuable information on potential fraudulent billing activities through their routine auditing of any Medicaid claims submitted by those providers.

5. Conclusion

The Committee's investigation has revealed that states face several challenges in auditing Medicaid programs effectively. Third-party contract auditors, such as those used in Minnesota to audit NEMT claims, can be effective at targeting a high-risk service area, but only when they are

[379] DHCS-E&C-005865 - DHCS-E&C-005878; DHCS-E&C-005879 - DHCS-E&C-005929; DHCS-E&C-005931 - DHCS-E&C-005947 (Documents on file with the Comm.).
[380] U.S. Centers for Medicare and Medicaid Services, FY2026 Hospices Non-Compliant for APU, https://www.cms.gov/files/document/pac-hospice-fy2026-apu-non-compliant.pdf (last visited Aug. 31, 2026).
[381] *Id.*
[382] U.S. Centers for Medicare and Medicaid Services, Hospice Outreach Email – June 2026, Hospice Quality Reporting Program (HQRP), 2 (June 2026), https://www.cms.gov/files/document/pac-hospice-outreach-email-june-2026-pdf.pdf.
[383] *Id.*

allowed to investigate fully. Other states do not consider programmatic trends when engaging audits of provider types, while others do not consider fraud a priority when designing program integrity activities. California's custody of hospice audit documents shows that state auditing is an important program integrity tool that can inform fraud investigations in other federal health care programs. States must consider investing in robust auditing activities to regularly verify provider billing activity and monitor broader fraud trends that may be occurring. Proactive auditing is an effective tool for states to review claims and target specific provider types for further scrutiny that may be experiencing fraud.

VIII. Trump Administration Actions to Root Out Fraud

FINDING: Recent efforts by the Trump Administration are making significant progress in increasing accountability for states that fail to do what it takes to root out fraud. Many of these efforts must be continued or codified to ensure that program integrity remains a priority of the U.S. Government.

FINDING: Heightened attention to fraud pays off. Federal efforts to combat health care fraud return $12.70 for every $1 spent, demonstrating that oversight pays for itself. Preventative "detect and prevent" program integrity strategies outperform traditional "pay and chase" approaches, reducing losses by identifying improper payments before they occur rather than trying to recover them after the fact.

A. White House Task force to Eliminate Fraud

The Trump Administration is surging federal government resources to antifraud efforts across federal programs.[384] On March 16, 2026, President Trump signed Executive Order 14395, "Establishing the Task Force to Eliminate Fraud."[385] The President's Anti-Fraud Task Force, chaired by Vice President J.D. Vance with Federal Trade Commission Chairman Andrew Ferguson serving as the Vice Chairman, convenes representatives from the entirety of the 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."[386] The President's Anti-Fraud Task Force has been integral in decisive Medicare and Medicaid fraud enforcement actions, including criminal charges, provider enrollment moratoriums and terminations, and facilitating information and data sharing between states and the federal government.[387]

Since its inception, the President's Anti-Fraud Task Force has identified over $260 billion in fraud across all government programs, and stopped nearly $72 billion of that from going to fraudsters.[388] In health care, the Anti-Fraud Task Force has saved $200 million in savings through the Medicaid Fraud War Room, $3 billion recovered from the crack down on fraud in Medicare hospice, HHAs, and DME, and the deferral of $2.5 billion in questionable Medicaid FFP for questionable claims submitted by California and Minnesota.[389]

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[384] *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/.
[385] 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.
[386] *Id.*
[387] *See, e.g.*, 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/.
[388] The White House, The Fraud Ledger, https://www.whitehouse.gov/fraud/ (last visited Sept. 25, 2026).
[389] *Id.*

B. U.S. Department of Justice

The DOJ is prioritizing prosecuting alleged widespread health care fraud across the U.S.[390] On January 8, 2026, President Trump announced a new Assistant Attorney General for National Fraud Enforcement that will "enforce the federal criminal and civil laws against fraud targeting federal government programs."[391] Subsequently, in April 2026, Assistant Attorney General Colin McDonald was sworn in and the new Fraud Division came together, with a mandate given by then-Acting Attorney General Todd Blanche to take "immediate action to expand the National Fraud Enforcement Division into a robust litigating division capable of reaching any fraud—large or small—perpetrated against taxpayer dollars."[392] In Minnesota, DOJ sent resources to assist federal prosecutors, and the FBI is investigating fraudulent providers with the help of forensic accountants and data analysts.[393] Across the nation, DOJ is strengthening its Health Care Fraud Strike Forces, recently instituting the West Coast Strike Force to target fraud schemes in Arizona, Nevada, and Northern California, and expanding the existing New England, Midwest, and Northeast Health Care Fraud Strike Forces to encompass additional federal districts and concentrate further federal resources towards prosecuting health care fraud.[394]

On August 24, 2026, DOJ announced the formation of the National Fraud Detection Center (NFDC), a cross-agency team of prosecutors and experts from the inspectors general community that will investigate fraud in government programs, "including illicit actors overseas and those operating fraud schemes across federal programs."[395] The NFDC will assist the government in breaking down barriers between federal agencies, inspectors general, and state governments to share information and investigate fraud from a whole of government approach.[396]

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[390] The White House, Fact Sheet: President Donald J. Trump establishes new Department of Justice division for national fraud enforcement (Jan. 8, 2026), https://www.whitehouse.gov/fact-sheets/2026/01/fact-sheet-president-donald-j-trump-establishes-new-department-of-justice-division-for-national-fraud-enforcement/.
[391] *Id.*
[392] U.S. Dep't of Justice, About the National Fraud Enforcement Division, https://www.justice.gov/fraud/about-national-fraud-enforcement-division (last visited Aug. 25, 2026).
[393] The White House, Fact Sheet: President Donald J. Trump establishes new Department of Justice division for national fraud enforcement (Jan. 8, 2026), https://www.whitehouse.gov/fact-sheets/2026/01/fact-sheet-president-donald-j-trump-establishes-new-department-of-justice-division-for-national-fraud-enforcement/; Press Release, U.S. Dep't of Justice, This Week in Fraud: The Fraud Division Announced Expansion of Midwest Task Force and Authorization to Hire 15 New Medicaid Prosecutors, an Unprecedented Minnesota Health Care Fraud Takedown, and a $2 Billion Telemedicine Health Care Fraud Scheme (May 22, 2026), https://www.justice.gov/opa/pr/week-fraud-fraud-division-announced-expansion-midwest-task-force-and-authorization-hire-15.
[394] Press Release, U.S. Dep't of Justice, The Fraud Division Announces Charges Against 19 Defendants for Medicaid Home Health Aid Schemes (Aug. 4, 2026), https://www.justice.gov/opa/pr/fraud-division-announces-charges-against-19-defendants-medicaid-home-health-aid-schemes.
[395] Press Release, U.S. Dep't of Justice, Department of Justice Announces Launch of National Fraud Detection Center to Combat Fraud Against Taxpayer-Funded Programs (Aug. 24, 2026), https://www.justice.gov/opa/pr/department-justice-announces-launch-national-fraud-detection-center-combat-fraud-against?utm_medium=email&utm_source=govdelivery.
[396] *Id.*

C. U.S. Department of Health and Human Services

HHS has recently taken action to hold states accountable for unaddressed single audit findings by instituting the Audit Enforcement and Risk Oversight (AERO) initiative.[397] AERO will use AI tools to detect chronic noncompliance with single audit findings, which often include discrepancies in Medicaid programs, and holds states accountable for not resolving issues that persist year after year.[398]

1. Centers for Medicare and Medicaid Services

i. Shift from "Pay and Chase" to "Detect and Prevent"

The Trump Administration is making progress in shifting antifraud efforts from after the fact enforcement of claims that have already been paid, to preventing fraudulent claims from being paid in the first place. These efforts leverage AI and machine learning to flag unusual patterns in testing, billing, results, and other documentation for further review and have been successful in preventing fraudulent payments.[399] A shift from the "pay and chase" to the "detect and prevent" model is significant because under the "pay and chase" model very few dollars are actually recovered once payments are released. Thus, under the "detect and prevent" model, the federal government is better positioned to save taxpayers a significant amount of money from being lost to fraud.

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."[400] Specifically, Administrator Oz highlighted the risk of fraudulent providers, especially those without NPIs, and urged states to closely review such providers.[401] Simultaneously, Administrator Oz sent letters to all state Medicaid directors asking them to submit a two-year provider revalidation strategy.[402] In the letter, Administrator Oz highlighted "a persistent and growing Medicaid threat posed by sophisticated actors knowingly exploiting these complex systems for financial gain."[403] Additionally, the request encouraged states to increase their oversight of high risk provider types by revalidating them more frequently than the required

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[397] Press Release, U.S. Dep't of Health and Human Services, HHS Cracks Down on Years of Unchecked Audit Findings (May 21, 2026), https://www hhs.gov/press-room/asfr-aero-audit-enforcement-risk-oversight-initiative html.
[398] *Id.*
[399] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Prevents $1.6 Billion in Fraudulent Medicare Laboratory Payments (Aug. 28, 2026), https://www.cms.gov/newsroom/press-releases/cms-prevents-1-6-billion-fraudulent-medicare-laboratory-payments.
[400] *E.g.*, Letter from The Hon. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Kay Ivey, Governor, State of Alabama, https://leadingage.org/wp-content/uploads/2026/04/042326-HHS-Letter-Alabama-Governor.pdf.
[401] *Id.*
[402] Letter from The Hon. Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to State Medicaid Directors (Apr. 23, 2026), https://leadingage.org/wp-content/uploads/2026/04/042326-HHS-Letter-Medicaid-Director.pdf.
[403] *Id.*

minimum of once every five years.[404] CMS also asked that SMAs include a strategy for assessing the enrollment of providers without NPIs.[405]

In response to CMS' requests of state governors and Medicaid directors to conduct comprehensive provider revalidation, some states were complementary of the Administration's efforts to strengthen Medicaid program integrity.[406] For example, the Nebraska Department of Health and Human Services released a statement in support of CMS' actions, sharing that it will fully comply with the request to conduct a swift revalidation and submit a comprehensive plan to improve provider screening.[407] Nebraska also highlighted the importance of provider revalidation, citing its role in protecting taxpayer dollars, preventing fraud, improving program accuracy, and focusing on high-risk areas.[408]

In June 2025, CMS launched the Fraud Defense Operations Center (FDOC), also known as the Fraud War Room, and announced cross-agency efforts to combat suspected fraud and improper payments in Medicare.[409] The FDOC brings together a "specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement" to use data analytics to identify irregular billing practices in real time.[410] In 2025, the FDOC's actions resulted in over $1.8 billion in payment suspensions, investigations of over 347 providers, and suspension of payment to 249 providers due to suspected fraud.[411] In the first half of 2026, the FDOC suspended over $371 million in Medicare payments to 267 providers and suppliers suspected of fraud, including $226 million in suspected DME fraud and $23 million in suspected hospice fraud.[412] Since January 2025, CMS has halted more than $1.6 billion in potentially fraudulent or improper Medicare laboratory claims and saved $72 million by revoking the Medicare certification of 157 fraudulent laboratory providers.[413]

After the FDOC's great success in 2025, CMS expanded the FDOC to include Medicaid in April 2026, utilizing its AI-enabled tools to detect Medicaid fraud.[414] In its first 88 days, the Medicaid Fraud War Room stopped $203 million in potentially improper payments, issued 42

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[404] *Id.*
[405] *Id.*
[406] News Release, Nebraska Department of Health and Human Services, Nebraska DHHS Announces Full Support for Federal Efforts to Strengthen Medicaid Integrity (Apr. 23, 2026), https://dhhs ne.gov/Pages/Nebraska-DHHS-Announces-Full-Support-for-Federal-Efforts-to-Strengthen-Medicaid-Integrity.aspx.
[407] *Id.*
[408] *Id.*
[409] U.S. Centers for Medicare and Medicaid Services, Fraud Defense Operations Center, Fast Facts: CMS' Fraud, Waste, and Abuse Sprint Strategy (Jun. 2025), https://www.cms.gov/files/document/cms-fraud-waste-and-abuse-sprint-strategy.pdf.
[410] *Id.*
[411] U.S. Centers for Medicare and Medicaid Services, Fraud Defense Operations Center, Fast Facts (Jan. 2026), https://www.cms.gov/files/document/fdoc-fact-sheet-updated.pdf.
[412] U.S. Centers for Medicare and Medicaid Services, Fraud Defense Operations Center, Fast Facts (Aug. 2026), https://www.cms.gov/files/document/cpi-fdoc-fact-sheet-updated-first-year.pdf.
[413] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Prevents $1.6 Billion in Fraudulent Medicare Laboratory Payments (Aug. 28, 2026), https://www.cms.gov/newsroom/press-releases/cms-prevents-1-6-billion-fraudulent-medicare-laboratory-payments.
[414] U.S. Centers for Medicare and Medicaid Services, Medicaid Fraud War Room, Fast Facts (Jun. 2026), https://www.cms.gov/files/document/medicaid-fraud-war-room-fast-facts.pdf.

Federal Notices of Intent to Exclude providers from federal health care programs, and identified 50 providers subject to state and/or federal enforcement actions.[415]

In February 2026, CMS issued a request for information (RFI) to help inform the development of a possible future rule under CMS' Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative by seeking input on ways to strengthen CMS' ability to prevent, detect, and respond to FWA, and program inefficiencies in Medicare, Medicaid, CHIP, and the Health Insurance Marketplace.[416] The CRUSH RFI sought stakeholder feedback to 13 prompts by March 30, 2026.[417] The prompts included: program integrity; enhanced identity proofing and ownership requirements; Preclusion List and Medicare Advantage enrollment requirements; reducing Medicare fraud related to laboratory tests; reducing risks from non-participating DME suppliers in Medicare Advantage; reducing fraudulent Medicare Parts A and B claims submissions; AI in Medicare Advantage coding oversight and hospital billing; beneficiary solicitation; beneficiary contact; surety bonds; Medicaid and CHIP; state-specific Medicaid and CHIP questions; and Federally Facilitated Exchanges and State-Based Exchanges.[418]

At the end of 2025, CMS updated the 2026 Medicare Physician Fee Schedule to introduce payment reforms for wound care skin substitutes.[419] These changes aim to reduce FWA after HHS-OIG noted sharp increases in Medicare Part B spending on skin substitutes in recent years, which rose from $389 million per quarter in 2022 to $2.88 billion per quarter in 2024.[420] Prior to payment reform, Medicare reimbursements for skin substitutes exceeded the cost of purchasing the supplies, incentivizing providers to engage in FWA by billing for, and using more units of these supplies than may be necessary, to pocket the difference.[421] Due to the payment reform, and targeted investigations of FWA in this area, Medicare claims for skin substitutes dropped from $14.4 billion in 2025, to just $1 million in the first half of 2026.[422] CMS credits

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[415] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Medicaid Fraud War Room Stops More Than $203 Million in Improper Payments During First 88 Days (July 28, 2026), https://www.cms.gov/newsroom/press-releases/cms-medicaid-fraud-war-room-stops-more-203-million-improper-payments-during-first-88-days.

[416] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.

[417] Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH), 91 Fed. Reg. 9803 (proposed Feb. 27, 2026) (to be codified at 42 C.F.R. pt. 424).

[418] *Id.*

[419] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Modernizes Payment Accuracy and Significantly Cut Spending Waste (Oct. 31, 2025), https://www.cms.gov/newsroom/press-releases/cms-modernizes-payment-accuracy-significantly-cuts-spending-waste; U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-BL-24-00420, MEDICARE PART B PAYMENT TRENDS FOR SKIN SUBSTITUTES RAISE MAJOR CONCERNS ABOUT FRAUD, WASTE, AND ABUSE (Sept. 2025), https://oig hhs.gov/documents/evaluation/10939/OEI-BL-24-00420.pdf.

[420] *Id.*

[421] *Id.*

[422] Press Release, U.S. Dep't of Justice, National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with over $14.6 Billion in Alleged Fraud (Jun. 30, 2026), https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

this payment reform with saving seniors approximately $11 a month, or $132 a year, on their Medicare Part B premiums.[423]

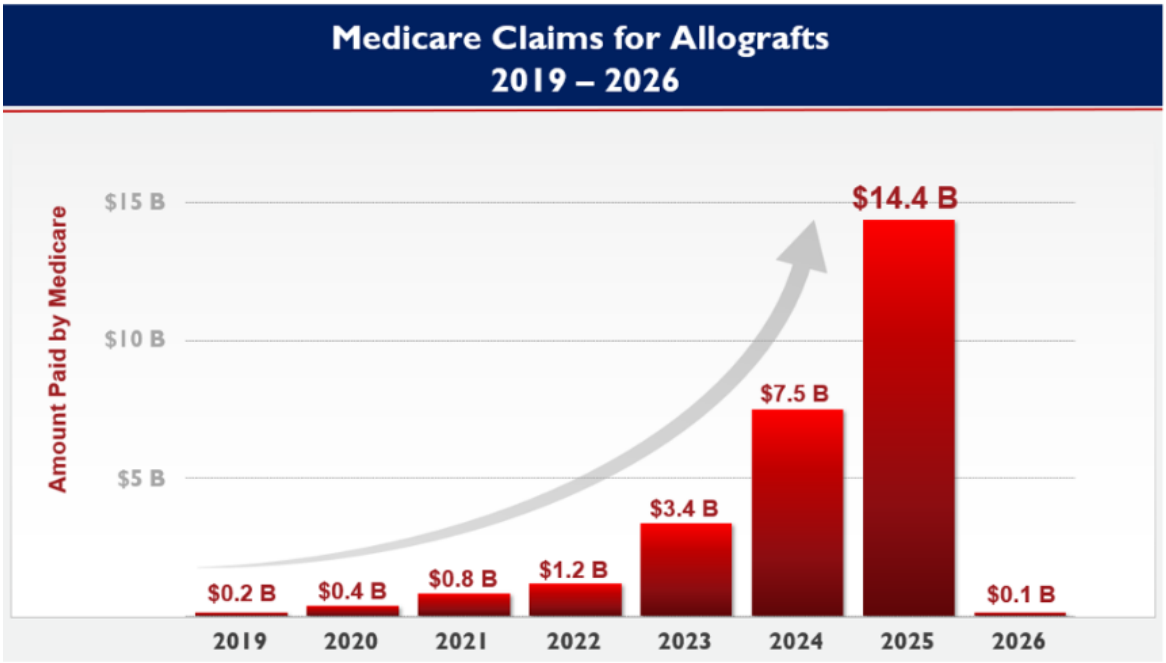

Figure 6: Medicare claims paid for allografts (skin substitutes), 2019-2026[424]

Secretary Kennedy recently announced a historic policy change by extending exclusion authority—previously only delegated to HHS-OIG—to CMS.[425] This expanded authority allows CMS to suspend or permanently remove bad actors from federal health care programs based on certain prohibited activities, misdemeanors, and criminal convictions.[426]

ii. Guidance on High-Risk Services

CMS provides additional resources for SMAs on high-risk Medicaid services that may be vulnerable to fraud.[427] In August 2026, CMS developed an ABA data book and 174-page toolkit, which include spending data and information on recommended guidelines for provider qualifications, credentialing, and enrollment and ownership; utilization management; and

[423] Dr. Mehmet Oz (@DrOzCMS), X, (Sept. 16, 2026, 5:00 P.M.), https://x.com/DrOzCMS/status/2100329056868687922.
[424] *Id.*
[425] U.S. Dep't of Health and Human Services, *Remarks by Secretary Robert F. Kennedy, Jr., Secretary, at news conference on combatting fraud at the U.S. Dep't of Health and Human Services, Washington, D.C.* (July 21, 2026), https://www.c-span.org/program/news-conference/hhs-secy-kennedy-dr-oz-and-others-news-conference-on-combating-fraud/683173.
[426] U.S. Dep't of Health and Human Services Office of Inspector General, Background Information & Exclusion Authorities, https://oig hhs.gov/exclusions/background-information-exclusion-authorities/ (last visited Sept. 4, 2026).
[427] U.S. Centers for Medicare and Medicaid Services, Crushing Fraud, Waste, & Abuse, https://www.cms.gov/fraud (last visited Sept. 1, 2026).

program integrity to assist states with administering this benefit.[428] The Toolkit does not establish new federal guidance on ABA services, but provides information about possible documentation characteristics that may be indicative of improper billing or fraud such as overlapping treatments or excessive treatment hours without documented patient outcomes.[429] CMS has also identified ADC and PCS, in addition to ABA, as "the biggest risks to the Medicaid program," sharing information about national trends in these programs, such as states with the highest amount paid per beneficiary and per provider.[430] With this information on national payment rates, states can compare their spending to others and adjust payment rates to align with regional or national trends.

iii. Enrollment Moratoria in High-Risk Programs

On February 25, 2026, CMS imposed a six-month nationwide enrollment moratorium for certain DME suppliers after stopping over $1.5 billion in suspected fraud in claims last year.[431] During the moratorium, CMS focused on identifying additional safeguards to prevent fraud in Medicare DME claims.[432] CMS plans to increase transparency by publishing information on the providers and suppliers whose participation in the Medicare program has been revoked to ensure these providers are not permitted to enroll in private insurance or other health care programs.[433] The DME moratorium expired on August 27, 2026; however, CMS has issued a new probationary prior authorization period for newly enrolled suppliers of certain types of DME beginning October 15, 2026.[434]

Shortly after CMS implemented its nationwide Medicare DME enrollment moratorium, Florida issued its own temporary moratorium that mirrored the federal action, halting enrollment of new DME providers in Medicaid for six months.[435] Florida's decision to reinforce federal

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[428] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Launches New State Toolkit to Protect Children with Autism, Strengthen Oversight of Applied Behavior Analysis Services (Aug. 4, 2026), https://www.cms.gov/newsroom/press-releases/cms-launches-new-state-toolkit-protect-children-autism-strengthen-oversight-applied-behavior; U.S. Centers for Medicare and Medicaid Services, Autism Services, https://www medicaid.gov/medicaid/benefits/autism-services (last visited Aug. 21, 2026).

[429] U.S. Centers for Medicare and Medicaid Services, State Medicaid & Children's Health Insurance Program Applied Behavior Analysis Toolkit (Aug. 2026), 34, https://www medicaid.gov/medicaid/downloads/autism-services-aba-toolkit.pdf.

[430] U.S. Centers for Medicare and Medicaid Services, Crushing Fraud, Waste, & Abuse, https://www.cms.gov/fraud (last visited Sept. 1, 2026).

[431] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.

[432] *Id.*

[433] *Id.*

[434] U.S. Centers for Medicare and Medicaid Services, Probationary Prior Authorization Process for Newly Enrolled Suppliers of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-pre-claim-review-initiatives/probationary-prior-authorization-process-newly-enrolled-suppliers-certain-durable-medical-equipment (last visited Sept. 9, 2026).

[435] Press Release, Florida Agency for Health Care Administration, Agency for Health Care Administration Issues Temporary Moratorium on Enrollment of New Medicaid Providers for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Mar. 26, 2026).
https://ahca.myflorida.com/content/download/28580/file/3.26.26_Moratorium_on_DME_Providers.pdf.

efforts and protect the state from potentially fraudulent providers demonstrates a strong commitment to partnering with the federal government to combat fraud in this vulnerable service area.

On May 13, 2026, CMS announced six-month enrollment moratoria on Medicare hospice and HHAs due to "deeply troubling fraud in hospice and home health."[436] During the enrollment freeze, CMS will ramp up focused fraud investigations of hospice and HHA providers, and newly enrolling providers or those changing ownership will be kept out of the Medicare system.[437] This action was taken in conjunction with other measures to crack down on hospice and HHA fraud, including removing 1,076 hospices from the Medicare program in California; targeted oversight of providers operating in Arizona, California, Georgia, Ohio, Nevada, and Texas; and a new hospice scoring system to increase public transparency of suspicious hospice facilities.[438]

iv. Deferrals of Medicaid Payments That Warrant Further Scrutiny

a. Minnesota

In response to widespread allegations of Medicaid fraud in Minnesota, CMS launched an audit of the Minnesota Medicaid program, freezing provider enrollment and deferring payments on 14 high risk programs including adult companion, autism behavioral therapy, rehabilitative mental health services, individualized home supports, and residential treatment services.[439] CMS warned Minnesota that if it does not take sufficient corrective actions to remedy the program integrity failures of its Medicaid programs, it risks the withholding of federal Medicaid funds.[440]

On January 14, 2026, CMS announced it intends to withhold quarterly federal funding for Minnesota's 14 high risk Medicaid programs, totaling $515,154,947.56, or approximately $2 billion a year, until "Minnesota demonstrates full and sustained compliance with federal

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[436] Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice and Home Health Agency Enrollment Moratoria (May 13, 2026), https://www.cms.gov/newsroom/press-releases/cms-announces-aggressive-nationwide-crackdown-fraud-six-month-hospice-home-health-agency-enrollment.
[437] *Id.*
[438] *Id.*; Press Release, The White House, Fraud.gov: Track the Trump Administration's Relentless War on Fraud (Aug. 6, 2026), https://www.whitehouse.gov/releases/2026/08/fraud-gov-track-the-trump-administrations-relentless-war-on-fraud/; Press Release, U.S. Centers for Medicare and Medicaid Services, CMS Proposes New Transparency Measures to Strengthen Oversight of Hospice Providers (Apr. 2, 2026), https://www.cms.gov/newsroom/press-releases/cms-proposes-new-transparency-measures-strengthen-oversight-hospice-providers.
[439] 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 The Hon. Mehmet Oz, Administrator, Centers for Medicare and Medicaid Services, to The Hon. Tim Walz, Governor, State of Minnesota (Jan. 6, 2026), https://x.com/DrOzCMS/status/2008737551016968580/photo/1.
[440] Notice of Opportunity for Hearing on Compliance of Minnesota State Plan Provisions Concerning Program Integrity and Fraud, Waste, and Abuse with Title XIX (Medicaid) of the Social Security Act, 91 Fed. Reg. 1539 (Jan. 14, 2026), https://www.federalregister.gov/documents/2026/01/14/2026-00512/notice-of-opportunity-for-hearingon-compliance-of-minnesota-state-plan-provisions-concerning.

Medicaid requirements."[441] Subsequently, on February 25, 2026, CMS announced it was deferring $259.5 million of Minnesota's Medicaid fourth quarter 2025 federal matching funds pending further review of questionable claims.[442] 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."[443] 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.[444]

On March 2, 2026, Minnesota filed suit against CMS, seeking a preliminary injunction of the $259.5 million deferral.[445] On April 6, 2026, the U.S. District Court for the District of Minnesota denied the state's attempt to block the CMS deferral of funds, finding that CMS' deferral notice met regulatory requirements under 42 C.F.R. § 430.40.[446]

On July 21, 2026, CMS deferred $199 million from Medicaid FFP to Minnesota after focused financial reviews were unable to validate claims associated with the14 high risk services.[447] CMS is continuing to review questionable claims and is seeking additional documentation from the state to address potential billing and eligibility concerns.[448]

b. California

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."[449] 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

[441] 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. 1542 (Jan. 14, 2026) https://www.govinfo.gov/content/pkg/FR-2026-01-14/pdf/2026-00512.pdf.
[442] Press Release, U.S. Centers for Medicare and Medicaid Services, Trump Administration Prioritizes Affordability by Announcing Major Crackdown on Health Care Fraud (Feb. 25, 2026), https://www.cms.gov/newsroom/press-releases/trump-administration-prioritizes-affordability-announcing-major-crackdown-health-care-fraud.
[443] *Id.*
[444] *Id.*
[445] Elizabeth Casolo, *Minnesota sues feds over nearly $244M in frozen Medicaid funds*, BECKER'S PAYER ISSUES (Mar. 4, 2026), https://www.beckerspayer.com/legal/minnesota-sues-feds-over-nearly-244m-in-frozen-medicaid-funds/.
[446] Ryan Luetkemeyer, *Judge refuses to block Trump's $243 million Medicaid deferral in Minnesota*, COURTHOUSE NEWS SERVICE (Apr. 6, 2026), https://www.courthousenews.com/judge-refuses-to-block-trumps-243-million-medicaid-deferral-in-minnesota/.
[447] Press Release, U.S. Dep't of Health and Human Services, HHS Defers More than $1 Billion in Medicaid Payments to California, Minnesota, Pending Review of High-Risk Claims in Crackdown on Fraud (July 21, 2026), https://www hhs.gov/press-room/hhs-defers-medicaid-payments-california-minnesota-fraud-review.html.
[448] *Id.*
[449] Letter from The Hon. 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.

home health care agencies and expenses concentrated in L.A. County, California.[450] In February 2026, the California Department of Health Care Services responded to CMS' inquiry.[451]

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."[452] The deferral consists of over $1.18 billion of claims for costs in the state's Community First Choice (CFC) Program and PCS programs.[453] CFC is a Section 1915(k) 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.[454] Specifically, CMS requested detailed claims data from California, which the state failed to submit to CMS in a timely manner.[455] 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."[456] After reviewing California's CFC-PCS claims, on July 21, 2026, CMS deferred $867.5 million in federal Medicaid payments to California until the state provides additional supporting documentation for those claims.[457]

2. U.S. Department of Health and Human Services Office of Inspector General

Federal law enforcement efforts to prosecute health care fraud are effective. In FY 2025, HHS-OIG recovered $12.70 for every $1 spent on investigative activity.[458]

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-

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[450] *Id.*

[451] Letter from Tyler Sadwith, State Medicaid Director, California Dep't of Health Care Services, to Dan Brillman, Director, U.S. Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, and Kimberly Brandt, Acting Director, U.S. Centers for Medicare and Medicaid Services, Center for Program Integrity (Feb. 17, 2026), https://www.dhcs.ca.gov/wp-content/uploads/2026/04/California27s-Response-to-CMS27-Program-Integrity-Request.pdf.

[452] 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-medicaid-fraud-california html.

[453] 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.

[454] U.S. Centers for Medicare and Medicaid Services, Medicaid, Community First Choice (CFC) 1915 (k), https://www medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k (last visited Sept. 8, 2026).

[455] 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.

[456] *Id.* at 5.

[457] Press Release, U.S. Dep't of Health and Human Services, HHS Defers More than $1 Billion in Medicaid Payments to California, Minnesota, Pending Review of High-Risk Claims in Crackdown on Fraud (July 21, 2026), https://www hhs.gov/press-room/hhs-defers-medicaid-payments-california-minnesota-fraud-review.html.

[458] U.S. Dep't of Health and Human Services Office of Inspector General, HHS-OIG Impact Brief (Jan. 2026), https://oig hhs.gov/documents/impact-briefs/11446/impact-brief-2025-overview--final--508.pdf.

fighting efforts.[459] Inspector General Bell notified the MFCUs that HHS-OIG intends to conduct thorough recertifications of each unit to ensure they are effectively fighting fraud.[460]

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 receive approximately $3 million annually in federal funds.[461] 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."[462] 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.[463] Moreover, the lack of MFCU activity is concerning given the growth in the state's Medicaid program over the last six years.[464]

On June 30, 2026, Inspector General Bell wrote to New York Attorney General Letitia James and MFCU Director Amy Held, formally denying the New York MFCU's recertification request on the grounds that it is "not effectively carrying out its statutory functions and responsibilities as required," "not adhering to the MFCU Performance Standards," and "not using its resources effectively to investigate cases of possible fraud in the administration of the Medicaid program."[465]

In particular, Inspector General Bell highlighted New York's failure to adhere to performance standards by failing to employ adequate investigative staff, receive referrals from MCOs, manage case progression in a timely manner, and cooperate with HHS-OIG on Medicare-Medicaid cases.[466] The MFCU's failure to investigate and prosecute fraud is highlighted by the fact that New York ranked last of five similarly sized MFCUs for criminal fraud convictions, with only 53 fraud convictions reported from 2023 to 2025, and was last in fraud indictments compared to similarly situated states.[467] Notably, New York's MFCU obtained less than 10 criminal fraud indictments in four of the last five years.[468]

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[459] *E.g.*, Letter from The Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services, 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.
[460] *Id.*
[461] Letter from The Hon. T. March Bell, Inspector General, U.S. Dep't of Health and Human Services, 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.
[462] *Id.*
[463] *Id.*
[464] *Id.*
[465] Letter from The Hon. T. March Bell, Inspector General, to The Hon. Letitia A. James, Attorney General, State of New York, and Amy Held, Director (June 30, 2026), https://oig hhs.gov/documents/medicaid-fraud-control-units/11727/NY_MFCU.pdf.
[466] *Id.*
[467] *Id.*
[468] *Id.*

IX. Conclusion

Medicare and Medicaid fraud affects every American. When criminals steal from these programs, it drives up costs and drains resources meant to support the elderly, people with disabilities, children, and pregnant women. It is imperative that states partner with the federal government and law enforcement to stop fraud and protect these vital programs. Keeping Medicare and Medicaid financially strong—and making sure they continue to provide high-quality health care—is the goal of the Committee's oversight efforts. Federal and state governments have a duty to steward precious federal funds wisely and ensure that funding is only spent on essential services.

The Committee's investigation uncovered alarming fraud risks in Medicare and Medicaid in addition to glaring discrepancies and deficiencies in state Medicaid program integrity. Specifically, the Committee identified multiple important observations:

- Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars per year. Rampant fraud jeopardizes the longevity and purpose of Medicare and Medicaid to deliver necessary health care services to vulnerable patients. Federal health care programs have limited resources, and every dollar spent on fraud is a dollar not going to a beneficiary that needs these critical services.

- Fraud is not a victimless crime. Patients suffer under the care of fraudulent providers. Patients have suffered from stolen identities, long wait lists, substandard health care, and, in some cases, neglect and death.

- There are nationwide trends in fraud that indicate certain services in Medicare and Medicaid are at risk.

    - In Medicare, areas with elevated fraud activity include hospice, home health services, DME, and genetic testing.

    - Medicaid programs experiencing high rates of fraud include ABA services, NEMT, HCBS, ADC, and SUD treatment.

- Medicare and Medicaid fraud have distinct and increasingly sophisticated patterns, with fraud schemes crossing state and international lines more than they have previously. TCOs are perpetrating fraud across the U.S., targeting state and federal health care programs and laundering money through overseas bank accounts.

- Medicaid services are not always designed with program integrity in mind. States have rapidly expanded benefits under HCBS Section 1915(c) waivers, resulting in sky rocketing program costs and leaving Medicaid vulnerable to fraud without proper programmatic safeguards.

- Medicaid provider screening is essential for verifying that providers are legitimate and qualified to deliver health care services. Current preventative program integrity efforts are not sufficient, and requirements for states to conduct provider screening activities are not adequate.

- States are not utilizing Medicaid provider risk levels as an essential program integrity tool and some states are not meeting current federal requirements. By not using available program integrity tools, states may be using federal standards as a loophole to avoid being held to further provider screening requirements.

- States are not using audit and investigative authorities to their fullest potential to prevent Medicaid fraud from occurring. States vary in auditing capacity and are generally not focusing on high-risk providers in their state.

- States are not taking fraud into account in their Medicaid auditing activities, dismissing the prevalence of fraud and its risks to program integrity and beneficiaries.

- Concerning patterns of fraud have also been identified hospice services, such as instances of networks of individuals associated with multiple hospice agencies and several hospices registered to the same address.

- SMAs often have information on fraud occurring in Medicare services and must play an important oversight role in detecting fraudulent billing through state licensing and routine auditing of Medicaid claims submitted by these providers.

- Heightened attention to fraud pays off. Federal efforts to combat health care fraud return $12.70 for every $1 spent, demonstrating that oversight pays for itself. Preventative "detect and prevent" program integrity strategies outperform traditional "pay and chase" approaches, reducing losses by identifying improper payments before they occur rather than trying to recover them after the fact.

- Recent efforts by the Trump Administration are making significant progress in increasing accountability for states that fail to root out fraud. Many of these efforts must be continued or codified to ensure that program integrity remains a priority of the U.S. Government.

In response to the Committee's oversight and the Trump Administration's historic efforts to hold states accountable, some states are beginning to take Medicaid fraud more seriously by imposing enrollment moratoria and reconsidering provider risk levels.[469] For example, New York

[469] *See* Maya Kaufman, *New York temporarily freezes Medicaid enrollments for high-risk providers*, POLITICOPRO (July 30, 2026), https://subscriber.politicopro.com/article/2026/07/new-york-temporarily-freezes-medicaid-enrollments-for-high-risk-providers-01017872; *State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies: Hearing Before the H. Comm. on Energy and Commerce, Subcomm. on Oversight and Investigations*, 119th Cong. 43 (statement of The Hon. John Joyce, Chairman, Subcomm. on Oversight and Investigations) (June 25, 2026), https://docs.house.gov/meetings/IF/IF02/20260625/119405/HHRG-119-IF02-Transcript-20260625.pdf.

has imposed enrollment moratoria on certain programs and is elevating the risk level of provider types experiencing fraud in the state.[470] These are notable steps in the right direction, but the Committee's findings indicate that there is more to be done. For instance, New York has failed to comply with federal Medicaid regulations by designating categorical risk levels for all its Medicaid provider types.[471] Additionally, states such as California and Oregon have failed to acknowledge ongoing fraud trends and re-evaluate provider risk levels accordingly in their states.[472] All states should take note of the findings of this report and assess the strength of their state's Medicaid program integrity in response.

Strong oversight by Congress is essential, and the Committee plays a critical constitutional role in overseeing the administration of public health insurance. The findings in this report inform the Committee's recommendations to Congress, states, and the Executive Branch, to strengthen Medicare and Medicaid and ensure accountability across these programs. Ultimately, these actions will help safeguard the integrity of Medicare and Medicaid and make certain they will continue to serve beneficiaries effectively for years to come.

[470] *Id.*
[471] Email from Ben Conery, Counsel to the New York Executive Chamber and New York Dep't of Health, to H. Comm. on Energy and Commerce Majority staff (July 2, 2026) (On file with the Comm.).
[472] Letter from Judith Recchio, Deputy Director and Chief Counsel, California Dep't of Health Care Services, to The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., 4 (Apr. 24, 2026) (Document on file with the Comm.); Letter from Sejal Hathi, Director, Oregon Health Authority, to The Hon. Brett Guthrie, Chairman, H. Comm. on Energy and Commerce, et al., 12 (Mar. 17, 2026) (Document on file with the Comm.).

X. Committee Recommendations

FINDING: Medicare and Medicaid fraud occurs nationwide and costs American taxpayers billions of dollars per year. Rampant fraud jeopardizes the longevity and purpose of Medicare and Medicaid to deliver necessary health care services to vulnerable patients. Federal health care programs have limited resources, and every dollar spent on fraud is a dollar not going to a beneficiary that needs these critical services.

- **Recommendation:** States should strengthen enforcement by adopting False Claims Act statutes, expanding whistleblower protections, and increasing independent oversight of Medicaid programs.

- **Recommendation:** CMS should consider allowing Medicare supplement (Medigap) carriers to temporarily pause and validate supplemental payments on Medicare claims when objective indicators of fraud, waste, abuse, billing error, or later Medicare adjustment risks are present.

- **Recommendation:** CMS should strengthen the Preclusion List to contain information about all previously revoked and barred Medicare providers.

- **Recommendation:** CMS should implement HHS-OIG's recommendation to require, or seek statutory authority to require, all Medicare Advantage DME suppliers be enrolled in Medicare.

- **Recommendation:** Per HHS-OIG's recommendation, Medicare Advantage organizations should strengthen oversight of out-of-network DME suppliers so that it aligns with the rigor used for in-network supplier screening.

- **Recommendation:** States should contractually require MCOs to refer potential fraud to the appropriate entities in a timely fashion and specify actions that will be taken if MCOs do not comply.

- **Recommendation:** States should improve fraud referral processes, provider enrollment verification requirements, and encounter data validation efforts to identify and recover improper payments.

- **Recommendation:** Congress should allow MFCU resources to be used to investigate and prosecute instances of fraud related to the application for, or receipt of, Medicaid benefits.

- **Recommendation:** Congress should strengthen state accountability by aligning federal financial incentives with program integrity performance, payment accuracy, and fraud recoveries.

FINDING: There are nationwide trends in fraud that indicate certain services in Medicare and Medicaid are at risk.

- **In Medicare, areas with elevated fraud activity include hospice, home health services, DME, and genetic testing.**
- **Medicaid programs experiencing high rates of fraud include ABA services, NEMT, HCBS, ADC, and SUD treatment.**

FINDING: Medicaid services are not always designed with program integrity in mind. States have rapidly expanded benefits under HCBS Section 1915(c) waivers, resulting in sky rocketing program costs, and leaving Medicaid vulnerable to fraud without proper programmatic safeguards.

- **Recommendation:** CMS should expand guidance and training provided to SMAs on the specific risks of high-risk Medicaid provider types.

FINDING: Fraud is not a victimless crime. Patients suffer under the care of fraudulent providers. Patients have suffered from stolen identities, long wait lists, substandard health care, and in some cases neglect and death.

- **Recommendation:** CMS and states should improve supporting beneficiary education and engagement initiatives that empower Medicaid recipients to identify and report FWA.

FINDING: Medicare and Medicaid fraud have distinct and increasingly sophisticated patterns, with fraud schemes crossing state and international lines more than they have previously. TCOs are perpetrating fraud across the U.S., targeting state and federal health care programs, and laundering money through overseas bank accounts.

- **Recommendation:** CMS should adopt HHS-OIG's recommendation to support periodic information sharing among Medicare, Medicaid, and stakeholder groups to mitigate evolving threats of electronic fund transfer fraud schemes.

- **Recommendation:** CMS and states should strengthen information sharing across Medicaid, Medicare, and other federal programs to improve provider screening and identify fraud schemes that cross state and program boundaries. This includes developing more comprehensive provider ownership databases, expanding the use of existing federal data systems to identify excluded providers, facilitating routine information sharing among federal and state partners, and supporting government-wide initiatives to resolve persistent Medicaid audit findings that place federal funds at risk.

FINDING: States are not utilizing Medicaid provider risk levels as an essential program integrity tool and some states are not meeting current federal requirements. By not using available program integrity tools, states may be using federal standards as a loophole to avoid being held to further provider screening requirements.

- **Recommendation:** CMS should consider strengthening regulatory guidance for SMAs to standardize Medicaid-only provider risk levels across more provider types.
- **Recommendation:** CMS should establish minimum qualifications and screening risk standards for Medicaid providers, particularly high-risk provider types.
- **Recommendation**: CMS should implement HHS-OIG's 2016 recommendation to establish minimum federal qualifications and screening standards for PCS workers, including background checks.
- **Recommendation:** CMS should conduct more frequent nationwide screenings of Medicaid providers to ensure states are complying with federal provider screening and revalidation requirements.
- **Recommendation:** States would benefit from regularly re-evaluating provider risk levels as a fraud prevention strategy, in addition to consideration of any changes in risk level designations required by CMS.

FINDING: Medicaid provider screening is essential for verifying that providers are legitimate and qualified to deliver health care services. Current preventative program integrity efforts are not sufficient and requirements for states to conduct provider screening activities are not adequate.

- **Recommendation:** CMS should require states to include more information about program integrity, including the categorical risk levels assigned to Medicaid providers, in State Plans.
- **Recommendation:** CMS should establish a nationwide provider registration database that gives SMAs access to information on Medicaid provider ownership in other states.
- **Recommendation:** States should invest in AI tools to streamline fraud detection in provider enrollment, revalidation, and pre- and post-payment claims processing.
- **Recommendation:** States should strengthen payment integrity by verifying provider enrollment, exclusion status, and claims information prior to payment and by improving oversight of high-risk services and providers.

FINDING: States are not using audit and investigative authorities to their fullest potential to prevent Medicaid fraud from occurring. States vary in auditing capacity and are not focusing on high-risk providers in their state.

- **Recommendation:** States should accommodate and encourage third-party oversight of their Medicaid auditing processes and take note of regional and national programmatic fraud trends to target enhanced oversight.

- **Recommendation:** States should make greater use of existing program integrity tools, including Medicaid RACs and stronger oversight of Medicaid managed care.

- **Recommendation:** CMS should require states to comprehensively report all pre- and post-payment audits including whether efforts are one-time or ongoing along with savings identified versus recovered (with explanations for variances) and details on vendor-proposed audits that were denied, including rationale.

- **Recommendation:** CMS should improve transparency by requiring more comprehensive reporting on audit activities, recoveries, and program integrity efforts, while encouraging consistent fraud referral training and contractual requirements that ensure Medicaid managed care organizations promptly report suspected fraud to the appropriate authorities.

FINDING: States are not taking fraud into account in their Medicaid auditing activities, dismissing the prevalence of fraud and its risks to program integrity and beneficiaries.

- **Recommendation:** States should consider incorporating GAO's Managing Improper Payments Framework into their auditing protocols, ensuring that fraud-risk assessments and preventative controls are fully integrated into overall Medicaid program integrity efforts.

- **Recommendation:** States should consider investing in more robust auditing activities to regularly verify provider billing activity and monitor broader fraud trends that may be occurring.

FINDING: Hospices have concerning patterns of fraud, such as instances of networks of individuals associated with multiple hospice agencies and several hospices registered to the same address.

- **Recommendation:** CMS should continue targeted oversight of hospice providers—applying tools such as Provisional Periods of Enhanced Oversight and enrollment moratoria—to protect the integrity of hospice services and patients against fraud.

FINDING: SMAs may have information about fraud occurring in Medicare services and play an important oversight role in detecting fraudulent billing through state licensing and routine auditing of Medicaid claims submitted by these providers.

- **Recommendation:** States should systematically monitor hospice licensure and require that licensure reviews are successfully completed, ensuring that hospice facilities comply with state standards before enrolling in Medicare.

- **Recommendation:** States should continue to share information gleaned from audit findings with state and federal partners, including in cases of credible allegations of fraud in their Medicaid program.

FINDING: Recent efforts by the Trump Administration are making significant progress in increasing accountability for states that fail to do what it takes to root out fraud. Many of these efforts must be continued or codified to ensure that program integrity remains a priority of the U.S. Government.

- **Recommendation:** Congress should codify President Trump's Executive Order 14395 establishing the Task Force to Eliminate Fraud to grant the federal government a permanent entity to investigate fraud with access to whole of government information sharing and facilitate cross-agency investigations by DOJ.

- **Recommendation:** HHS should continue the AERO initiative and hold states accountable for persistent single audit findings related to Medicaid and work with states to resolve audit findings to protect federal dollars from FWA.

- **Recommendation:** Congress should codify the HHS Open Data Platform to strengthen government transparency and data accessibility, enhance oversight, and expanded research opportunities that support program integrity efforts.

FINDING: Heightened attention to fraud pays off. Federal efforts to combat health care fraud return $12.70 for every $1 spent, demonstrating that oversight pays for itself. Preventative "detect and prevent" program integrity strategies outperform traditional "pay and chase" approaches, reducing losses by identifying improper payments before they occur rather than trying to recover them after the fact.

- **Recommendation:** CMS and states should continue to shift Medicaid program integrity toward a prevention-focused model by encouraging greater use of pre-payment reviews and payment suspensions when there are credible allegations of fraud.

- **Recommendation:** CMS and HHS-OIG should further enhance proactive fraud detection through advanced analytics, AI, increased reporting by states, and investigations of unusual billing patterns.

- **Recommendation:** Congress should strengthen existing federal program integrity efforts by providing additional resources for fraud prevention, data analytics, investigations, and recovery activities to help agencies identify and stop fraud before improper payments occur.