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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-3641
Minority (202) 225-2927

March 3, 2026

The Honorable Gavin Newsom
Governor
State of California
1021 O St., Ste. 9000
Sacramento, CA 95814

Ms. Kim Johnson
Secretary
California Health and Human Services Agency
1215 O St.
Sacramento, CA 95814

Dear Governor Newsom and Secretary Johnson:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, California Medicaid (Medi-Cal) spending surpassed $157 billion (over $97 billion in federal funding) and covered about 13.5 million people.[3] In fiscal year 2025, Medi-Cal, California's Medicaid program, is estimated to cost over $188 billion.[4] California broadly defines Medicaid eligibility and Medi-Cal's multi-billion dollar budget shortfalls are partly driven by the state's expansion of Medi-Cal health care coverage to illegal immigrants aged 26 to 49.[5] Medi-Cal also administers several Medicaid programs that are considered high risk for FWA.[6] In California, these include home and community based services (HCBS), such as the In-Home Supportive Services (IHSS) program, in addition to home health and hospice.[7] On January 27, 2026, the U.S. Centers for Medicare and Medicaid Services (CMS) Administrator, Dr. Mehmet Oz, wrote to you, requesting more information about "program integrity, eligibility verification, and provider oversight within California's Medi-Cal program," including concerning trends in the IHSS program, home health, and hospice.[8]

The IHSS program, which operates under Medi-Cal as an in-home assistance benefit to "eligible aged, blind, and disabled individuals," has experienced 348 percent growth in the last decade.[9] As part of sweeping indictments announced by the U.S. Department of Justice in the 2025 National Health Care Fraud Takedown, five individuals were charged for their role in fraudulent Medi-Cal billing for IHSS services.[10] These defendants are alleged to have submitted

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

[4] State of California Dep't of Health Care Services, Medi-Cal November 2024 Local Assistance Estimate for Fiscal Years 2024-25 and 2025-26, 2, https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2024_November_Estimate/N24-Medi-Cal-Local-Assistance-Estimate.pdf.

[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 18, 2026); Ana B. Ibarra, *California's Medi-Cal shortfall hits $6.2 billion with 'unprecedented' cost increases*, CAL MATTERS (Mar. 18, 2025), https://calmatters.org/health/2025/03/medi-cal-shortfall-worsens/.

[6] *See* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services at 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[7] *See* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Colin May, *Home is not where the help is: Fraud in home health care*, Association of Certified Fraud Examiners (Mar. 2025), https://www.acfe.com/acfe-insights-blog/blog-detail?s=fraud-in-home-health-care; *see also* U.S. Centers for Medicare and Medicaid Services, Hospice Fast Facts (July 2025), https://www.cms.gov/files/document/cpi-hospice-fast-facts.pdf.

[8] Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Gavin Newsom, Governor of California (Jan. 27, 2026), https://leadingage.org/wp-content/uploads/2026/01/HHS-Letter-012726-Gov-Newsom.pdf.

[9] California Dep't of Social Services, In-Home Supportive Services (IHSS) Program, https://www.cdss.ca.gov/in-home-supportive-services (last visited Feb. 18, 2026); *Id.*

[10] 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 Feb. 18, 2026).

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.[11]

Home health care and hospice agencies are experiencing unprecedented growth rates in California, specifically Los Angeles (L.A.) County.[12] In January, the Committee, alongside the House Committee on Ways and Means, wrote to U.S. Department of Health and Human Services (HHS) Inspector General, T. March Bell, highlighting disturbing patterns in provider enrollment and suspected overbilling of both Medi-Cal and Medicare in home health and hospice.[13] Disturbing patterns include an explosion of home health and hospice agencies registered in L.A. County, "representing almost 9% of total FFS [fee-for-service] home health spending for the entire country, though comprising just 2% of national FFS enrollment."[14]

As part of the 2025 National Health Care Fraud Takedown, another six individuals, including two physicians, were indicted for their connection to an alleged $2.7 million Medi-Cal and Medicare hospice fraud scheme.[15] In this scheme, patients—who did not qualify for hospice because they were not terminally ill—were allegedly fraudulently enrolled in hospice with the intent to defraud Medi-Cal and Medicare.[16] Seven additional individuals were recently arrested in connection with $3 million in Medi-Cal and Medicare hospice fraud in Monterey County and are similarly alleged to have recruited and enrolled patients to hospice who were not eligible due to not having a terminal illness.[17] In 2024, eight individuals were indicted for their alleged participation in a home health scheme that defrauded Medi-Cal of nearly $60 million between 2016 and 2022.[18] One defendant, Gerardo Santillan, was previously excluded from participation in Medi-Cal due to prior fraud convictions, yet was able to establish other home health agencies and conspire with others to fraudulently bill Medi-Cal.[19]

At the Committee's request, CMS briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[20] The Committee's Subcommittee on Oversight and

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[11] *Id.*
[12] 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.
[13] *Id.*
[14] *Supra*, note 8.
[15] *Supra*, note 10.
[16] *Id.*
[17] Press Release, State of California Dep't of Justice, Attorney General Bonta Announces Seven Arrests for Hospice Fraud: My Office is On It! (Feb. 5, 2026), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-seven-arrests-hospice-fraud-my-office-it.
[18] Press Release, State of California Dep't of Justice, Attorney General Bonta Announces Indictment of Southern California Healthcare Provider for Medi-Cal Fraud of Nearly $60 Million (Sept. 18, 2024), https://oag.ca.gov/news/press-releases/attorney-general-bonta-announces-indictment-southern-california-healthcare.
[19] *Id.*
[20] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[21] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[22] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[23] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[24] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[25]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[26] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

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[21] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[22] *Id.*

[23] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[24] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[26] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [27]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[28] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

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[27] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.
[28] Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).

a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [29] If yes, please describe these processes.

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

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

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

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

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

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

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

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

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

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

   a. program name;
   b. provider category risk level;
   c. effective date;

[29] *Id.*

d. spending;
e. enrollment;
f. services offered;
g. FWA measures; and
h. eligibility.

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

    a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
    b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
    c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
    d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
    e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

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

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

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

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March 3, 2026

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

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

Dear Governor Polis and Executive Director Bimestefer:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

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

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

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

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

[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[6] *See* U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation: Medicaid Non-Emergency Medical Transportation Booklet for Providers, 7, https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf; *see also* Isaac Asamoah Amponsah, *Ethics at Risk: Addressing Fraudulent Behavior in ABA Therapy,* Association of Certified Fraud Examiners (July 2024), https://www.acfe.com/acfe-insights-blog/blog-detail?s=ethics-risk-addressing-fraudulent-behavior-aba-therapy; *see also* U.S. Dep't of Health and Human Services Office of Inspector General, Nationwide Genetic Testing Fraud, https://oig.hhs.gov/newsroom/media-materials/media-materials-nationwide-genetic-testing-fraud/ (last visited Feb. 20, 2026).

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

[8] *Id.* at Klamann.

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

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

Last month, the U.S. Attorney for the District of Colorado and the Colorado Attorney General's Office announced charges of two individuals for defrauding Health First Colorado's NEMT program.[13] The first defendant, Ashley Marie Stevens, is alleged to have billed over $1 million in NEMT rides, $400,000 of which were billed for rides for herself and family members, and most of which were not associated with transportation to medical appointments.[14] Ms. Stevens also billed "ghost rides" for rides that did not occur at all and for rides that did not include a medical destination, in addition to over $450,000 for rides that were 400 miles or more, improbable for a single beneficiary in a single day.[15] The second defendant, Wesam Yassin, billed Health First Colorado for $3.3 million in NEMT rides, including $283,000 for 64 rides for a single beneficiary, $165,000 of which occurred after the beneficiary had died.[16] Ms. Yassin similarly billed ghost rides and beneficiary rides that were not associated with a medical destination.[17]

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

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[10] *Supra,* note 7 at Klamann.
[11] *Id.*
[12] *Id.*
[13] Press Release, U.S. Attorney's Office, District of Colorado, Federal charges filed in two separate cases involving non-emergent medical transportation fraud (Feb. 10, 2026), https://www.justice.gov/usao-co/pr/federal-charges-filed-two-separate-cases-involving-non-emergent-medical-transportation.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-09-24-02004, COLORADO MADE AT LEAST $77.8 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR APPLIED BEHAVIOR ANALYSIS PROVIDED TO CHILDREN (Feb. 25, 2026), https://oig.hhs.gov/documents/audit/11493/A-09-24-02004.pdf.
[19] *Id.*
[20] *Id.* at 9.
[21] *Id.* at 10.

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

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

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

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[22] *Id*. at 4-5; 30; Jennifer Brown, *Colorado could have to pay back $60 million to feds in autism therapy for children*, THE COLORADO SUN (Dec. 24, 2025), https://coloradosun.com/2025/12/24/autism-therapy-colorado-federal-payback/.
[23] *Supra,* note 18 at 30.
[24] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[25] Press Release, U.S. Attorney's Office, District of Colorado, Seven people charged with over $40 million in Medicare and Medicaid fraud (Sept. 24, 2024), https://www.justice.gov/usao-co/pr/seven-people-charged-over-40-million-medicare-and-medicaid-fraud.
[26] *Id.*
[27] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[28] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[29] *Id.*
[30] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

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

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

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

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

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

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[31] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[32] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[33] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

[34] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-3641
Minority (202) 225-2927

March 3, 2026

The Honorable Maura Healey
Governor
Commonwealth of Massachusetts
Massachusetts State House
24 Beacon St.
Boston, MA 02133

Dr. Kiame J. Mahaniah, MD
Secretary
Executive Office of Health and Human Services
1 Ashburton Pl., 11th Fl.
Boston, MA 02108

Dear Governor Healey and Secretary Mahaniah:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Massachusetts Medicaid (MassHealth) spending totaled over $26 billion ($14.7 billion in federal funding) and covered over 1.6 million people.[3] According to the Governor's 2026 budget, MassHealth spending is expected to increase 12.6 percent in fiscal year 2026."[4] The Massachusetts State Auditor Diana DiZoglio recently announced that the Bureau of Special Investigations (BSI) identified $1.3 million in MassHealth fraud in fiscal year 2025.[5] Massachusetts broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[6] In Massachusetts, these include non-emergency medical transportation (NEMT), the Personal Care Attendant (PCA) program, home health, and clinical laboratory services.[7]

Recent fraud investigations and convictions related to MassHealth are concerning. Last month, the Massachusetts Attorney General announced an indictment of an individual for multiple charges of NEMT fraud and money laundering.[8] In this scheme, the defendant and his transportation company allegedly billed MassHealth for nearly 17,000 rides, totaling more than $770,000, for rides purportedly given to MassHealth patients seeking opioid addiction treatments at methadone clinics.[9] An additional 100 rides were billed for patients who were deceased at the time.[10] These rides were allegedly not provided and the defendant is purported to have laundered

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 45, https://www macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 26 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.
[4] Massachusetts Taxpayers Foundation, MTF Bulletin: Fiscal Year 2026 Budget: A Closer Look (Mar. 6, 2025), https://www.masstaxpayers.org/sites/default/files/publications/2025-03/MTF%20Brief%20-%20Health%20Care%20Spending%20in%20FY%202026.pdf.
[5] Press Release, Massachusetts Office of the State Auditor, Auditor DiZoglio's Bureau of Special Investigations identifies nearly $12 million in public benefit fraud in FY25 (Jan. 30, 2026), https://www.mass.gov/news/auditor-dizoglios-bureau-of-special-investigations-identifies-nearly-12-million-in-public-benefit-fraud-in-fy25.
[6] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.
[7] *See* U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation: Medicaid Non-Emergency Medical Transportation Booklet for Providers, 7 https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf; *see also* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* U.S. Centers for Medicare and Medicaid Services, Fact Sheet, Preventing Fraud, Waste, and Abuse in Medicaid Home Health Services and Durable Medical Equipment (May 2016), https://www.cms.gov/files/document/hcbs-preventingfwahhdmefs050216pdf; *see also* 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.
[8] Press Release, Massachusetts Office of the Attorney General, AG's Office secures indictments against Waltham-based non-emergency medical transportation provider and former owner over money laundering and Medicaid fraud scheme (Feb. 11, 2026), https://www mass.gov/news/ags-office-secures-indictments-against-waltham-based-non-emergency-medical-transportation-provider-and-former-owner-over-money-laundering-and-medicaid-fraud-scheme.
[9] *Id.*
[10] *Id.*

the fraudulent funds through banks, real estate, and investment accounts before sending the money overseas to Uganda where he now lives.[11] This follows a case in 2025, in which a Worcester-based NEMT company and its proprietor were indicted for more than $3 million in NEMT services not provided.[12] In this case, not only is the accused alleged to have billed for rides never provided, rides with no corresponding medical visits, patients who canceled their trips, and patients who were hospitalized or deceased at the time, he is also alleged to have employed drivers that impersonated MassHealth patients by stealing their identity, allowed illicit drug use and sales during rides, sexually assaulted patients, and failed to transport wheelchair patients in accessible vehicles.[13]

The PCA program pays workers to assist seniors and those with disabilities with in-home care services, such as bathing and dressing.[14] From 2015 to 2024, PCA annual costs increased from $841 million to $1.75 billion.[15] Recently, a Northampton man was indicted for a $99,000 MassHealth fraud scheme in which he is alleged to have billed MassHealth for PCA services purportedly provided by his 95 year old mother and son, despite his mother "not physically being able to assist him with the services he claimed he needed" and his son living out of state.[16] Prior to this charge, another individual pleaded guilty to fraudulently conspiring with a PCA recipient to bill MassHealth over $157,000 for caretaker services that were purportedly provided while he was incarcerated.[17] Late last year, a woman pleaded guilty to $500,000 in fraudulent billing to MassHealth for PCA, home health, and adult foster care services.[18] In this scheme, the woman invited disabled, elderly, and homeless people to live in her home while she enrolled them in MassHealth services, without their knowledge or consent, and billed MassHealth as their caretaker, despite not providing these services.[19]

As noted in the Oversight and Investigations Subcommittee's recent hearing on common schemes in Medicare and Medicaid, "[l]aboratory services and genetic testing continue to be a

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[11] *Id.*
[12] Press Release, Massachusetts Office of the Attorney General, Worcester-based medical transportation company and its owner indicted for MassHealth fraud, patient abuse and neglect, and money laundering (Apr. 1, 2025), https://www.mass.gov/news/worcester-based-medical-transportation-company-and-its-owner-indicted-for-masshealth-fraud-patient-abuse-and-neglect-and-money-laundering.
[13] *Id.*
[14] Sam Drysdale, Working group targets meal prep, overtime for cuts from $1.7B personal care attendant program, WORCESTER BUSINESS JOURNAL (Jan. 2, 2026), https://wbjournal.com/article/working-group-targets-meal-prep-overtime-for-cuts-from-1-7b-personal-care-attendant-program/.
[15] *Id.*
[16] Press Release, Massachusetts Office of the Attorney General, AG's office secures indictments against Northampton resident for causing more than $99,000 in false claims to MassHealth (Aug. 5, 2025), http://mass.gov/news/ags-office-secures-indictments-against-northampton-resident-for-causing-more-than-99000-in-false-claims-to-masshealth.
[17] Press Release, Massachusetts Office of the Attorney General, Personal care attendant pleads guilty to defrauding MassHealth while incarcerated (June 25, 2025), https://www.mass.gov/news/personal-care-attendant-pleads-guilty-to-defrauding-masshealth-while-incarcerated.
[18] Press Release, Massachusetts Office of the Attorney General, AG Campbell secures guilty plea from ringleader of Worcester-based home health fraud scheme exploiting vulnerable residents (Sept. 15, 2025), https://www.mass.gov/news/ag-campbell-secures-guilty-plea-from-ringleader-of-worcester-based-home-health-fraud-scheme-exploiting-vulnerable-residents.
[19] *Id.*

problem."[20] Last year, a $7.8 million alleged home health and clinical laboratory services MassHealth fraud and kickback scheme targeting sober homes was revealed.[21] In the scheme, indictments against two clinical laboratories, a home health agency, their owners, and a physician detail allegations that the laboratories, home health agency, and the physician were participating in a mutual kickback scheme in which they billed MassHealth for millions of dollars in fraudulent claims for urine tests and home health services that never occurred, were not medically necessary, or were not accompanied by a physician's orders.[22] In this case, the indicted physician is alleged to have provided orders for these fraudulent services without ever seeing the patients.[23]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[24] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[25] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[26] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[27] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), NEMT, home and community based services

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[20] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[21] Press Release, Massachusetts Office of the Attorney General, Home health agencies, laboratory, and physician indicted for MassHealth fraud and kickback schemes involving over $7.8 million in false claims (Mar. 12, 2025), https://www.mass.gov/news/home-health-agencies-laboratory-and-physician-indicted-for-masshealth-fraud-and-kickback-schemes-involving-over-78-million-in-false-claims.

[22] *Id.*

[23] *Id.*

[24] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[26] *Id.*

[27] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

(HCBS), laboratory services, substance use disorder (SUD) treatment, and hospice.[28] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[30] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [31]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of

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[28] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

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

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

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

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

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a. program name;
b. provider category risk level;
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If you have any questions about this request, please contact the Majority Committee Staff at (202) 225-3641.

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515-6115
Majority (202) 225-3641
Minority (202) 225-2927

March 3, 2026

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

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

Dear Governor Mills and Commissioner Gagné-Holmes:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Maine Medicaid (MaineCare) spending totaled $4.7 billion ($3.1 billion in federal funding) and covered 343,000 people.[3] Maine broadly defines Medicaid eligibility and MaineCare's recent $118 million budget shortfall was partly driven by unsustainable costs of care that have increased 33 percent since 2019 despite declining enrollment.[4] MaineCare administers several Medicaid programs that are considered high risk for FWA.[5] In Maine, these include Rehabilitative and Community Support (RCS) services for children with Autism Spectrum Disorder (ASD), and home and community based services (HCBS), such as home health and interpreting services.[6] On February 6, 2026, U.S. Centers for Medicare and Medicaid Services (CMS) Administrator, Dr. Mehmet Oz, wrote to you, requesting more information about "program integrity, eligibility verification, and provider oversight within Maine's MaineCare program," and concerning trends in the behavioral health billing, including the RCS program, interpreting services, psychosocial rehabilitation services, HCBS personal care services, and residential habilitation services.[7]

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

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

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

[4] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 18, 2026); Harris Van Pate, *Maine's predictable MaineCare funding shortfall,* MAINE POLICY INSTITUTE (Sept. 16, 2025), https://mainepolicy.org/maines-predictable-mainecare-funding-shortfall/.

[5] *See* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[6] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, A-01-24-00006, MAINE MADE AT LEAST $45.6 MILLION IN IMPROPER FEE-FOR-SERVICE MEDICAID PAYMENTS FOR REHABILITATIVE AND COMMUNITY SUPPORT SERVICES PROVIDED TO CHILDREN DIAGNOSED WITH AUTISM (Jan. 16, 2026), https://oig hhs.gov/documents/audit/11447/A-01-24-00006.pdf; *See* U.S. Centers for Medicare and Medicaid Services, Fact Sheet, Preventing Fraud, Waste, and Abuse in Medicaid Home Health Services and Durable Medical Equipment (May 2016), https://www.cms.gov/files/document/hcbs-preventingfwahhdmefs050216pdf; *see also* Sawyer Loftus, *A Maine cop warned of interpreter fraud 5 years ago. The state is just catching up.,* BANGOR DAILY NEWS (Dec. 24, 2025), https://www.bangordailynews.com/2025/12/24/mainefocus/mainefocus-government/maine-interpreter-fraud-warning-joam40zk0w/.

[7] *Supra*, note 5.

[8] *Supra*, note 6.

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

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

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

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

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

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

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

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

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

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

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

At the Committee's request, CMS briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[22] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[23] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs

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[13] Sawyer Loftus, *Maine stops payments to embattled health care provider facing fraud allegations*, THE MAINE MONITOR (Dec. 26, 2025), https://themainemonitor.org/mainecare-payments-gateway-halted/.
[14] *Id.*
[15] *Id.*
[16] Sawyer Loftus, *Criminal case focuses on immigrant health provider that billed millions to MaineCare*, BANGOR DAILY NEWS (Jan. 9, 2026), https://www.bangordailynews.com/2026/01/09/mainefocus/mainefocus-government/criminal-case-immigrant-health-provider-mainecare-joam40zk0w/.
[17] *Id.*
[18] Seamus Othot, *Five Star Fraud: Records Show Home Health Agency Over-Billed MaineCare by Nearly $400K, Disappeared*, THE MAINE WIRE (Jan. 19, 2026), https://www.themainewire.com/2026/01/five-star-fraud-records-show-home-health-agency-over-billed-mainecare-by-nearly-400k-disppeared/.
[19] *Id.;* Rich McHugh, *Maine building houses 10 health care firms; landlord rarely sees anyone,* NEWSNATION (Jan. 20, 2026), https://www newsnationnow.com/vargasreports/maine-healthcare-firms-landlord/.
[20] *Id.* at McHugh.
[21] *Id.*
[22] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[23] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

vulnerable to fraud; and high risk areas for fraud in these programs.[24] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[25] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services for children with ASD, non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[26] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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[24] *Id.*
[25] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.
[26] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.
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Brett Guthrie
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H. Morgan Griffith
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cc: The Honorable Frank Pallone, Jr., Ranking Member, Committee on Energy and Commerce
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BRETT GUTHRIE, KENTUCKY
CHAIRMAN

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ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-3641
Minority (202) 225-2927

March 3, 2026

The Honorable Jim Pillen
Governor
State of Nebraska
P.O. Box 94848
Lincoln, NE 68509

Dr. Steve Corsi, PsyD
Chief Executive Officer
Nebraska Department of Health and Human Services
301 Centennial Mall South
Lincoln, NE 68508

Dear Governor Pillen and Dr. Corsi:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Nebraska Medicaid spending totaled $3.8 billion ($2.5 billion in federal funding) and covered nearly 340,000 people.[3] Nebraska broadly defines Medicaid eligibility and administers several Medicaid programs that are generally considered high risk for FWA.[4] In Nebraska, these include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), home and community-based services (HCBS), including personal assistant and personal care services, and behavioral health.[5]

Recent audits, fraud investigations, and convictions related to Nebraska's Medicaid programs are concerning. In September 2025, the Nebraska Auditor of Public Accounts issued a report examining Medicaid ABA services amid concerns about explosive spending and enrollment in the program.[6] Nebraska Medicaid paid $82.8 million for ABA services for about 1,500 beneficiaries in 2024, a more than 1,700 percent increase in spending since 2020.[7] However, Nebraska recently reduced Medicaid reimbursement rates for ABA services to better match rates in surrounding states, which is expected to reduce costs.[8] According to the auditor's report, five ABA service providers billed over $54 million in 2024, with just one provider accounting for over half of those billings.[9] The auditor's report also found that the ABA services program was riddled with duplicate claims, inaccurate claims data, service providers without appropriate credentials, a lack of adequate supervision of providers, incorrect reimbursement rates, and a lack of adequate supporting documentation.[10]

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 27 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

[4] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 26, 2026); *see* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[5] *See* Isaac Asamoah Amponsah, *Ethics at Risk: Addressing Fraudulent Behavior in ABA Therapy,* Association of Certified Fraud Examiners (July 2024), https://www.acfe.com/acfe-insights-blog/blog-detail?s=ethics-risk-addressing-fraudulent-behavior-aba-therapy; *see also* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Colin May, *Wealth over well-being: Case studies of behavioral health fraud*, Association of Certified Fraud Examiners (Dec. 2025), https://www.acfe.com/acfe-insights-blog/blog-detail?s=case-studies-behavioral-health-fraud.

[6] Jolie Peal, *State auditor finds issues in top ABA service providers*, NEBRASKA PUBLIC MEDIA (Sept. 23, 2025), https://nebraskapublicmedia.org/en/news/news-articles/state-auditor-finds-issues-in-top-aba-service-providers/.

[7] NEBRASKA AUDITOR OF PUBLIC ACCOUNTS, ATTESTATION REPORT OF THE NEBRASKA DEP'T OF HEALTH AND HUMAN SERVICES – APPLIED BEHAVIOR ANALYSIS, CALENDAR YEARS ENDED DEC. 31, 2023, AND DEC. 31, 2024 (Sept. 23, 2025), https://auditors.nebraska.gov/APA_Reports/2025/SA25-09232025-January_1_2023_through_December_31_2024_Applied_Behavior_Analysis_Attestation_Report.pdf.

[8] News Release, Nebraska Dep't of Health and Human Services DHHS explains Medicaid rate adjustment in response to provider misinformation (July 18, 2025), https://dhhs ne.gov/Pages/DHHS-Gives-Update-on-Medicaid-Rate-Adjustments-Sets-Record-Straight-on-Misinformation.aspx.

[9] *Supra*, note 7 at 2.

[10] *Id.* at 7.

A December 2025 interim report by the Nebraska Auditor of Public Accounts found more examples where Medicaid paid for personal assistance and personal care services that had numerous billing issues, including inadequate supporting documentation, excess billing hours, providers working multiple jobs in addition to caretaking, providers caring for too many clients at one time, and claims for weekly services that were being provided daily.[11] The state auditor randomly selected five personal assistance services providers and found that all five providers had issues in their claims.[12] This finding came shortly after an alarming report by the state auditor in 2024, that estimated up to $1.5 million in questionable billings to Nebraska Medicaid for personal care and personal assistance services.[13] The state auditor found similar billing patterns to the most recent interim report, including suspected fraud and billing for "impossible" work weeks of 118 hours, a provider billing for over 80 hours a week of personal care services in three cities in one week while also maintaining two other jobs, and a provider billing for services provided while she was traveling out of state.[14]

Additionally, a personal assistant services provider was found guilty last year of billing over $12,000 for services not rendered for three Medicaid recipients after being banned from the Omaha Housing Authority apartment complex in which the recipients lived.[15] Last year, a former HCBS services provider, Love Community, LLC, which contracted with shared living arrangement service providers for Medicaid patients, was accused of contracting with service providers who were not in compliance with Medicaid regulations, billing for services that were rendered by a different Medicaid provider, and failing to maintain sufficient documentation, resulting in over $211,000 in improperly paid Medicaid claims.[16]

Earlier this year, a former Lincoln area mental health therapist and operator of a non-profit program for at-risk youth was found guilty of submitting 226 Medicaid claims, totaling more than $47,000 for services that were not rendered.[17] In the scheme, the therapist billed for mental health services when "children were getting help with homework or playing basketball or other games."[18]

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[11] Letter from Terence Heiser, Audit Manager, Nebraska Auditor of Public Accounts, to Dr. Steven Corsi, Chief Executive Officer, Nebraska Dep't of Health and Human Services, 3 (Dec. 1, 2025), https://auditors nebraska.gov/APA_Reports/2025/SA25-12012025-July_1_2024_through_June_30_2025_Medicaid_Single_Early_Management_Letter.pdf.
[12] *Id.* at 10.
[13] Cindy Gonzalez, *NE auditor: 'Flagrant abuses.' up to $1.5M in questionable billings suspected in DHHS program*, NEBRASKA EXAMINER (Feb. 28, 2024), https://nebraskaexaminer.com/2024/02/28/ne-auditor-flagrant-abuses-up-to-1-5m-in-questionable-billings-suspected-in-dhhs-program/.
[14] News Release, Nebraska Attorney General Mike Hilgers, Lancaster judge awards state nearly $800,000 in Medicaid fraud case (Jun. 13, 2025), https://ago.nebraska.gov/news/lancaster-judge-awards-state-nearly-800000-medicaid-fraud-case.
[15] News Release, Nebraska Attorney General Mike Hilgers, Omaha woman fined for Medicaid fraud (May 21, 2025), https://ago nebraska.gov/news/omaha-woman-fined-medicaid-fraud.
[16] *Id.*
[17] News Release, Nebraska Attorney General Mike Hilgers, Former Lincoln area therapist sentenced for Medicaid fraud (Jan. 27, 2026), https://ago nebraska.gov/news/former-lincoln-area-therapist-sentenced-medicaid-fraud.
[18] *Id.*

In November 2025, a former Nebraska Department of Health and Human Services employee was arrested for falsifying documents to assist her husband with obtaining $40,350 in Medicaid and $2,691 in Supplemental Nutrition Assistance Program (SNAP) benefits.[19] The former employee was found to have accessed her husband's case records to improperly verify his employment and write case notes.[20]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[21] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[22] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[23] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[24] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include ABA services for children with ASD, non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[25] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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[19] Bill Schammert, *Former Nebraska DHHS supervisor accused of SNAP and Medicaid fraud,* KETV 7 OMAHA (Nov. 12, 2025), https://www.ketv.com/article/former-nebraska-dhhs-supervisor-accused-snap-medicaid-fraud/69408586.
[20] *Id.*
[21] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[22] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[23] *Id.*
[24] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.
[25] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[26]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[27] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [28]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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[26] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[27] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

[28] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.

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

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[29] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

    a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [30] If yes, please describe these processes.

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

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

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

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

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

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

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

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

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

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

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

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

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

   a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
   b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
   c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
   d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
   e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

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

    a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.
    b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.

c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.
d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
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March 3, 2026

The Honorable Kathy Hochul
Governor
State of New York
NYS State Capitol Building
Albany, NY 12224

Dr. James V. McDonald, MD, MPH
Commissioner
New York State Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Dear Governor Hochul and Commissioner McDonald:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In state fiscal year 2025, New York Medicaid spending totaled $115.6 billion ($69.2 billion in federal funding) and covered nearly 7 million people.[3] According to the New York State Office of the Budget, "[T]he [Medicaid] program has continued to grow at unsustainable levels[….]"[4] New York broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[5] In New York, these include personal care services, known as the Community-Driven Personal Assistance Program (CDPAP), social adult day care centers, and non-emergency medical transportation (NEMT).[6]

Recent fraud investigations and convictions related to New York's Medicaid programs are concerning. For example, CDPAP, which Governor Hochul has referred to as a "racket," allows chronically ill and disabled Medicaid patients to hire their own in-home caregivers.[7] CDPAP program costs have skyrocketed from $1.5 billion in 2017 to $11.2 billion in 2023, and the program has been identified as vulnerable to fraudulent billing for self-reported hourly caregiving.[8] 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.[9] Over several years, Mr. Hossain and ten others were paid to be caregivers for his mother, who resided out of the country.[10] To carry out the scheme, Mr. Hossain's brother posed as the mother during routine

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[3] Office of the New York State Comptroller Thomas P. DiNapoli, Federal Funding and New York: Medicaid, https://www.osc.ny.gov/reports/budget/fed-funding-ny/medicaid (last visited Feb. 9, 2026).
[4] New York State, FY 2026 NYS Executive Budget Briefing Book, 69, https://www.budget.ny.gov/pubs/archive/fy26/ex/book/healthcare.pdf.
[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Department of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.
[6] *See* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3 https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Erin Rutzler, *FWA insights: Spotting red flags in adult day care claims*, COTIVITI https://resources.cotiviti.com/fraud-waste-and-abuse/fwa-insights-spotting-red-flags-in-adult-day-care-claims (last visited Feb. 11, 2026); *see also* U.S. Centers for Medicare and Medicaid Services, Non-Emergency Medical Transportation: Medicaid Non-Emergency Medical Transportation Booklet for Providers, 7 https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/nemt-booklet.pdf.
[7] Laura Nahmias, *New York City's biggest job engine has become a 'racket,' Hochul says,* BLOOMBERG (July 22, 2024), https://www.bloomberg.com/news/articles/2024-07-22/ny-s-cdpap-home-health-aide-job-program-has-become-a-racket-hochul?srnd=all&embedded-checkout=true.
[8] PPL, PPL uncovers fraud risks in CDPAP and works with state to safeguard program (Sept. 15, 2025), https://pplfirst.com/news/ppl-uncovers-fraud-risks-in-cdpap/; *see also* Isabel Vincent, *Notoriously fraudulent NY health program lost $1.2 billion to scammers and middlemen: 'Minnesota multiplied by 10'*, NEW YORK POST (Jan. 8, 2026), https://nypost.com/2026/01/08/us-news/nys-fraudulent-cdpap-program-lost-1-2-billion-to-scammers-and-mismanagement/; Grace Ashford, *N. Y. lawmakers press officials about home health program's issues,* NEW YORK TIMES (Aug. 25, 2025), https://www.nytimes.com/2025/08/21/nyregion/cdpap-new-york.html.
[9] 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.
[10] *Id.*

site visits.[11] Separately, last month, two individuals pleaded guilty to a seven year $68 million Medicaid fraud scheme involving two Brooklyn-based adult day cares and a home health company.[12] In this scheme, the two men received kickbacks and bribes as marketers and recruiters for social adult daycares and a home health care fiscal intermediary, billing for induced or not provided Medicaid services.[13] Recently, two Queens men who owned social adult daycare centers and a pharmacy were charged with $120 million in alleged Medicaid and Medicare fraud schemes, including illegal cash kickbacks to Medicaid recipients to fill prescriptions at their pharmacies and enroll in their adult day care.[14]

Last year, investigations into New York NEMT companies were initiated for fake billing of transportation services intended to assist Medicaid patients traveling to and from non-emergency medical appointments.[15] New York's Medicaid Fraud Control Unit investigated 25 transportation companies, finding evidence that many defrauded Medicaid by billing for fake trips, inflating costs with fraudulent toll charges or extended mileage, and using unlicensed drivers.[16] Last month, one transportation company owner was convicted for submitting over $1 million in fraudulent Medicaid claims for NEMT services that were not rendered.[17] Some of these patients were deceased, incarcerated, or hospitalized at the time of these fraudulent claims.[18]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[19] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in

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[11] *Id.*
[12] Press Release, U.S. Department 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.
[13] *Id.*
[14] Press Release, U.S Department 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.
[15] Press Release, New York State Attorney General Letitia James, Attorney General James secures more than $13 million in sweeping takedown of transportation companies for defrauding Medicaid (Jun. 30, 2025), http://ag.ny.gov/press-release/2025/attorney-general-james-secures-more-13-million-sweeping-takedown-transportation.
[16] *Id.*
[17] Press Release, New York State Attorney General Letitia James, Attorney General James announces conviction and sentencing of Suffolk County transportation company owner for stealing over $1 million from Medicaid (Jan. 14, 2026), https://ag.ny.gov/press-release/2026/attorney-general-james-announces-conviction-and-sentencing-suffolk-county.
[18] *Id.*
[19] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

Medicare and Medicaid."[20] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[21] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[22] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), NEMT, home and community based services (HCBS), laboratory services, substance use disorder (SUD) treatment, and hospice.[23] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[24]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[25] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided;

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[20] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce.house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[21] *Id.*

[22] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[23] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[24] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. 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.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

> (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [26]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[27] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

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[26] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.
[27] Screening levels for Medicaid providers, 42 C.F.R. § 455 subpart E (2011).

a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [28] If yes, please describe these processes.

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

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

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

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

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

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

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

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

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

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

   a. program name;
   b. provider category risk level;
   c. effective date;

[28] *Id.*

d. spending;
e. enrollment;
f. services offered;
g. FWA measures; and
h. eligibility.

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

    a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
    b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
    c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
    d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
    e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

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

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

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Majority (202) 225-3641
Minority (202) 225-2927

March 3, 2026

The Honorable Tina Kotek
Governor
State of Oregon
900 Court St., Ste. 254
Salem, OR 97301

Ms. Liesl Wendt
Director
Oregon Department of Human Services
500 Summer St. NE, E15
Salem, OR 97301

Dear Governor Kotek and Director Wendt:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Oregon Medicaid (Oregon Health Plan) spending totaled $15.3 billion ($11.5 billion in federal funding) and covered 1.3 million people.[3] Oregon Health Plan is experiencing higher-than-expected costs, largely attributed to high utilization of behavioral health services, and is straining the state's budget.[4] In 2026, Oregon Health Plan is projected to cost almost $354 million more than initial budget estimates.[5] Oregon broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[6] In Oregon, these include home and community based services (HCBS), such as the Consumer-Employed Provider (CEP) Program, substance use disorder (SUD) treatment, and nursing home services.[7]

Recent fraud investigations and convictions related to Oregon Health Plan are concerning. In January, an Oregon mother and daughter were indicted by a federal grand jury for coerced labor and services of three victims who immigrated to the United States from Haiti to work for little or no pay in an adult foster home.[8] The mother is separately charged with participating in a conspiracy to request Medicaid "exceptional payments" for additional paid care hours for high-needs patients (while paying the victims little to nothing for their work) and falsifying a disability claim that allowed her daughter to be paid as her homecare worker via Oregon's CEP Program.[9]

In September 2025, State Representative Ed Diehl wrote to the Oregon Department of Justice and U.S. Department of Health and Human Services Office of Inspector General asking for an investigation into suspicious Medicaid billing by Uplifting Journey LLC, a SUD treatment sober living home operator that received $2.3 million in Medicaid reimbursements in less than a

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 27 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.
[4] Kristine de Leon, *Oregon lawmakers confront ballooning Medicaid costs,* THE OREGONIAN (Jan. 14, 2026), https://www.oregonlive.com/health/2026/01/oregon-lawmakers-confront-ballooning-medicaid-costs.html.
[5] *Id.*
[6] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 18, 2026); *see* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.
[7] *See* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Isaac Asamoah, *Fraud, waste, and abuse schemes in the addiction treatment industry*, Association of Certified Fraud Examiners (Dec. 2023), https://www.acfe.com/acfe-insights-blog/blog-detail?s=fraud-waste-and-abuse-addiction-treatment-industry; *see also* U.S. Centers for Medicare and Medicaid Services, Nursing Home Toolkit: Nursing Homes – A Guide for Medicaid Beneficiaries' Families and Helpers, 10 (Nov. 2015), https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nursinghome-beneficiary-booklet.pdf.
[8] Press Release, U.S. Dep't of Justice, Oregon mother and daughter facing new charges related to forced labor and health care fraud (Jan. 26, 2026), https://www.justice.gov/opa/pr/oregon-mother-and-daughter-facing-new-charges-related-forced-labor-and-health-care-fraud.
[9] *Id.*

year.[10] In these allegations, State Representative Diehl points out that Uplifting Journey operated a sober living house that was later tied to alleged members of the Tren de Aragua (TdA), an organized crime syndicate originating in Venezuela.[11] Specifically, the address of the sober living home has been identified as the residence of a TdA criminal who was arrested for attempted murder and is alleged to have "kidnapped Maria Guadalupe Hernandez Velasquez outside her Seattle home, drilled into her hands with a power drill to force her to provide them her PIN for her debit card, robbed her of gold and cash, shot and wounded her and left her for dead in rural Washington."[12] When red flags were raised about the legitimacy of the sober living home and potential ties to criminal activity, the home and its business were subsequently abandoned.[13] The founder of Uplifting Journey, Julius Maximo, subsequently registered a second company, Restorative Journey (Life Restoration Missions LLC) as a Medicaid provider for SUD treatment.[14] State Representative Diehl expressed further frustration with Oregon's Medicaid provider oversight, including questions about the state's required credentialing process.[15]

In another case, a woman was sentenced to federal prison in late 2024, for her role in an identity theft scheme that defrauded the Oregon Health Plan's SUD counseling services benefit.[16] In this scheme, the woman used her company, a Medicaid provider for SUD counseling services, to improperly access patient information from the Medicaid Management Information System (MMIS) and steal PII for the purposes of submitting fraudulent claims for more than 45 victims, some of whom were targeted by searching publicly available information about arrests for drug and alcohol related offenses.[17] The false claims totaled over $3 million and resulted in $1.5 million in fraudulent Medicaid reimbursements.[18]

As part of the 2025 National Health Care Fraud Takedown, an Oregon nursing home facilitator agreed to pay $2 million and take corrective action after allegations surfaced that the company operated a substandard skilled nursing home due to insufficient staffing levels,

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[10] Letter from State Representative Ed Diehl to Sheen Wu, Director, Oregon Dep't of Justice Medicaid Fraud Control Unit, and Juliet T. Hodgkins, Acting Inspector General, U.S. Dep't of Health and Human Services (Sept. 23, 2025), https://www.oregonlegislature.gov/diehl/PressReleases/Letter%20to%20Request%20Investigation%20into%20Medicaid%20Fraud.pdf.

[11] *Id.*; *See* Fact Sheet, U.S. Dep't of State, Designation of International Cartels (Feb. 20, 2025), https://www.state.gov/designation-of-international-cartels.

[12] Mark Hemingway, *Model city: Portland's journey from symbol of chic to shabby*, REALCLEARINVESTIGATIONS (Feb. 5, 2026), https://www.realclearinvestigations.com/articles/2026/02/05/model_city_portlands_journey_from_symbol_of_chic_to_shabby_1162950.html; Jeff Eager, *Oregon paid $2.3M to company running home of alleged gangster/attempted murderer,* OREGON ROUNDUP (Aug. 17. 2025), https://oregonroundup.substack.com/p/oregon-paid-23m-to-company-running.

[13] *Supra,* note 10.

[14] *Id.*

[15] *Id.*

[16] Press Release, U.S. Attorney's Office, District of Oregon, Prineville woman sentenced to federal prison for multi-million dollar drug treatment fraud scheme (Sept. 25, 2024), https://www.justice.gov/usao-or/pr/prineville-woman-sentenced-federal-prison-multi-million-dollar-drug-treatment-fraud.

[17] *Id.*

[18] *Id.*

resulting in patient harm and suffering, including preventable urinary tract infections, pressure sores, and falls.[19]

Last year, an Oregon urgent care chain paid $490,000 to settle claims that it overbilled Oregon Health Plan for medically unnecessary COVID-19 testing and inflated billing of routine office visits.[20] In this scheme, the urgent care's former owner directed staff to use higher billing codes and at least 1,900 Medicaid claims were tied to patients with no symptoms or exposure to COVID-19 who later tested negative.[21]

In December 2025, CareOregon, the state's largest Medicaid managed care provider, alerted more than 5,000 people participating in Oregon Health Plan that their personally identifiable information (PII), including name, date of birth, health plan information, Medicaid ID number, Medicare ID number, and primary care provider information was improperly viewed in a data breach.[22] CareOregon warned patients that "some of your information may have been used to create fake insurance claims. We do not know if your information was used to create these claims."[23] This data breach is concerning and warrants further scrutiny to prevent Medicaid fraud and ensure program integrity in Oregon Health Plan.

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[24] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[25] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[26] The hearing reinforced that Medicaid fraud is not

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[19] Press Release, U.S. Attorney's Office, District of Oregon, U.S. Attorney's Office participates in National Health Care Fraud Takedown resulting in $2 million civil settlement (July 1, 2025), https://www.justice.gov/usao-or/pr/us-attorneys-office-participates-national-health-care-fraud-takedown-resulting-2-million.
[20] Kristine de Leon, *Oregon urgent care chain will pay $490K to settle allegations of pandemic Medicaid fraud*, THE OREGONIAN (Sept. 10, 2025), https://www.oregonlive.com/health/2025/09/oregon-urgent-care-chain-will-pay-490k-to-settle-allegations-of-pandemic-medicaid-fraud.html.
[21] *Id.*
[22] Lynne Terry, *Oregon Medicaid insurer's data breach could lead to insurance fraud*, THE LUND REPORT (Jan. 13, 2026), https://www.thelundreport.org/content/oregon-medicaid-insurers-data-breach-could-lead-insurance-fraud-0.
[23] Letter from CareOregon and Health Share of Oregon to CareOregon participants (Dec. 26, 2025), https://www.careoregon.org/docs/default-source/members/news/data-breach-co-122625.pdf?sfvrsn=28efe597_1.
[24] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[26] *Id.*

limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[27] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), HCBS, laboratory services, SUD treatment, and hospice.[28] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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[27] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[28] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[29] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 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.

[30] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [31]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[32] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

    a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [33] If yes, please describe these processes.

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

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

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

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

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

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

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

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

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

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

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

    a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
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    d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
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10. Please provide information regarding screening, oversight, and enforcement actions related to Medicaid fiscal intermediaries, including:

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    c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.
    d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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March 3, 2026

The Honorable Josh Shapiro
Governor
Commonwealth of Pennsylvania
501 North 3rd St.
508 Main Capitol Bldg.
Harrisburg, PA 17120

Dr. Valerie A. Arkoosh, MD, MPH
Secretary
Pennsylvania Department of Human Services
625 Forster St.
Harrisburg, PA 17120

Dear Governor Shapiro and Secretary Arkoosh:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Pennsylvania Medicaid spending totaled over $44 billion ($26.8 billion in federal funding) and covered over 3 million people.[3] Between 2018 and 2025, the state budget for the Pennsylvania Department of Human Services increased 58 percent, despite the population only growing 2 percent in that time.[4] According to the most recent U.S. Department Health and Human Services Office of Inspector General (HHS-OIG) Medicaid Fraud Control Units Annual Report for fiscal year 2024, the Pennsylvania Attorney General's Medicaid Fraud Control Section charged more Medicaid fraud than any other state and was ranked third for criminal convictions nationwide.[5] Pennsylvania's Medicaid fraud recoveries totaled more than $11.13 million in 2024.[6] Moreover, in a 2020 press conference about Medicaid fraud, Governor Shapiro, while serving as Attorney General stated that "it's possible, no, likely, that Pennsylvania is losing $3 billion a year to fraud."[7] Pennsylvania broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[8] In Pennsylvania, these include home and community-based services (HCBS), such as personal and home care services and behavioral health.[9]

Recent fraud investigations and convictions related to Pennsylvania's Medicaid programs are concerning. As part of the U.S. Department of Justice's 2025 National Health Care Fraud Takedown, a Philadelphia woman was charged for her connection to home care fraud schemes that fraudulently billed Medicaid more than $1 million.[10] In this scheme, the woman is alleged to have received kickbacks to refer home care patients to home care agencies, in addition to billing

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, Dec. 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 27 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

[4] Megan Martin, *Minnesota's Medicaid disaster is a warning Pennsylvania must heed*, PENNLIVE (Jan. 21. 2026), https://www.pennlive.com/opinion/2026/01/minnesotas-medicaid-disaster-is-a-warning-pennsylvania-must-heed-opinion html.

[5] U.S. DEP'T OF HEALTH AND HUMAN SERVICES OFFICE OF INSPECTOR GENERAL, OEI-09-25-00090, MEDICAID FRAUD CONTROL UNITS ANNUAL REPORT: FISCAL YEAR 2024 (Mar. 11, 2025), https://oig hhs.gov/reports/all/2025/medicaid-fraud-control-units-annual-report-fiscal-year-2024/.

[6] *Id.*

[7] John Micek, *Pa. lawmakers roll out bipartisan proposal aimed at curbing Medicaid fraud*, PENNSYLVANIA CAPITAL-STAR (Jan. 13, 2020), https://penncapital-star.com/government-politics/biz-leaders-false-claim-law-aimed-at-curbing-medicaid-fraud-will-make-problems-worse/.

[8] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[9] *See* U.S. Centers for Medicare and Medicaid Services, Monitoring Fraud, Waste, & Abuse in HCBS Personal Care Services, 3, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-3a-fwa-in-pcs-training.pdf; *see also* Colin May, *Wealth over well-being: Case studies of behavioral health fraud*, Association of Certified Fraud Examiners (Dec. 2025), https://www.acfe.com/acfe-insights-blog/blog-detail?s=case-studies-behavioral-health-fraud.

[10] Press Release, U.S. Attorney's Office, Eastern District of Pennsylvania, Bensalem woman charged in home care fraud kickback scheme that caused loss to Medicaid of nearly $1.1 million (Jun. 30, 2025), https://www.justice.gov/usao-edpa/pr/bensalem-woman-charged-home-care-fraud-kickback-scheme-caused-loss-medicaid-nearly-11.

Medicaid for home care services that were not rendered.[11] This was achieved by forging physicians' signatures on patient certification documents and unlawfully using Medicaid patients' personally identifiable information (PII) to enroll them in home care services they were not qualified for, despite the patients living outside of the United States.[12]

Last year, several Pennsylvania defendants were charged or pleaded guilty to allegations of Medicaid fraud related to personal care services.[13] In one case, a woman was charged for allegedly submitting $33,000 in Medicaid claims for personal care services for a patient that was deceased.[14] In a similar case, a man pleaded no contest to Medicaid fraud charges related to his submission of over 400 hours of personal care services that were not rendered due to the patient being hospitalized at the time.[15] In another case, a licensed practical nurse pleaded guilty to $96,000 in Medicaid fraud related to billing 2,000 hours of nursing services that were not provided because she was supposedly caring for two patients at the same time or traveling at the time services were allegedly rendered.[16] Through a personal care services business that she ran with her sister, the woman similarly billed for fraudulent personal care services that were not possible due to her and her sister traveling.[17] Two other defendants pleaded guilty in separate cases in which they were billing Medicaid for personal care services rendered while they were working another job.[18]

A Scranton blended case manager—a mental health professional that assists children with severe mental health concerns—was charged for the submission of over $72,000 in false claims paid by Medicaid for services that were not rendered.[19] In some instances patients' families reported not seeing the provider in over a year and a review of facility access records showed that the man was in his office despite billing records reflecting work in clients' homes and other places outside of the office.[20] An unlicensed Pennsylvania counselor was charged with having inappropriate sexual contact with a patient during sessions that were billed for over $7,000 to Medicaid.[21] In these sessions, it is alleged that the counselor smoked marijuana and engaged in sexual acts with a patient in her home during a session that was billed to Medicaid.[22] The patient

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[11] *Id.*
[12] *Id.*
[13] Press Release, Pennsylvania Attorney General David W. Sunday, Jr., Report: Pa. Attorney General's Medicaid Fraud Control Section charged more Medicaid fraud cases than any other state in the 2024 fiscal year (Mar. 17, 2025), https://www.attorneygeneral.gov/taking-action/report-pa-attorney-generals-medicaid-fraud-control-section-charged-more-medicaid-fraud-cases-than-any-other-state-in-the-2024-fiscal-year/.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] Press Release, Pennsylvania Attorney General David W. Sunday, Jr., AG Sunday charges PA. therapist accused of sexploiting patient as part of National Health Care Fraud Take Downs (July 1, 2025), https://www.attorneygeneral.gov/taking-action/ag-sunday-charges-pa-therapist-accused-of-sexploiting-patient-as-part-of-national-health-care-fraud-take-downs/.
[20] *Id.*
[21] *Id.*
[22] *Id.*

was intimidated and coerced by the counselor, reporting that she was afraid she would lose access to the therapy she needed if she did not comply.[23]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[24] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[25] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[26] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[27] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[28] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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

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[23] *Id.*

[24] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dep't of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[26] *Id.*

[27] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[28] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

> monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[29]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[30] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [31]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

John Joyce, M.D.
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H. Morgan Griffith
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cc: The Honorable Frank Pallone, Jr., Ranking Member, Committee on Energy and Commerce
The Honorable Yvette D. Clarke, Ranking Member, Subcommittee on Oversight and Investigations
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March 3, 2026

The Honorable Phil Scott
Governor
State of Vermont
109 State St., Pavilion
Montpelier, VT 05609

Ms. Jenney Samuelson
Secretary
Vermont Agency of Human Services
280 State Dr., Center Bldg.
Waterbury, VT 05676

Dear Governor Scott and Secretary Samuelson:

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Vermont Medicaid spending totaled $2.3 billion ($1.45 billion in federal funding) and covered nearly 156,970 people.[3] Medicaid costs in the state are on the rise, despite declining enrollment.[4] In January, DeShawn Groves, Commissioner of the Department of Vermont Health Access, requested a $33 million budget adjustment to cover higher-than expected Medicaid costs this fiscal year.[5] Vermont broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[6] In Vermont, these include behavioral health and home and community based services (HCBS) personal care services.[7]

Recent fraud investigations and convictions related to Vermont's Medicaid programs are concerning. Late last year, a Burlington mental health provider was ordered to pay $200,000 to resolve allegations of Medicaid from 2022 to 2024.[8] In this case, a nonprofit outpatient mental health care provider, Revolution Youth, "backdated records, inflated billing hours, and submitted claims that did not meet the state's minimum treatment and documentation standards."[9] According to the Vermont Medicaid Fraud and Residential Abuse Unit settlement document, "Revolution Youth fabricated entire records."[10] In a similar case in October 2025, a licensed psychologist was charged with defrauding Medicaid over $600,000 by submitting claims for psychotherapy sessions that were not provided and not maintaining adequate patient records.[11]

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www.macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, Dec. 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 27 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.
[4] Dep't of Vermont Health Access, DVHA FY2026 Budget Adjustment, 5 (Jan. 14, 2026), https://legislature.vermont.gov/Documents/2026/Workgroups/Senate%20Appropriations/FY%202026%20Budget%20Adjustment/Human%20Services/W~DaShawn%20Groves~DVHA%20BAA%20Presentation~1-14-2026.pdf.
[5] *Id.*
[6] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.
[7] *See* Colin May, *Wealth over well-being: Case studies of behavioral health fraud*, Association of Certified Fraud Examiners (Dec. 2025), https://www.acfe.com/acfe-insights-blog/blog-detail?s=case-studies-behavioral-health-fraud; *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.
[8] Lola Duffort, *Burlington mental health provider to pay $200K to settle Medicaid fraud claims*, VERMONT PUBLIC (Dec. 29, 2025), https://www.vermontpublic.org/local-news/2025-12-29/burlington-mental-health-provider-to-pay-200k-to-settle-medicaid-fraud-claims.
[9] *Id.*
[10] Settlement Agreement, *State of Vermont v. Revolution Youth, Inc.*, 3 (Dec. 29, 2025), https://ago.vermont.gov/sites/ago/files/2025-12/2025-12-29%20MFRAU%20-%20Revolution%20Youth%20Executed%20SA.pdf.
[11] Press Release, Office of the Vermont Attorney General, Bethel psychologist charged with Medicaid fraud (Oct. 1, 2025), https://ago.vermont.gov/blog/2025/10/01/bethel-psychologist-charged-medicaid-fraud.

In June 2024, the Vermont Attorney General filed civil enforcement actions against two behavioral health service providers for conspiring to upcode Medicaid billing to inflate reimbursements.[12] In the scheme, one defendant who is a licensed psychotherapist, allowed his business partner, a man who was not licensed in medicine or psychotherapy, to provide therapy services to Medicaid patients and billed it at a licensed clinical therapist's full rate.[13] Additionally, the psychotherapist billed an "impossible" amount of time, purportedly providing more than 24 hours of services in a single day.[14]

Last year, a Vermont couple was charged as co-defendants in a Medicaid fraud scheme in which it is alleged that the husband provided caretaking services for a Medicaid recipient that he was not authorized to care for, enabling his wife to submit false timesheets to bill Medicaid for caretaker services while being paid as a caretaker for another individual.[15] In another case that was resolved in February, a woman pleaded guilty to a misdemeanor charge of Medicaid fraud.[16] The woman submitted false timesheets to Vermont Medicaid for caretaker services, resulting in over $14,000 in payments for services she did not perform.[17]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[18] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[19] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[20] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes

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[12] Press Release, Office of the Vermont Attorney General, Mental health service providers accused of defrauding Vermont Medicaid (Jun. 3, 2024), https://ago.vermont.gov/blog/2024/06/03/mental-health-service-providers-accused-defrauding-vermont-medicaid.
[13] *Id.*
[14] *Id.*
[15] Press Release, Office of the Vermont Attorney General, Lamoille residents charged with Medicaid fraud (Apr. 3, 2025), https://ago.vermont.gov/blog/2025/04/03/lamoille-residents-charged-medicaid-fraud.
[16] Press Release, Office of the Vermont Attorney General, Former Medicaid caregiver pleads guilty to Medicaid fraud (Feb. 10, 2026), https://ago.vermont.gov/blog/2026/02/10/former-medicaid-caregiver-pleads-guilty-medicaid-fraud.
[17] Felix Day, *Richford woman charged with felony Medicaid fraud*, CBS 6 NEWS (May 20, 2025), https://cbs6albany.com/newsletter-daily/richford-woman-charged-with-felony-medicaid-fraud.
[18] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dep't of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.
[19] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.
[20] *Id.*

cross state lines far more than they used to."[21] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), HCBS, laboratory services, substance use disorder (SUD) treatment, and hospice.[22] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

> The concerns around these [ABA] services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[23]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[24] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [25]

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[21] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[22] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[23] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. 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.

[24] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[26] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

    a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [27] If yes, please describe these processes.

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

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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.

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

[27] *Id.*

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

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

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

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

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

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

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

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

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

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

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

a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

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

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

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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

BRETT GUTHRIE, KENTUCKY
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED NINETEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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WASHINGTON, DC 20515-6115
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March 3, 2026

The Honorable Bob Ferguson
Governor
State of Washington
P.O. Box 40002
Olympia, WA 98504-0002

Ms. Angela Ramirez
Secretary
Washington State Department of Social and Health Services
1115 Washington St. SE
Olympia, WA 98504

Dear Governor Ferguson and Secretary Ramirez:

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

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

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[1] Alyssa Chen, *Report: Poor policy language may have cost $1.7B across 14 Medicaid services in Minnesota*, MINNESOTA REFORMER (Feb. 6, 2026), https://minnesotareformer.com/2026/02/06/report-poor-policy-language-may-have-cost-minnesota-1-7b-across-14-medicaid-services/; *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[2] Joe Walsh, *What to know about Minnesota's "industrial-scale fraud" scandal, as more charges are filed and Trump weighs in*, CBS NEWS (Dec. 19, 2025), https://www.cbsnews.com/news/what-to-know-minnesota-fraud-scandal-more-charges-filed-trump-walz/; Press release, The Office of Minnesota Attorney General Keith Ellison, Two plead guilty to Medicaid fraud in case Attorney General Ellison investigated jointly with U.S. Attorney's Office (Oct. 22, 2025), https://www.ag.state.mn.us/Office/Communications/2025/10/22_EvergreenRecovery.asp.

In fiscal year 2024, Washington State Medicaid (Apple Health) spending totaled $21 billion ($13.2 billion in federal funding) and covered over 1.8 million people.[3] Medicaid spending in Washington State has quintupled, from $7.85 billion in the 2013-2015 state operating budget to $42 billion in the 2025-2027 state operating budget."[4] Washington State broadly defines Medicaid eligibility and administers several Medicaid programs that are considered high risk for FWA.[5] In Washington State, these include clinical laboratory services, durable medical equipment (DME), and behavioral health and substance abuse disorder (SUD) treatment.[6]

Recent fraud investigations and convictions related to Washington State's Apple Heath programs are concerning. As noted in the Oversight and Investigations Subcommittee's recent hearing on common schemes in Medicare and Medicaid, "[l]aboratory services and genetic testing continue to be a problem."[7] Last year, an urgent care clinic was allegedly overbilling Apple Health and Medicare for respiratory and urinary tract infection diagnostic tests through a fraud scheme known as unbundling.[8] Unbundling inflates billing costs by separating laboratory tests that are typically billed together, which increases the cost, and often involves unnecessary testing.[9] The urgent care agreed to pay $2.8 million to resolve the claims of fraudulent overbilling.[10]

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[3] Medicaid and CHIP Payment Access Commission, MACStats, Exhibit 16, Medicaid Spending by State, Category, and Source of Funds, FY 2024, 46, https://www macpac.gov/wp-content/uploads/2026/01/EXHIBIT-16.-Medicaid-Spending-by-State-Category-and-Source-of-Funds-FY-2024.pdf; U.S. Centers for Medicare and Medicaid Services, December 2024: Medicaid and CHIP Eligibility Operations and Enrollment Snapshot, 27 (Apr. 30, 2025), https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-december2024.pdf.

[4] TJ Martinell, *Fiscal fallout: How Washington Medicaid spending quintupled over a decade*, THE CENTER SQUARE (July 22, 2025), https://www.thecentersquare.com/washington/article_8d11d348-4dcd-46a5-845a-83e542462438.html.

[5] U.S. Centers for Medicare and Medicaid Services, Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels (last visited Feb. 9, 2026); *see also* Letter from Mehmet Oz, Administrator, U.S. Centers for Medicare and Medicaid Services, to The Hon. Janet Mills, Governor of Maine and Sara Gagné-Holmes, Comm'r, Maine Dep't of Health and Human Services, 2 (Feb. 6, 2026), https://x.com/DrOzCMS/status/2019894197466116237/photo/1.

[6] *See* Health Care Fraud Prevention Partnership, Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership, 7 (May 2018), https://www.cms.gov/files/document/download-clinical-laboratory-services-white-paper.pdf; *see also* U.S. Centers for Medicare and Medicaid Services, CMS Fraud Hot Spot: DMEPOS Suppliers (Sept. 2025), https://www.cms.gov/files/document/hot-spot-dmepos-suppliers.pdf; *see also* Isaac Asamoah, *Fraud, waste, and abuse schemes in the addiction treatment industry*, Association of Certified Fraud Examiners (Dec. 2023), https://www.acfe.com/acfe-insights-blog/blog-detail?s=fraud-waste-and-abuse-addiction-treatment-industry.

[7] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[8] Press Release, U.S. Attorney's Office, Eastern District of Washington, Tri-Cities urgent care clinic agrees to pay $2.8 million to resolve claims of overbilling for diagnostic tests (Sept. 24, 2025), https://www.justice.gov/usao-edwa/pr/tri-cities-urgent-care-clinic-agrees-pay-28-million-resolve-claims-overbilling.

[9] *Id.*

[10] *Id.*

A recent case prosecuted by the U.S. Attorney's Office for the Eastern District of Washington exposed a DME fraud scheme that was perpetrated by a sleep medicine physician.[11] To perpetrate the scheme, the physician purchased recalled Continuous Positive Airway Pressure (CPAP) and Bilevel Positive Airway Pressure (BiPAP) machines, modified them, and gave them to his patients for the purposes of fraudulently billing Medicaid as if they were new devices.[12] The adulterated devices were previously recalled due to serious potential health risks, including "inflammatory response, asthma, nausea or vomiting, and toxic or cancer-causing effects" and were not suitable for use.[13]

Last year, a Florida-based company, Lincare Holdings, Inc., was ordered to pay Washington State $1.15 million for overbilling leased oxygen DME to Washington State Medicaid for a period of two years more than was allowable under state law.[14] This followed the U.S. Attorney's Office for the Eastern District of Washington reaching a settlement with Lincare to pay $29 million to resolve claims of overbilling Medicare for oxygen equipment.[15]

In 2022, Paul Means, a psychiatric and mental health nurse practitioner and operator of Abilia Healthcare was charged with billing Apple Health more than $5 million in false claims lacking documentation, including instances of creating false patient diagnoses and billing for psychotherapy that did not take place.[16] In this elaborate and years-long alleged scheme, Means and his employees would provide medical services to patients in SUD facilities, often holding short 10 or 15 minute sessions with patients, but would bill for more elaborate patient psychotherapy evaluations and encounters by altering patient medical records.[17] Mr. Means altered patient notes after the fact with the assistance of individuals residing in the Philippines and text-generating software.[18]

A mental health counselor in Spokane and his company paid $135,000 to settle allegations that he fraudulently billed Washington State Medicaid for unlicensed and unqualified

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[11] Press Release, U.S. Attorney's Office, Eastern District of Washington, Local physician pleads guilty to adulterating and misbranding medical devices with the intent to defraud (Dec. 18, 2025), https://www.justice.gov/usao-edwa/pr/local-physician-pleads-guilty-adulterating-and-misbranding-medical-devices-intent.
[12] *Id.*
[13] *Id.*
[14] News Release, Washington State Office of the Attorney General, Lincare to pay Washington State $1.15 million in AG Ferguson's Medicaid fraud investigation (Jan. 13, 2025), https://www.atg.wa.gov/news/news-releases/lincare-pay-washington-state-115-million-ag-ferguson-s-medicaid-fraud.
[15] Press Release, U.S. Attorney's Office, Eastern District of Washington, Lincare Holdings Agrees to Pay $29 Million to Resolve Claims of Overbilling Medicare for Oxygen Equipment in Largest-Ever Health Care Fraud Settlement in Eastern Washington (Aug. 28, 2023), https://www.justice.gov/usao-edwa/pr/lincare-holdings-agrees-pay-29-million-resolve-claims-overbilling-medicare-oxygen.
[16] News Release, Washington State Office of the Attorney General, Attorney General files criminal charges against Spokane-based health business for fraud, organized crime (Dec. 16, 2022), https://www.atg.wa.gov/news/news-releases/attorney-general-files-criminal-charges-against-spokane-based-health-business.
[17] *Id.*
[18] *Id.*

mental health therapy that did not meet Medicaid qualification requirements, were not contracted with the state to provide services, and were not eligible for Medicaid reimbursement.[19]

At the Committee's request, the Centers for Medicare and Medicaid Services (CMS) briefed the Committee in January on what is currently known about the Medicaid fraud in Minnesota and actions CMS has taken to date to investigate FWA in other states. This further underscored the need for the Committee's oversight to ensure program integrity in states nationwide. The Committee subsequently launched an investigation into Medicaid fraud in Minnesota.[20] The Committee's Subcommittee on Oversight and Investigations then held a hearing on February 3, 2026, entitled "Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid."[21] The hearing examined fraud within Medicare and Medicaid, including common fraud schemes plaguing these programs, and how these schemes have changed over time; aspects of program design that make these programs vulnerable to fraud; and high risk areas for fraud in these programs.[22] The hearing reinforced that Medicaid fraud is not limited to Minnesota and confirmed that Medicaid fraud investigators "see that fraud schemes cross state lines far more than they used to."[23] Expert witnesses testified that Medicaid programs experiencing high rates of fraud include Applied Behavioral Analysis (ABA) services for children with Autism Spectrum Disorder (ASD), non-emergency medical transportation (NEMT), home and community based services (HCBS), laboratory services, SUD treatment, and hospice.[24] Regarding ABA services fraud, Jessica Gay, a Certified Fraud Examiner, testified that:

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[19] Press Release, U.S. Attorney's Office, Eastern District of Washington, Spokane mental health counselor agrees to pay more than $135,000 for fraudulent Medicaid billing (Feb. 25, 2022), https://www.justice.gov/usao-edwa/pr/spokane-mental-health-counselor-agrees-pay-more-135000-fraudulent-medicaid-billing?.

[20] Letter from The Hon. Brett Guthrie, Chairman of H. Comm. on Energy & Commerce, et al., to The Hon. Tim Walz, Governor of Minnesota and Temp. Comm'r, Minnesota Dept. of Human Services (Jan. 16, 2026), https://d1dth6e84htgma.cloudfront.net/1_16_2026_MN_Medicaid_Fraud_Letter_944a806843.pdf.

[21] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. (Feb. 3, 2026), https://energycommerce house.gov/events/oversight-and-investigations-common-schemes-real-harm-examining-fraud-in-medicare-and-medicaid.

[22] *Id.*

[23] *Id.* at 35 (statement of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), Unofficial Hearing Transcript.

[24] *See Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 9 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf; *see also Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

> monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.[25]

Mrs. Gay further noted that in Medicaid programs relying on self-attestation, such as HCBS, "there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility."[26] Additionally, Kaye Lynn Wootton, President of the National Association of Medicaid Fraud Control Units, testified that:

> Non-Emergency Medicaid Transportation fraud schemes include providers illegally billing Medicaid for: (1) "ghost rides" that were never provided; (2) tolls that were never incurred during trips, (3) individually billed rides when group rides were actually provided; (4) trips that were falsely billed when recipients were deceased, incarcerated or hospitalized; (5) trips provided by providers that paid kickbacks to Medicaid recipients to induce them to choose that provider to provide transportation; and (6) trips that never occurred but for which the provider paid the recipient a kickback. [27]

Ensuring Medicaid program integrity is critical to preserving access to vital health care services for those that need it most. Every dollar stolen from the Medicaid program by fraudsters is taken from children, pregnant women, the elderly, and people with disabilities. It is the duty of states to design Medicaid programs with adequate fraud control measures and work with CMS to swiftly identify and address vulnerabilities in programs. To assist the Committee in its oversight, please provide written responses and all responsive documents regarding Medicaid program integrity by March 17, 2026:

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

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

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

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[25] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 4 (Feb. 3, 2026) (written testimony of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-GayCPCAHFICFEJ-20260203.pdf.

[26] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 26 (Feb. 3, 2026) (statement of Jessica Gay, Vice President and Co-Founder, Integrity Advantage), Unofficial Hearing Transcript.

[27] *Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid: Hearing Before the H. Comm. on Energy & Commerce, Subcomm. on Oversight & Investigations,* 119th Cong. at 11 (Feb. 3, 2026) (written testimony of Kaye Lynn Wootton, President, National Association of Medicaid Fraud Control Units), https://docs.house.gov/meetings/IF/IF02/20260203/118917/HHRG-119-IF02-Wstate-WoottonJDK-20260203.pdf.

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

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

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

5. How are Medicaid service providers screened for compliance with federal law?[28] Please describe the process for screening, enrolling, and revalidating Medicaid providers, including but not limited to credentialing and site visits.

    a. Are additional provider screening efforts imposed in addition to federal requirements to screen, enroll, and revalidate Medicaid providers? [29] If yes, please describe these processes.

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

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

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

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

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

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

    a. If so, please detail the programs that have experienced abnormal or statistically significant increases since January 1, 2021, the data that was

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

collected on the programs, and how this data has been used to inform assessments of program vulnerability to FWA.

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

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

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

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

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

   a. Total Medicaid improper payments identified annually from January 1, 2021, to present, broken out by provider type and service category where available.
   b. Total recoveries and recoupments of improper Medicaid payments annually from January 1, 2021, to present.
   c. The average amount of time between identification of suspected fraudulent or improper payments and recovery, enforcement action, or case resolution.
   d. The extent to which the state utilizes payment suspension authority pursuant to 42 CFR § 455.23, including the number of payment suspensions issued annually since January 1, 2021, and the provider types or services impacted.
   e. The extent to which the state has pursued civil enforcement actions, including actions under state or federal False Claims Act authorities, related to Medicaid FWA since January 1, 2021.

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

    a. Screening, enrollment, credentialing, and monitoring requirements for fiscal intermediaries participating in Medicaid programs.
    b. Oversight mechanisms used to monitor caregiver time reporting, billing accuracy, and verification of services furnished through fiscal intermediaries.

c. The frequency and scope of audits conducted on fiscal intermediaries since January 1, 2021, including audits conducted by the state or third-party contractors.
d. The number of fiscal intermediaries that have been terminated, sanctioned, suspended, or otherwise subject to corrective action since January 1, 2021, and the basis for those actions.

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

Sincerely,

Brett Guthrie
Chairman
Committee on Energy and Commerce

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

H. Morgan Griffith
Chairman
Subcommittee on Health

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