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Statement for the Record

Energy and Commerce Oversight & Investigations Subcommittee

Hearing on "Protecting Patients and Safeguarding Taxpayer Dollars: The Role of CMS in Combatting Medicare and Medicaid Fraud"

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Chair Joyce, Vice Chair Balderson, Ranking Member Pallone, and Ranking Member Clarke, on behalf of Families USA, we thank you for holding this important and timely hearing. We strongly support efforts to identify and address waste, fraud and abuse in our health care system, including within the Medicaid and Medicare programs. At the same time, we must stress how essential it is for oversight efforts to strengthen, rather than undermine, the programs' ability to serve the millions of Americans who rely on them for health coverage.

Nearly 80 million Americans, including more than 36 million children, across all 50 states and the District of Columbia are currently enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[1] These programs provide essential health coverage and affordable access to care for low-income individuals and families, safeguarding the financial stability and well-being of households at a time when health care costs are rising and the nation faces a growing chronic disease burden.[2] Similarly, the Medicare program provides affordable, high-quality health care for nearly 70 million older adults and people with disabilities, protecting some of our nation's most vulnerable adults from having to make impossible tradeoffs between accessing health care or paying for basic necessities like food and rent.[3]

Fraud within Medicaid and Medicare is obviously unacceptable. Identifying, addressing, and resolving cases of fraud is essential to protecting program integrity and ensuring that taxpayer dollars are used appropriately and efficiently. Yet we urge the subcommittee to exercise caution as it conducts its investigation, ensuring that existing state and federal program integrity efforts are appropriately considered and efforts to enhance program oversight and accountability do not disrupt access to care. **For example, recent actions by the Centers for Medicare & Medicaid Services (CMS) to intensify fraud enforcement through unprecedented measures—such as deferring $259.5 million in Medicaid funding to Minnesota—jeopardize the entire program by disrupting critical health care services and harming seniors, people with disabilities, and low-income families.[4]**

Recklessly withholding broad swaths of federal matching funds for the Medicaid program does nothing to target isolated sources of fraud or abuse, but it does serve as an attack on the health and wellbeing of people with disabilities, older Americans, and the workers who deliver their essential care – workers who are disproportionately women, people of color, and immigrants.[5]

Any additional oversight efforts should build upon existing structures and support effective investigations rather than weakening critical health coverage programs. This is particularly important given the strain already placed on state budgets and families' access to care by H.R. 1, which significantly undermined health insurance marketplaces and made the largest cuts to Medicaid funding in the program's history. **We particularly recommend that the Committee focus its efforts on areas of well-documented waste and abuse in**

the health care system, including within the Medicare Advantage program, where unchecked corporate profiteering has resulted in significant wasteful spending that undermines Medicare's promise to seniors and taxpayers.

Existing Role of CMS in Fraud Oversight

Over their 60-year history, there have been discrete instances of fraud committed against Medicare and every state Medicaid program. That is why there are existing federal and state oversight structures in place to investigate and prosecute fraud, including through the Medicaid Fraud Control Units (MFCUs) run in all states by the U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG), and through the work of state and independent auditors.[6,7]

Federal oversight findings from HHS OIG, the U.S. Government Accountability Office (GAO), and the U.S. Department of Justice make clear that the most significant threats to Medicare and Medicaid program integrity come from organized provider fraud and market-based schemes, not from individual beneficiaries. These investigations have uncovered networks in which marketers, brokers, telemedicine platforms, laboratories, and equipment suppliers collaborate to generate medically unnecessary claims.[8,9] These examples are evidence that the misaligned financial incentives of our health care payment and delivery system are a far greater vulnerability for fraudulent billing schemes than the need for low-income children and seniors to get health insurance coverage.

Addressing fraud within the Medicaid system can take years of collaborative work between CMS and a state Medicaid agency. For a timely example, look to Minnesota's recent program integrity efforts to root out fraud.[10] When the Minnesota Department of Human Services identifies a case of fraud, officials turn it over to the MFCU for prosecution. Since 2020, the Department has "conducted over 3,000 investigations and referred over 500 cases to law enforcement." Through these efforts, officials have identified "more than $50 million for recovery."[11] These ongoing program integrity efforts in Minnesota demonstrate the extensive work already underway to detect and address fraud. **As Congress and the administration consider additional actions, it is critical to ensure that oversight efforts support, rather than disrupt, ongoing investigations and existing program integrity structures.** While Minnesota and other states may need more resources or tools to effectively investigate fraud and hold bad actors accountable, blunt actions that strip Medicaid funding from the vulnerable Americans who need it do nothing to support program integrity.

It is also important to distinguish mechanisms that detect genuine instances of fraud from other kinds of program integrity efforts. For instance, CMS's Payment Error Rate Measurement (PERM) measures improper payments in Medicaid, such as underpayments or overpayments, but it does not measure fraud.[12] Most Medicaid improper payments

result from documentation or administrative errors rather than fraudulent activity. Recent findings involving Medicaid payments associated with deceased beneficiaries should be viewed in this broader context. Audits by the HHS OIG have identified situations in which capitation payments continued briefly after an enrollee's death due to delays in updating eligibility and death-record data across systems.[13] These audits point to administrative and data coordination challenges, not widespread beneficiary fraud, and represent a very small fraction of total program spending.

These findings suggest two things: first, states need resources and tools to improve administrative systems to reduce human error. Second, tackling true fraud in the system will require targeted investments in oversight, auditing, and investigative capacity.[14] **Strengthening eligibility systems, improving data sharing, and modernizing program integrity safeguards are important steps to protect taxpayer dollars and should be advanced. Broad funding restrictions that risk disrupting care for beneficiaries do not reduce administrative error or build system capacity to uncover fraud.**

Impact of Recent CMS Actions on States and Communities – A Closer Look at Minnesota

In February 2026, CMS deferred approximately $259.5 million in federal funding to Minnesota following a review that identified "unusually high spending and rapid growth in certain services areas, including personal care services and home- and community-based services (HCBS)."[15] **Of course, growth in the use of HCBS is not in and of itself evidence of fraud.** After all, these services are critical to allowing seniors and people with disabilities the freedom and opportunity to remain in their communities and receive care, rather than in institutional settings.[16] In Minnesota, approximately 15 percent of Medicaid beneficiaries experience a disability, many of whom rely on HCBS for daily supports and long-term care services.[17] And as America's baby boom population ages, so too does the demand for HCBS.[18]

Providers and patients have fought hard for these services to become available in their communities because, for many people, HCBS offers higher quality care.[19] States have also supported HCBS growth as a means of reducing Medicaid program expenses–CMS reports that community-based services offer care at less than half of the cost of institutional care[20]–and most states deploy one or more mechanisms to rein in HCBS spending (for example, by caping enrollment or spending per participant).[21] Bad actors who seek to defraud Minnesota and CMS out of HCBS funding need to be identified and prosecuted. However, the fact that Minnesota has seen growth in demand for HCBS is not a function of fraud, but a function of consumer preference.[22]

Deferring Minnesota's Medicaid funds risks disrupting the state's ability to sustain these critical services and may force challenging budget decisions about how to allocate limited HCBS funding and resources across the Medicaid program (in ways that could result in greater use of more expensive institutionalized care). In addition, as HCBS programs are

not delivered in a silo, restricting HCBS funding impacts broader access to care for Minnesotans who rely on Medicaid coverage to attain and maintain their best possible health.[23] While CMS' decision to defer federal funding was intended to encourage Minnesota to address HCBS fraud within the program (which the state is and has been actively pursuing) its impact will be to limit access to care for all Medicaid recipients without offering Minnesota additional tools or resources that it may need to target and rectify any true HCBS fraud.

Prior to this hearing, this Committee sent letters to ten states to request information about their current program integrity efforts.[24] While these letters seek additional information, they may also signal the potential for expanded federal oversight actions. CMS has already issued program integrity inquiry letters to states including California, Maine, and New York, which could precede the planned next step of implementing a funding deferral similar to the recent action taken in Minnesota.[25]

Before Congress or CMS initiates Medicaid funding deferral actions in these or any other state, it must take stock of what, if anything, has been achieved in Minnesota. Medicaid beneficiaries depend on federal leadership to ensure that program dollars are spent honestly and appropriately on their care needs; these communities deserve better than blanket, indiscriminate approaches that strip Medicaid funding broadly and disrupt their access to care.

Addressing Waste and Abuse in Medicare Advantage

There are areas within federal health programs where stronger oversight could meaningfully reduce waste and protect taxpayer dollars. One clear example is the Medicare Advantage (MA) program — now covering more than 33 million older adults[26] — which was created to deliver higher-quality, more coordinated care at a lower cost. But Medicare Advantage has failed to deliver on its core promise. Since 2007, MA overpayments have drained nearly $600 billion from the Medicare program.[27] In 2025 alone, taxpayers will spend $84 billion more to cover people in MA than if they were in traditional Medicare — an average 20% overpayment per enrollee.[28] These excess payments drive up Part B premiums for all Medicare beneficiaries and push the Medicare Hospital Insurance Trust Fund closer to insolvency, projected as soon as 2033.[29] And all that spending fails to deliver better care, with MA plans demonstrating inconsistent performance on health care quality and access compared with traditional Medicare.[30]

MA insurers have built a business model that prioritizes profits at the expense of patients. Through systematic upcoding, deceptive marketing of supplemental benefits, and wrongful care denials, corporate health plans exploit flaws in the system to inflate their payments. Seniors are promised better care, but instead often face barriers, delays and denials. For example, there were nearly 90,000 inappropriate denials in 2019 alone, with

83% of appeals overturned in 2023.[31] These practices hurt patients and drain taxpayer dollars.

One well-documented and clear-cut abuse within MA is systemic upcoding practices which have resulted in significant overpayments to insurers. The intent of the MA payment system is to incentivize insurers to compete on the cost, quality, and efficiency of the coverage they offer to enrollees relative to other MA insurers and to Traditional Medicare.[32] Under this system, CMS adjusts payments to MA plans using a risk adjustment model to increase or decrease payments to MA insurers based on the characteristics and diagnoses of each enrolled patient to account for differences in health care costs between healthier and sicker enrollees.[33] However, this model is vulnerable to gaming. MA plans can use certain billing and coding practices to make their enrollees appear sicker and more expensive relative to Traditional Medicare beneficiaries in order to generate a higher reimbursement from the federal government.[34]

This systematic "upcoding" occurs despite the fact that MA enrollees actually tend to be healthier and less costly to cover overall than those in Traditional Medicare.[35] Since MA plan payments are risk-adjusted primarily by the numbers and types of diagnoses reported by MA plans on behalf of their enrollees (e.g. plans are paid more to cover enrollees with relatively more diagnoses or diagnoses linked to higher care and treatment costs), MA plans have a strong financial incentive to identify and record as many diagnoses as possible among their enrolled beneficiaries - often without delivering additional care or coverage to beneficiaries.[36] Most concerningly, some MA plans go as far as assigning patient diagnoses that are not even supported by the patient's medical record, relying on sham health risk assessments and chart reviews.[37]

These coding abuses of the risk adjustment system further inflate Medicare payments to MA plans, costing Medicare an additional $40 billion every year.[38] If Congress' goal is to root out waste and fraud in the health care system, there is no clearer starting place than the abuse being done by these MA insurance companies. Strengthening the risk adjustment system would help protect against this industry gaming. The Congressional Budget Office estimates that if Congress were to enact the policies put forward under the bipartisan *No UPCODE Act*, it would save Medicare $1.5 billion over 10 years.[39]

Conclusion

State and federal oversight efforts must continue to investigate and prosecute occurrences of fraud within the Medicare and Medicaid programs, but the policies designed to address fraud should be carefully targeted to avoid inadvertently undermining access to care. We appreciate the efforts of this subcommittee to highlight the critical role that the Medicare and Medicaid play in the lives of individuals, families, and communities across the nation, and look forward on continuing to work with you to improve affordable and accessible health care.

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