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COMMON SCHEMES, REAL HARM: EXAMINING FRAUD IN MEDICARE AND MEDICAID

TUESDAY, FEBRUARY 3, 2026

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:30 a.m., in Room 2360, Rayburn House Office Building, Hon. John Joyce [Chairman of the Subcommittee] presiding.

Present: Representatives Joyce, Balderson, Palmer, Crenshaw, Allen, Fulcher, Harshbarger, Rulli, Guthrie (ex officio) Clarke, DeGette, Tonko, Trahan, Fletcher, Ocasio-Cortez, Mullin, and Pallone (ex officio).

Also Present: Representatives Carter of Georgia, Dingell, and Shrier.

Staff Present: Christian Calvert, Press Assistant, Press; Jessica Donlon, General Counsel; Reagan Dye, Professional Staff Member, Oversight and Investigations; Eliot Fletcher, GAO Detailee, Oversight and Investigations; Sydney Greene, Director, Finance and Logistics; Brittany Havens, Chief Counsel, Oversight and Investigations; Annabelle Huffman, Clerk, Health; Megan Jackson, Staff

Director; AT Johnson, Special Advisor; Sophie Khanahmadi, Deputy Staff Director; Alan Slobodin, Chief Investigative Counsel, Oversight and Investigations; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Dariele Campbell, Minority Law Clerk; Keegan Cardman, Minority Staff Assistant; Addison Dascher, Minority Law Clerk; Austin Flack, Minority Professional Staff Member; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Jackson Hall, Minority Intern; Will McAuliffe, Minority Chief Counsel, Oversight and Investigations; Elisabeth Mellen, Minority Intern; Constance O'Connor, Minority Senior Counsel; Christina Parisi, Minority Professional Staff Member; Harry Samuels, Minority Counsel; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; and Caroline Wood, Minority Research Analyst.

Mr. Joyce. Good morning. The Subcommittee on Oversight and Investigations will now come to order. The chair now recognizes himself for 5 minutes for an opening statement.

Welcome to today's hearing entitled Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid. Recent criminal prosecutions and continued allegations of fraud in the State of Minnesota's Medicaid and other benefit programs have shown a spotlight on how vulnerable these programs are. Americans are outraged.

Any amount of waste, fraud, or abuse of resources and taxpayer funds is too much, but it's particularly alarming when it happens on a scale as large as what's being uncovered in Minnesota. What's happening in Minnesota's Medicaid program is critical and worth discussing. But it is just the tip of iceberg. Medicare and Medicaid fraud is common. It's happening nationwide.

And it has been egregious for decades. Some estimates place annual Medicare and Medicaid fraud losses at \$100 billion annually. This is only a conservative estimate because fraud can only be accounted for if it is detected.

The Government Accountability Office placed Medicare on its inaugural high risk list in 1990 and it has remained there ever since.

Medicaid has also joined Medicare on the high risk list in 2003. The Department of Health and Human Services Office of the Inspector General has also sounded the alarm on the unsustainable rate of waste, fraud, and abuse. We have to adjust and address this issue. Here are just some of the examples of the fraud schemes that we are seeing today in these programs.

In New York, an adult daycare owner defrauded Medicaid over \$68 million through illegal patient referral kickbacks and bribery schemes. In Arizona, a man based in Pakistan and United Arab Emirates allegedly billed Arizona Medicaid \$650 million in a fraud scheme targeting the homeless and Native Americans seeking substance abuse treatment.

Another case last year seven defendants across Arizona and Nevada were charged in connection with an alleged \$1.1 billion Medicare fraud scheme for medically unnecessary amniotic lute allografts, commonly known as skin substitutes. And just a few weeks ago a Florida laboratory owner pleaded guilty to a \$52 million in medically unnecessary genetic tests billed on behalf of Medicare beneficiaries.

In all of these cases, patients suffer from unnecessary, inadequate or a complete lack of medical care. In other cases, patients are unknowingly victims of identity theft or misleading marketing practices perpetrated by these fraudsters. And as highlighted in one of the above examples, nation states and oversea criminal gangs are also targeting Medicare and Medicaid.

Recent medical criminal indictments and convictions show the trend is getting worse and exemplify the scale of fraud. It has been said that healthcare fraud is becoming easier and more lucrative than the illicit drug trade. Patients will suffer if these healthcare programs cannot continue on responsible fiscal paths. It is our duty in Congress to protect these programs for our most vulnerable programs. American taxpayers place hundreds of billions of dollars into Medicare and Medicaid.

We must do better to protect these programs from fraud that is draining them of billions of dollars annually. We applaud law enforcement efforts that investigate fraud and prosecute fraud. But we can save more, more money by detecting and preventing fraud before it even occurs, rather than paying and chasing funds after they have already been dispensed to the criminals. The increased focus on this subject from Dr. Oz, the administrator of CMS has also been a improvement over the previous administration.

I want to thank our witnesses for being here today. Your knowledge about this important topic will help us understand the challenge of Medicare and Medicaid. As our witnesses will testify today, these are real legitimate fraud schemes.

With that, I now recognize our ranking member of the subcommittee, Ms. Clarke, for her opening statement.

[The prepared statement of Mr. Joyce follows:]

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Ms. Clarke. Thank you very much, Mr. Chairman. And good morning, everyone.

If we really want to get serious about fraud, the administration needs to stop terrorizing our communities. Red line after red line has been crossed by this administration. First, Renee Good was shot and killed by a Federal agent while out protecting her neighbors. Instead of investigating her killing, Stephen Miller, Secretary Noem, and Vice President Vance claim that Renee was carrying out domestic terrorism. Then, Alex Pretti, who worked as a VA ICU nurse, was shot multiple times and killed by two Federal agents while he was protecting a woman that officers had shoved to the ground. Secretary Noem called him a domestic terrorist and Stephen Miller called him an assassin.

This past week, journalist Don Lemon and Georgia Forte were arrested just for reporting on a protest at a church. Several protesters were also arrested in the White House, not content with merely arresting these individuals, even released an altered photo of one of them to make it appear as if she was crying.

An individual in ICE custody sustained eight skull fractures, that ICE officers said were caused by running into a wall, but medical officials said that the patient's injuries could not have been caused by running into a wall.

ICE said that another man who died in ICE custody was attempting suicide and staff was trying to save him, but we learned later from his autopsy that he was actually suffocated when he was held down by guards in a detention facility.

It is lie after lie after lie from this administration and it is only getting worse. Our children are not safe, a five-year-old boy was used by Federal agents as bait to lure out members of his family and community from their house. The other day children in Portland were tear gassed while participating in a peaceful protest.

And it is not just happening in cities, recent video from rural Minnesota show mass Federal agents pulling in front of the vehicle of an observer, getting out with guns drawn and aiming them at the driver. That's just a sampling of the horrors that we've seen.

And these are only the ones that we know about because brave citizens have been out there on the streets recording. I can only imagine how many more abuses are happening away from the cameras. No one is exempt from the tyranny of this administration. And any of my colleagues who think they or their constituents are somehow immune from this Administration's flailing cruelty better wake up quickly because it could be your community next.

Now, what does all this have to do with fraud? Don't ask me, ask Attorney General Bondi who has justified the continued presence of Federal agents in Minneapolis due to the existence of fraud in that State.

In a letter she sent on January 24th, Attorney General Bondi tried to extort Minnesota by seeking voter data and other sensitive records in exchange for relief from Federal terror. And in doing so, she referred the letter sent by community -- committee Republicans investigating fraud in Minnesota. It was truly a dark day when this committee's reputation is used to justify the oppression of American communities.

Our country was founded by people who stood up to the tyranny of a mad king across the ocean. But now the tyranny and madness is coming from inside the house, specifically the White House.

We have seen image after image and video after video of outrageous abuses, any of which could have scandalized any other administration, but for this administration there's clearly no bottom and totally inability to feel shame. I can assure you that when Democrats are back in charge, we will not sit by silently while the President runs roughshod over the constitution and the American people.

And to the people of Minnesota and other communities who are living in fear, I want you to know that on my side of the aisle we hear you, we see you, and we will keep fighting for you.

With that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Ms. Clarke follows:]

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Mr. Joyce. Thank you. The chair now recognizes the chairman of the full committee, Mr. Guthrie for 5 minutes for an opening statement.

The Chair. Thank you. Thank you, Chairman Joyce. I appreciate you for holding this hearing and I really appreciate all of the witnesses being here today. Today's hearing sounds the alarm on the tremendous loss of taxpayer dollars to fraud and the real consequences for patients, providers in the public trust.

Together Medicare and Medicaid provide health coverage to more than 140 million Americans, including seniors, people with disabilities, low-income families, pregnant women and children. These programs are lifelines not abstract budget figures. When they are exploited and plundered, Americans lose access to care, confidence in the system, and resources intended to improve those health outcomes.

Each year tens of billions of dollars are lost to fraud, waste, and abuse. But financial loss is not only the consequence of these fraud schemes, when providers bill for services never rendered or criminals flood Medicare or Medicaid with fake claims the system becomes harder to oversee, less responsive to avoid legitimate patients and financially unstable.

Healthcare costs rise for everyone and trust in these critical programs erode. Operation Gold Rush illustrates the growing scale of the problem. This recent nationwide enforcement action by the Department of Justice was the largest healthcare fraud takedown in history. This operation targeted several healthcare fraud schemes leading to criminal charges against 324 defendants in 50 Federal districts in 12 State Attorneys General's offices across the U.S.

The various schemes involved over -- excuse me -- \$14.6 billion in intended loss. Twenty-nine of those defendants were charged for their roles in transnational criminal organizations that use stolen identities of over 1 million Americans, spanning all 50 States to submit over 10 billion in fraudulent claims to Medicare for durable medical equipment that patients never ordered or received.

Many seniors learn that their Medicare or other personally identifiable information had been compromised only after being denied legitimate care.

This is not an administrative error, it was organized crime exploiting our Nation's healthcare programs. We must ensure taxpayer dollars are used for quality healthcare, not siphoned off by criminal enterprises.

Republicans took steps in this in H.R. 1 and we must continue the effort to preserve Medicare and Medicaid for those who need these programs. I look forward to hearing from our witnesses. I appreciate you all taking the time to be her today.

And with that, Mr. Chairman, I appreciate this hearing. And I will yield back.

[The prepared statement of The Chair follows:]

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Mr. Joyce. Thank you. The chair recognizes the ranking member of the full committee, Mr. Pallone, for 5 minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

As anyone who has been around long enough knows fraud is a very real persistent challenge, fraud happens in both red States and blue States. But the word fraud has unfortunately become a convenient excuse for Republicans to just do just whatever they want. Their solution to combating elusive claims of fraud in Medicaid was cutting millions of Americans off of their health coverage and instead giving money to companies like Deloitte to push eligible beneficiaries off of the Medicaid rolls.

Republicans' Big Ugly Bill is cutting \$1 trillion from our healthcare system while also stripping healthcare away from 15 million Americans and closing hospitals and nursing homes all around the Nation. And now fraud is being invoked as a justification for Federal agents terrorizing communities.

The Trump administration is using claims of fraud in State programs, including Medicaid, as an excuse to recklessly deploy Department of Homeland Security, DHS officials from Immigration and Customs Enforcement, ICE, and Customs and Border Protection in Minneapolis, Minnesota. But it has become clear that this was purely a pretext for the administration to continue targeting the States and cities President Trump views as political adversaries.

Instead of providing assistance to Minnesota and other States in protecting federally funded programs from waste, fraud, and abuse, the Trump administration has mobilized to take drastic punitive measures that do nothing to harm the bad actors that perpetrate waste, fraud, and abuse and instead harm the people who count on these programs for their healthcare and their livelihood.

In December, the Department of Homeland Security began Operation Metro Surge in Minnesota with the alleged purpose of cracking down on fraud and illegal immigration. Since that time, two innocent Minnesotans, Renee Good, and Alex Pretti have been shot and killed by Federal

agents and countless more have been terrorized and traumatized.

Renee Good was shot multiple times and Federal agents on the scene refused to allow a doctor who was on site to administer first aid. Rather than investigating the shooting, the Department of Justice instead pushed prosecutors to investigate Renee Good and her widow. At least 14 Federal prosecutors as of today have resigned in protest.

All told the Minnesota U.S. Attorneys Office which handles these fraud cases or prosecutions is at half its strength. Alex Pretti was an ICI nurse who worked at a VA hospital, video shows that he was trying to assist and protect a woman who had been shoved by an agent when he himself was tackled by multiple agents and then shot by two of them. These are two lives lost in a matter of weeks due to the unjustified invasion of Federal forces into an American city on the pretext of addressing fraud.

And the Republicans on this committee are complicit. Last month, Attorney General -- the Attorney General Bondi sent a letter to Minnesota Governor Tim Walz seeking to extort sensitive health and voter data in exchange for Federal forces withdrawing. In her letter, she cited to an investigation by committee Republicans as a justification.

Now the Department of Homeland Security operations in Minneapolis must cease immediately for the safety of all and a thorough independent investigation must be conducted into these two murders. It is also time for the Trump administration to begin work with the States and communities that investigate and prosecute fraud.

Instead of providing assistance to Minnesota and other States and protecting federally funded programs from waste, fraud, and abuse, the Trump administration has mobilized to take drastic punitive measures that do nothing to harm the bad actors, as I have said before.

It is also after all when it comes to taking real productive steps to prevent and punish fraud, the Republicans fail to do so. Committee Republicans have ignored our request for a hearing to examine Trump's firing of at least 17 Inspector Generals, including the Inspector General of the

Department of Health and Human Services.

Inspector Generals are the very people who work to prevent and detect fraud and abuse in our Federal agencies. And Republicans have silently stood by as Trump fired 17 of them.

Now, Republicans also refuse to join us in raising concerns when DOGE pushed out career staff at the HHS Office of the Inspector General. And they haven't said a thing about Trump continuing to pardon criminals who were convicted of Medicare and Medicaid fraud.

If you want to get serious about waste, fraud, and abuse start with President Trump and the harm he's doing to our Nation. His Federal agents are laying waste to our communities. His actions are making fraud worse, not better, and he is abusing his authority every day.

And with that, Mr. Chairman, I yield back the balance of my time.

[The prepared statement of Mr. Pallone follows:]

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Mr. Joyce. The gentleman yields.

That concludes members' opening statements. The chair would like to remind members that pursuant to the committee rules all members' written opening statements will be made part of the record.

We want to thank our witnesses for being here today and for taking time before -- to testify before the subcommittee. You will have the opportunity to give an opening statement followed by a round of questions from members.

Our witnesses today are Jessica Gay, vice president and cofounder Integrity Advantage, Kaye Lynn Wooton, President Nation Association of the State Medicaid Fraud Control Units, Stephen Nuckolls, chief executive officer Coastal Carolina Healthcare, the Treasurer and former board chair of the National Association of Accountable Care Organizations.

And Jessica Tillipman, government contracts advisory council distinguished professional lecturer in government contracts law, practice and policy at the George Washington University Law School. We appreciate all of you being here today and look forward to hearing from you. You're aware that this committee is holding an oversight hearing and when doing so has the practice of taking the testimony under oath. Do you have an objection to testifying under oath.

Seeing no objection, we will proceed. The chair advises you that your entitled to be advised by counsel pursuant to House rules. Do you desire to be advised by counsel during your testimony today?

Seeing none, please rise, raise your right hand.

Do you promise to tell the truth, the whole truth and nothing but the truth, so help you God?

Seeing the witnesses have answered in the affirmative you're now sworn in and under oath. Subjective to the penalties set forth in Title 18, section 1001 of the United States Code.

With that, we that we now recognize Ms. Gay for 5 minutes to give an opening statement.

TESTIMONY OF JESSICA GAY, CPC, AHFI, CFE, VICE PRESIDENT AND CO-FOUNDER, INTEGRITY ADVANTAGE; KAYE LYNN WOOTTON, J.D., PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS; STEPHEN W. NUCKOLLS, CHIEF EXECUTIVE OFFICER, COASTAL CAROLINA HEALTH CARE, P.A. AND TREASURER AND FORMER BOARD CHAIR, NATIONAL ASSOCIATION OF ACCOUNTABLE CARE ORGANIZATIONS (NAACOS); AND JESSICA TILLIPMAN, J.D., GOVERNMENT CONTRACTS ADVISORY COUNCIL DISTINGUISHED PROFESSORIAL LECTURER IN GOVERNMENT CONTRACTS LAW, PRACTICE & POLICY, GEORGE WASHINGTON UNIVERSITY LAW SCHOOL

TESTIMONY OF JESSICA GAY

Ms. Gay. Chairman Dr. Joyce, Chairman Guthrie, Ranking Member Pallone and Ranking Member Clarke, members of the subcommittee, thank you for having me here today. My name is Jessica Gay, I'm currently the vice president and cofounder of Integrity Advantage and the president of the Maryland chapter of certified fraud examiners. For over 15 years I've partnered with more than 60 payers across Medicare, Medicaid, FEHBP, commercial plans, CHIP programs, conducting fraud, waste, and abuse detection analysis and investigations.

The healthcare industry is about \$5.3 trillion spent in 2024 and we estimate as high as \$500 billion of that is FWA. We process nearly this 30 million claims a day across well over 1,000 payers with varying rules, coverage determinations and data elements. Oversight of this magnitude is bound to need attention.

FWA is not a victimless crime, unnecessary services expose patients to real medical risk while fraudulent billing drains resources intended for those who legitimately need it. Patient harm occurs through unnecessary or unsafe for the sake of reimbursement, overall patients suffer in reduced access. And we are the patients, the taxpayers are also the patients, you know, in this scenario. Taxpayers we are paying for it twice. We are paying for the FWA that is on top of the already big

spend, as well as the rising costs for our individual healthcare. And the honest providers, whose reputation suffers fraud undermines the trust of our healthcare system.

Common schemes in this area, some of which were already addressed, include advanced or applied -- excuse me -- behavioral analysis services. These are a huge issue across Medicaid fraud and we see missing records, completely unqualified staff, billing that is inconsistent with authorizations, treatment plans that are not tailored to these members' needs and excessive services. Nonemergency medical transportation continues to be an issue as well. We have trips to nowhere, inflated mileage and upcoding to hire services.

Home and community-based services also continue to be a big issue. We see falsified State authorizations, round the clock services for low acuity diagnoses, including hypertension and billing for one on one when delivering care to many patients in one home.

Laboratory services and genetic testing continue to be a problem. We mentioned skin substitutes, which is really a highly targeted area due to excessive units. I've seen payments for secondary payers, up to \$30,000 for one member and that's after Medicare already paid their portion.

DME continues to be an issue. These are not isolated issued to one State or one payer. They are discussed consistently across national platforms and antifraud forums. Of course we have a lot of challenges in anything this big and we could do better.

Some of the things that I would recommend is a look at policy. I would invite fraud professionals to the table as we design policy and we think about benefit coverage. We have a different perspective, we tend to think about the holes as a fraud professional, but generally we see inadequate State, Federal and plan level policies that result in inconsistent and unenforceable coverage rules.

We need to strengthen our frameworks with clear coverage guidelines and Federal defaults in the event that States or plans lack sufficient definition. We need resources and I'm not just talking

people, whether that is people, process, technology things are changing and the fraudsters are winning. We need to keep up with that and we need some collaboration there.

And therefore efficiency between the State, the Federal, the commercial players, whether that's through data and joint investigations. For those that know me, I'm just bringing up data as the last point but data is a big issue in healthcare fraud.

We have complicated data and core data criteria in general. It is very inconsistent and hard to understand. With limited visibility and to provider credentialing, sanctions and improved tracking of rendering personnel.

Healthcare after FWA harms patients, it undermines legitimate providers, it drains taxpayer resources and increasingly funds sophisticated criminal networks. With strong policy, better technology and enhanced collaboration we can significantly reduce the waste and protect the integrity of our healthcare system.

I give you my time back.

[The prepared statement of Ms. Gay follows:]

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Mr. Joyce. Thank you. Ms. Wooton, you now recognized for 5 minutes for your opening statement.

TESTIMONY OF KAYE LYNN WOOTTON

Ms. Wooton. Mr. Chairman, Chairman Guthrie, Ranking Member Clarke, Ranking Member Pallone and members of the committee, thank you for this opportunity to testify. My name is Kaye Lynn Wooton and I am testifying as president of the National Association of Medicaid Fraud Control

Units, known as NAMFCU. I also serve as director of the Medicaid Fraud Control Unit in Utah or MFCU and with me today are NAMFCU vice president F. Edward Kirby who also serves as the MFCU director in North Carolina and Barbara Zelner, executive director of NAMFCU.

Chairman Joyce, you recently said ensuring Medicaid program integrity is critical to preserving access to vital healthcare 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, we agree.

Medicaid fraud control units are State based law enforcement agencies established in the late 1970s to address these exact concerns. Our two-fold mission is to investigate and prosecute fraud committed by providers against the Medicaid program and resident or patient abuse, neglect and misappropriation of patient funds. To address these problems, MFCUs utilize both criminal and civil enforcement actions.

MFCU actions are often filed in State courts, but MFCU attorneys may be cross designated as special assistant U.S. attorneys or SAUSAs and prosecuting Federal court. As a SAUSA I value the opportunity to partner closely with the U.S. attorneys office and Federal agencies such as HHS OIG, FBI, DEA and others who investigate healthcare fraud.

State program integrities are also critical for identifying and referring provider fraud cases and numerous State partners refer cases of abuse and neglect. At times MFCU cases overlap with cases of abuse and neglect. For example, a MFCU receives a referral for allegations of resident neglect and an investigation shows that the resident was indeed neglected. It would not be complicated in that scenario to charge and aide or a nurse for the direct care or lack of care for that resident.

But MFCUs have to dig deeper nowadays and hold higher level staff accountable for funds being shoveled off to profits rather than resident care, understaffing is so prevalent that employees cannot provide adequate care and other schemes. Only through these complex cases are we able to hold the real perpetrators accountable and improve nursing home conditions.

I have been a registered nurse since 1984. It was not until late in life that I became an attorney and started working for a MFCU. At first, I believed that providers must have gotten into healthcare for the right reasons and then gone astray and committed fraud. While that is likely true for some defendants, what we are now seeing is far more sinister.

Companies are being created for the purpose of committing fraud. For example, last year the MFCU directors in the western NAMFCU region met to share fraud schemes and collaborate on ways to combat fraud. These conversations we learned of a substance use disorder fraud that started in Nevada where multiple people were convicted, then it moved to Arizona.

In Arizona those providers could not treat patients because they had been excluded by HHS OIG. So instead they taught others how to commit fraud. Arizona has charged and convicted many people there, but as we met we realized it is unusual when we have open criminal investigations to share the name of fraudsters or potential defendants, but we became aware this environment is now different.

We became aware that this environment is now different, we became aware that it was the only way to get on top of these schemes is to be able to collaborate more openly. As a result, we have collaborated and now have open cases in numerous States. In Utah, we have six open case with the same parties that were involved in Arizona and Nevada.

NAMFCU creates this bipartisan forum for all MFCUs to collaborate and trains MFCU's staff how to identify and prosecute fraud. NAMFCU has also coordinated a large number of multistate Federal investigations since '92. These global cases have resulted in over \$12 billion to the Medicaid program, the return on investment is invaluable.

In March of '25 HHS OIG published the Medicaid fraud control unit annual report and reported a total of 1,151 convictions, 1,042 individuals excluded from Federal programs, 493 civil judgments, totaling 1.4 billion. Again, chairman Joyce and committee members, thank you for this opportunity to testify and we at NAMFCU are proud to be part of the efforts aimed at solving these

problems.

[The prepared statement of Ms. Wooton follows:]

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Mr. Joyce. Thank you. Mr. Nuckolls, you are now recognized for 5 minutes for your opening statement.

TESTIMONY OF STEPHEN W. NUCKOLLS

Mr. Nuckolls. Chairman Guthrie, chairman Joyce, Ranking Member Pallone, Ranking Member Clarke and members of the subcommittee, thank you for the opportunity to testify today. My name is Steve Nuckolls and I serve as the chief executive officer of Coastal Carolina Healthcare, an independent physician-led practice in eastern North Carolina. I'm also a board member of the Nation Association of ACOs.

I view fraud, waste, and abuse with two lenses, as a rural medical practice where fraudulent billing disrupts patient care and as an ACO, accountable for both, cost and quality.

Fraud is not an abstract budget problem in Operation Gold Rush authorities stopped a transnational scheme that used stolen identities and purchased DME companies to build \$10.6 billion in fraudulent claims.

Medicare largely did not pay, but coordination of beneficiary protections fell short. Here are the consequences. First, direct patient harm, when fraudulent claims appear in a beneficiary's record, legitimate medically necessary items can be delayed or denied because coverage appears to be exhausted. For example, one of our patients needed therapeutic shoes, but Medicare records show that shoes had already been provided by an out-of-state supplier which our patient never received.

The supplier was no longer operational and the patient ultimately had to pay out-of-pocket for the shoes. That is the harm, legitimate care denied because fraudulent billing contaminated the record.

Second, increased cost to the healthcare system, when CMS follows Department of Justice

guidelines and pays suspected fraudulent claims into escrow while an investigation proceeds, supplemental insurers are required to pay those claims.

The Operation Gold Rush indictment indicated that Medicare supplemental insurers paid roughly \$900 million to DME companies involved. Those calls are passed along to beneficiaries to hire supplemental premiums.

Third, hindering the growth and adoption of value based care and ACOs, ACOs are charged with improving quality while managing total cost of care, yet in traditional Medicare ACOs and treating clinicians do not have the same practical tools that Medicaid Advantage plans used to prevent fraud, such as prior authorization, prepayment review and supplier controls. Instead ACOs operate a pay and chase environment. We can identify and report suspected patterns, counsel patients, but we often see the same billing continues for months with no visibility into enforcement.

This uncertainty is especially serious for ACOs and two-sided risk where we repay CMS its spending exceeds the benchmark provided. My practice is in the 100 percent risk ACO reach track. In 2025, we identified 6.3 million in suspected fraudulent DME claims from six companies. In our Arizona market these claims were more than \$1,000 for beneficiaries per year. That's triple, triple the national average for DME from just a few years ago. Yet, we don't know if these claims were paid, held in escrow or whether we will be held financially responsible for them.

That uncertainty undermines confidence in the model and discourages participation of value based care. And if organizations like ours are forced to exit we would have to end successful programs that have rooted out fraud, reduced wasteful spending, and likely our community average over time would revert back and would roughly increase 25 percent in our market.

Even after Operation Gold Rush, fraud continues to harm Medicare beneficiaries, ACOs and taxpayers. My written statement highlights several ways where my colleagues at other ACOs have seen ongoing fraud over the past year, including concerning spikes in durable medical equipment, billing and misuse of skin substitutes.

To improve coordination and beneficiary protection after detection we recommend the following, first close the recording feedback loop, acknowledge reports, provide case status and notify impacted ACOs and secondary payers when high confidence fraud is detected. Second, create rapid notification and beneficiary friendly or record correction process.

Third, strengthen DME supplier integrity, one simple way to do this would be to require surety bonds as a way to accomplish this. Lastly hold ACOs harmless for fraud outside their controls by excluding fraud, waste, and abuse from expenditures.

ACOs are willing to reduce wasteful spending and deliver better care, but we need timely information and aligned accountability so that fraud is stopped before it harms patients and those trying to do the right.

Thank you.

[The prepared statement of Mr. Nuckolls follows:]

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Mr. Joyce. Thank you Mr. Nuckolls.

Ms. Tillipman, you're recognized for 5 minutes for your opening statement.

TESTIMONY OF JESSICA TILLIPMAN

Ms. Tillipman. Thank you. Chairman Joyce, Ranking Member Clarke, Chairman Guthrie, Ranking Member Pallone and the members of the subcommittee, thank you for the opportunity to testify today. My name is Jessica Tillipman and in addition to leading the government procurement law program at GW Law School I also teach a course on anticorruption and compliance. I begin every semester with a simple reminder no system is immune to misconduct. And when programs are large, complex and responsible for trillions in public spending the risk of abuse increases. That understanding shapes the oversight architecture of Medicare and Medicaid.

These programs assume misconduct will occur and are designed with multiple layers to address this persistent challenge. Inspectors General, the Government Accountability Office, the DOJ, whistleblower incentives and State fraud control units overlap by design.

That structure avoids a single point of failure and creates multiple detection and enforcement channels to give the government the best chance at preventing, detecting and mitigating fraud. But redundancy only helps to deter fraud when three other conditions are present, the oversight bodies coordinate, they have stable capacity and they are credibly independent. When any one of those breaks, the system becomes slower, more fragmented and easier to exploit.

The evidence shows the system can deliver results when it is appropriately resourced and coordinated. Last year the False Claims Act recovered \$6.8 billion, more than \$5.7 of which was from healthcare and the 2025 national healthcare fraud takedown 324 defendants were charged in schemes involving alleged intended lawsuits, exceeding \$14 billion. Those results reflect important enforcement work, but they also illustrate a reoccurring pattern, we tend to focus public attention on

episodic high profile surges. Those surges can be valuable. But they do not substitute for the routine controls that prevent everyday losses.

In my experience, many of the most important solutions are frankly not that glamorous. Robust data infrastructure, risk based screening and verification practices and the implementation of open GAO and IG recommendations. That is also what sustains public confidence because people trust systems that apply rules competence, because people trust systems that apply rules consistently and do the basics well. With that frame I want to highlight three areas where the system remains particularly vulnerable.

First there are well known verification gaps and enrollment in prepayment screening. Program must balance access and the program integrity. The solution must be risk based. Stronger front end controls where feasible and targeted post payment tools when they are not.

Technology is also part of that verification story, advanced analytics in AI can strengthen detection verification but only with strong data infrastructure, transparent governance and meaningful safeguards. But the same tools that help in the fight against fraud can also be used against it.

In the 2025 national healthcare fraud takedown, DOJ charged defendants who allegedly used AI generated audio to fabricate beneficiary consent underscoring how quickly bad actors adapt.

Second, some services are harder to validate because they lack the built in controls of facility-based care, telehealth has no physical presence. Home health occurs in private homes. Durable medical equipment is shipped directly to patients. In these settings a single encounter may generate multiple claims and verification is increasingly more difficult.

Third, managed care distributes program integrity responsibility across States and plans, more than 70 percent of Medicaid beneficiaries receive care through managed care arrangements. When responsibility is diffuse, accountability depends on clear referral pipelines and feedback loops. Audits have flag gaps and referrals, coordination and follow through and those gaps are not confined

to any one State.

These vulnerabilities highlight a deeper oversight challenge, fraud, waste and error are often treated as interchangeable but they are not. Fraud is a legal conclusion requiring proof of intent. Recklessness can trigger False Claims Act liability, improper payments may result from documentation gaps or administrative errors. Each of these issues is important but each requires a distinct remedy. When every error is labeled fraud we miss diagnosing the problem and applying the wrong solution.

I'll close with this, Medicare and Medicaid already have robust oversight structures, the question is whether the structures are functioning as designed. Deterrents requires redundancy, coordination, stable capacity and credible independence.

Thank you. I look forward to your questions.

[The prepared statement of Ms. Tillipman follows:]

***** COMMITTEE INSERT *****

Mr. Joyce. I thank you all for your testimony. We will now move to questioning. I will begin and recognize myself for 5 minutes.

Mr. Nuckolls, beyond durable medical equipment, ill-intentioned providers that were increasing turning a profit by ordering expensive wound care supplies also known as skin substitutes. Why are skin substitutes vulnerable to fraud and abuse?

Mr. Nuckolls. That's a great question. I think the main reason that we're seeing so much fraud in there is the large profit margins that providers have made when they utilized these products. Under the FDA clearance the prices are not set by Medicare and they have increased substantially.

We in the ACO community have brought this issue up to CMS and to others for multiple times. We've asked for local coverage determinations to come in on this. The good news is that Secretary Oz has a decisive program that he implemented first starting January 1. And from the industry observers that I've talked to and other providers, I believe this problem is solved.

Mr. Joyce. So you reference that what happened January 1st was moving to go skin substitutes to have a flat rate with the goal of reducing the fraud, that it had driven the high cost. Again, can I ask you for the record to reiterate do you believe that this reform will reduce fraudulent or excessive billing for these services for skin substitutes?

Mr. Nuckolls. It will absolutely reduce it. And I believe it will eliminate it.

Mr. Joyce. Ms. Gay, are there fraud, waste, and abuse risks in State Medicaid programs and providers are allowed to self attest to becoming a rule.

Ms. Gay. I do believe, I will say most of my appearance is not working directly with the States but with managed care organizations and Medicare Advantage plans. But I do think that there needs to be additional oversight in our self-reporting across the board for eligibility both for provider participation as well as member eligibility.

Mr. Joyce. Do you think that there is increased risk of fraud in State Medicaid programs that provides services that are billed hourly such as personal care services or adult daycare?

Ms. Gay. Absolutely.

Mr. Joyce. New York's consumer directed personal assistance program is under scrutiny due in large part to the increases in spending and the lack of provider oversight. In CDPAP, individuals hire their own caregivers, including immediate family members that are paid through a fiscal intermediary to provide assistance with daily living activities.

In one case, a man signed up to be a personal caregiver for 10 relatives. To get away with this scheme this man's brother posed as their mother, a recipient of Medicaid home care services herself and other welfare benefits. However, there's a little detail that was missed. She lives in Bangladesh and she lived in Bangladesh for the entire time. This man was eventually caught and convicted for his crimes.

Ms. Gay, are you aware of our State Medicaid programs with similar program design to CDPAP for personal or healthcare services?

Ms. Gay. Yes.

Mr. Joyce. What are the issues that you have identified with how this program and the category with that structuring has opened the door to so much overt fraud.

Ms. Gay. I think one of the things that we see that might be helpful. So oftentimes these personal care services are being rendered by somebody that doesn't have an NPI. An NPI is your national provider ID you are supposed to use to bill. If I am setting up care for my mother, I don't have one of those IDs and that billing goes under a 10 for an organization that I might be working with. So there's a discrepancy or a challenge I guess in how we look at that claims file data and there is also disparate data sources.

So if I am working through one MCO for one member and another MCO for another member they can't see that I'm rendering services to multiple members nor can they potentially see that it is me individually rendering the services at all.

So there really is some data issues. I think our system was initially more designed for

providers and practitioners that were will billing services. And now that we are extending those services with good intention, we are creating other limitations in our ability to fight back.

Mr. Joyce. Ms. Wooton, the HHS Office of the Inspector General has recently begun a target review of fraud, waste, and abuse in Medicaid non-emergency medical transportations programs. In some cases we have seen these nonemergent medical transportation providers bill for impossible amounts for their daily service, such as scores of unique trips that cover thousands of miles in a single day, which we know is unachievable. What aspects of these programs open the door for fraud?

Ms. Wooton. Thank you. Because individuals are performing services where you're not in a hospital where there's administrators overseeing the program and knowing if the services occurred. Yet you will operate on a basis of trust. And we do see a great deal in the area of non-medical -- or medical nonemergency transport. We see them billing for group rates.

Our individual rates when groups are being transported, we see them billing for toll fees and other charges that were never incurred. We see ghost trips patients were never involved. And I think it is because they are a one-on-one type service or one on a small group that it is difficult to oversee.

Mr. Joyce. Thank you. My time has expired.

I now recognize the ranking member, Ms. Clarke, for her 5 minutes of questioning.

Ms. Clarke. Thank you very much, Mr. Chairman.

I want to thank all of our witnesses today. Your testimony really centers us where we need to be were we in a climate that we could actually get something done around this.

However, Federal immigration agents are terrorizing communities and children across this country. There are reports of school buses being pulled over while transporting students and being followed stop after stop to and from school. Families are avoiding public spaces, keeping their children home from school and missing doctor appointments. This experience of living in terror as

kids can follow children through adulthood.

Hardworking Americans and immigrants are afraid to go to their jobs, restaurants, grocery stores, businesses, particularly now in Minneapolis are struggling to make ends meet due to the pervasive fear that has gripped their community.

All of this is due to the actions of an administration trying to justify its brutality, particularly against immigrants and minorities as a response to fraud.

First, on December 31, 2025, a post on Truth Social, President Trump said, much of the Minnesota fraud, up to 90 percent is caused by people who came into our country illegally. Low lives like these can only be a liability to our country's greatness. Send them back where they came from.

Second, on December 19, 2025, deputy chief of staff Stephen Miller appeared on FOX News and said, we should not be shocked, when you import a population whose primary occupation is pirate then they are going to come here and steal everything we have.

Third, on January 6th, 2024, post on X by the Department of Homeland Security stated the largest DHS operation is happening right now in Minnesota. POTUS Trump and Secretary Noem have rallied DHS law enforcement personnel to keep Americans safe and eradicate fraud. We are not leaving until this problem is solved.

I ask for unanimous consent for these three documents the December 31, 2025, Truth Social post, the transcript segment of the December 19, 2025, FOX News interview and the Stephen Miller January 6th, 2026, DHS post on X to be entered into the record.

Mr. Chairman?

Mr. Joyce. Yes, ma'am, you --

[The information follows:]

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Ms. Clarke. Thank you. Ms. Tillipman, one of the things that both you and Ms. Wooton raised in your testimony is the importance of whistleblowers in rooting out fraud. I'm deeply concerned that whistleblowers will not come forward if they think that the Federal Government is going to use their allegations as part of an agenda that terrorizes immigrant communities.

Why is it important for potential whistleblowers to have confidence that the Federal Government will use their allegations and evidence to root out fraud rather than cynically use it to advance a partisan agenda?

Ms. Tillipman. Thank you for your question. Whistleblower regimes.

Ms. DeGette. You need to turn on your mic.

Ms. Clarke. Your mic.

Ms. Tillipman. I think I actually turned it off.

Whistleblower regimes depend on confidence and comfort that when credible allegations are reported that they will be kept confidential, that the individual will be secure and that they believe that a response will be taken in relation to their reporting. So those are important across the board whether it's a government employee or it's a private citizen.

Ms. Clarke. Thank you. Ms. Wooton, similarly it is important for whistleblowers to have confidence in the intentions of the Federal law enforcement. What happens when that confidence is lost?

Ms. Wooton. As with any whistleblower they need to be comfortable, coming forward, telling the truth, helping with the issue, not be focused on side issues. And those whistleblowers are vital because they often have insight information whether they are transnational or not, they bring in information.

They may have seen firsthand with the provider, they may have experienced the fraud and we need all whistleblowers to feel safe to come in and report those frauds so we can work with them to investigate.

Ms. Clarke. Again, I appreciate all of your expertise and I thank you for testifying today.

I have one last document to enter into the record, this is the statement from the family of Alex Pretti, issued after Alex was murdered in cold blood in the streets of Minneapolis. It says, Alex was a kind-hearted- soul who cared deeply for his friends and family. Also the American veterans for whom he cared as an ICU nurse at the Minneapolis VA Hospital. Alex wanted to make a difference in this world, unfortunately he will not be with us to see his impact.

I ask for unanimous consent for this statement to be entered that the record.

Mr. Joyce. So ordered.

[The information follows:]

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Ms. Clarke. I yield back.

Mr. Joyce. The gentlelady yields.

The chair now recognizes the gentleman from Idaho, Mr. Fulcher for his 5 minutes of questioning.

Mr. Fulcher. Thank you, Mr. Chairman and to the panel, thank you for your input today. I would like to say I enjoyed it, but not necessarily joy is the right word but we need to hear it and it is important information so thank you.

Question for Mrs. Gay first. I'm from the State of Idaho, sometimes may not be the first that you think about when there might be fraud but that is kind of the basis of my question. Have you noticed any trends where States might get targeted or regions might get targeted as a function of potentially having a lower barrier for entry or maybe perceived as not being as likely to be audited.

Ms. Gay. Absolutely. Probably we talk a lot in the industry how it can be regionally generated. It tends to start in one particular area, and then I don't know if they are all hanging out talking to each other or how that spreads, but it does tend to start in certain populations and then branch out from there, based on controls but certainly flying under the radar could be something.

Mr. Fulcher. You see that happening.

Ms. Gay. Oh, absolutely.

Mr. Fulcher. Not surprising. I'm going to Ms. Wooton here next, but either Ms. Wooton or Ms. Gay if you have a comment, what if a bad actor is foreign, a foreign actor? How much of that that, do you see that? And if so, what kind of a challenge does that bring to potentially pursuing that fraud if it's perpetrated by a foreign actor?

Ms. Wooton. Certainly States have seen both fraud cases perpetrated by foreign and by U.S. citizens or people in the United States. And from our perspective as being a Medicaid fraud control unit, it makes no difference. We look at allegations, try to identify, is there something we can do about them? Is the dollar amount something we can pursue? Are we going to be able to get

value back for the Medicaid program, do we have the laws in place to prosecute whatever type of fraud is referred and we move forward with that investigation.

Mr. Fulcher. Specifically the laws is kind of what I was trying to get some clarification on, it's more gray, pursuing a foreign actor or is it? Are the laws in place necessary the tools that you need?

Ms. Wooton. The tools are in place if the bad actor is in your own State, right? We can use our State laws and go after that person. Victims are also at risk when people commit fraud and we work regardless of what their background is or what the risks are. I think our State laws that we can follow and hold people accountable.

Mr. Fulcher. Okay. Thank you for that.

Ms. Gay, back to you, if I may. What are some common fraud schemes that you run across?

Ms. Gay. Yeah, I mean, I think some of the biggest ones as I have already mentioned, but the applied behavioral analysis is a huge scheme that we continue to see across particularly Medicaid, nonemergency transportation and then we see labs.

We see a lot of the home and community based services and these are broad ranged and they vary based on the State what their regulation is, what services are covered. That takes up a lot of our case time right now as an organization, working with these home and community bases, because these are not practitioners, these aren't physicians that are rendering services so we see nonlicensed individuals. It is very hard for us to actually know what's actually happening.

And for myself and my organization, we see per -- data per health plan and not necessarily aggregated data across --

Mr. Fulcher. Okay so maybe that is part of my next question. What is the trigger, what are some of the indicator, red flags?

Ms. Gay. Yeah, I mean, some of the indicators are impossible days, when we are looking at that feels impossible and I am just looking at one health plan in an area. I'm not considering all the

other services that that provider may be rendering, so impossible days is a big one, outlier analysis is a huge tool of ours.

Mr. Fulcher. Okay I am going to Ms. Wooton, but again either one of you if you have input on this, but how are these schemes evolving, changing, more sophisticated, less sophisticated, more blatant? How are these schemes changing over time and how we are tracking them?

Ms. Wooton. Throughout the time I have been with Medicaid fraud what we see changing most is, as I mentioned, they are not for the large part providers who are just doing a fraudulent act now and then. These are people who are committed to committing fraud. They are working on it. We see that fraud schemes across State lines for more than they used to, that's why we need to collaborate to find out what's going on.

And each time we hear of a fraud each State goes back sees what they can find and then we collaborate. I think that it's difficult as we've put in some provisions into healthcare that are beneficial like electronic medical records and different devices that make it easier for a provider. It is also more difficult on our end to be able to see a legitimate document because electronic medical records can print off an amazing medical record that looks like a full service was done. Whereas if in the past if you had to write out that note, you might have seen what was really performed.

Mr. Fulcher. Thank you for your feedback.

Mr. Chairman, I yield back.

Mr. Joyce. The gentleman yields.

The chair now recognizes the gentlewoman from Colorado. Mr. DeGette for her 5 minutes of questioning.

Ms. DeGette. Thank you so much, Mr. Chairman. And I want to thank everybody for coming today, all of us are concerned about fraud in Medicare and Medicaid.

I -- when we do these markups of these bills and we have these debates so frequently people talk about fraud in these programs as if it is the beneficiaries who are committing the fraud. So Ms.

Wooton, I would like to ask you, what is the percentage of fraud in Medicaid that's carried out by providers versus the fraud that's carried out by patients themselves.

Ms. Wooton. Thank you. I appreciate that question. Medicaid fraud control units and thus NAMFCU, we only have the authority to pursue provider fraud, unless the fraud is perpetrated in collaboration weather recipient.

Ms. DeGette. Right. How much of the fraud would you say is committed by the providers versus the patients?

Ms. Wooton. I couldn't speak to the amount for the individuals exactly, but I would say far more is committed by providers and the large dollars amounts are going to the large types of providers.

Ms. DeGette. The large types of providers, yeah.

And you know States like all of our States are constantly on the lookout for fraud. And Ms. Gay, I would agree with you, in Colorado what we are finding lately, a lot of that fraud is from transportation. Just last week there was a huge coding discovery in Colorado that showed that some people were getting \$650 for a transportation under Medicaid versus what should have been \$65.

Last spring Colorado's official actions uncovered a ring that improperly charged Coloradoans millions of dollars for nonemergency transportation resulting in blocking \$25 million in fraudulent payments. And I'd like to put in the record a Denver Post article from June 21st, 2026.

Mr. Joyce. So ordered.

[The information follows:]

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Ms. DeGette. Thanks. So Ms. Tillipman, you said that adequate fraud investigation requires coordination on all levels of government. Is that correct?

Ms. Tillipman. Yes, that's correct.

Ms. DeGette. And one of those levels is the Federal Government. Is that also correct?

Ms. Tillipman. Yes, that is correct.

Ms. DeGette. Now, at the Federal level the Department of Health and Human Services Inspector General was one of at least 17 IGs terminated in the first days of this administration. So Ms. Tillipman, I would also suspect that you and probably the rest of the panel would agree that when you're going to hire inspectors general they need to be qualified for the job and they themselves need to be not committing fraud. Is that right?

Ms. Tillipman. Yes, of course.

Ms. DeGette. Of course. Now, the Inspector General who used to be there was a respected professional who honorably served in HHS for over 2 decades. He was replaced by Thomas March Bell who was once forced out of a Virginia State government job for misspending taxpayer dollars. And I would ask unanimous consent to put into the record this Washington Post article dated June 17, 1997 about Mr. Bell.

Mr. Joyce. So ordered.

[The information follows:]

***** COMMITTEE INSERT *****

Ms. DeGette. Thank you.

Now, Ms. Tillipman, about how many fewer employees are at the HHS Office of the Inspector General now than there were at the beginning of this administration.

Ms. Tillipman. Well, I don't have the exact number. I believe in the OIG's office it is in the dozens.

Ms. DeGette. It's about 200 and I would ask unanimous consent -- I would ask unanimous consent to put a New York Times article, dated January 9, 2026 into the record.

Mr. Joyce. So ordered.

[The information follows:]

***** COMMITTEE INSERT *****

Ms. DeGette. That's a loss of more than 10 percent of the employees in the office responsible for keeping watch for waste, fraud, and abuse in HHS. So Ms. Wooton, I want to ask you, are States and Medicaid fraud control units better to detect and respond to fraud when the HHS IG office is fully staffed and well resourced.

RPTR MCGHEE

EDTR HUMKE

[11:29 a.m.]

Ms. Wootton. Certainly in all areas of fraud, to research it, we need a team of individuals who can work together to do that, and when there's a shortfall on one side or the other, we collaborate and make sure that we find the resources we can use to combat fraud.

Ms. DeGette. Thank you. Last month, Department of Justice prosecutors who were leading the fraud investigations in Minnesota that the chairman talked about resigned in protest after they were directed to investigate the widow of Renee Good who was murdered by ICE agents in Minnesota, and just yesterday an additional eight prosecutors in the Minnesota U.S. Attorney's Office left in protest leaving the office with fewer than 20 staffers.

And so, Mr. Chairman, if everybody's going -- who's supposed to be doing this enforcement is going to leave, I don't think that it's going to help very much to try to investigate waste, fraud, and abuse, and I yield back.

Mr. Joyce. Gentlelady leads. The chair now recognizes the gentlelady from Tennessee, Dr. Harshbarger, for her five minutes of questioning.

Mrs. Harshbarger. Thank you, Mr. Chairman, and thank you to the witnesses for being here today.

I'll start with Ms. Wootton. Are civil and criminal penalties sufficient to deter repeat offenders who commit Medicaid fraud?

Ms. Wootton. They are if we can find the scope of fraud that we're looking for. Unfortunately, you're sometimes finding the tip of the iceberg, but then we can prevent that fraud from continuing, and that helps. There are also penalties.

I think the HHS OIG exclusion that doesn't allow them to bill Medicare and Medicaid sometimes is more -- impacts a provider more than a civil or a criminal fine, but we try to use all of

the tools as we combat fraud.

Mrs. Harshbarger. As long as they check that advice. Is there evidence that repeat offenders can enroll as providers of Medicaid programs in other states after enforcement actions, and if so, why?

Ms. Wootton. If the enforcement action has excluded them on the HHS OIG exclusion, you would at least have remedies if they attempted to practice, because they are not allowed to bill government programs. It's more difficult if there are prefiling resolutions and those are not public or criminally -- in a criminal database.

Mrs. Harshbarger. Absolutely. Do Medicaid fraud control units communicate and share information with one another to identify repeat offenders and recurring schemes?

Ms. Wootton. Absolutely. We meet regularly. We meet with multiple MFCUs. We also meet with federal partners. Three weeks ago, I was with CMS, DEA, FBI, OIG all trying to get on top of this, and we even conduct training specific to certain types of fraud and teach nurses, auditors, investigators, and attorneys how to combat fraud.

Mrs. Harshbarger. There has to be red flags and people know if you've been in the healthcare industry. I guess this is Ms. Gay or Ms. Wootton, is physician participation or authorization required to perpetrate Medicaid or Medicare fraud schemes? Ms. Gay?

Ms. Gay. If the proper controls are put into place, then yes, but oftentimes, those controls are skirted in some way or another.

Mrs. Harshbarger. They totally are.

Ms. Wootton. I would say another role of the MFCUS besides investigating and prosecuting, we make program recommendations to the state Medicaid agency, and often those are to say we believe this code or this practice may open doors to allow fraud and we make program recommendations on how that can be improved, so we're trying to solve the future, not just convict the past.

Mrs. Harshbarger. Totally. Are all providers that commit fraud doing so willingly, or are there physicians that unknowingly participate in these schemes? Because not every physician or provider who's in charge of something knows what's being built.

Ms. Wootton. I think that's the difficult part of a MFCU investigation. You're trying to figure out who is culpable and who maybe didn't understand, right?

Mrs. Harshbarger. Yeah.

Ms. Wootton. It's shocking sometimes when a physician will say that they didn't understand the billing but they seem to understand the service and getting through med school and everything else, but there are certainly innocent victims who get caught up in these schemes, I would say particularly in nursing homes. Many of those staff members and providers want to do a great job and they're unaware that the money is being siphoned off to investors or to other uses.

Mrs. Harshbarger. Yeah. Given that physicians are meant to examine and know the patient before authorizing orders, how many providers, or do you have a percent of these providers who unwillingly know about these -- really that authorized the fraudulent orders for say DME or testing?

Ms. Wootton. That's a great question, and it's difficult sometimes, because if a name appears on an order, it appears they've ordered it, and it takes boots on the ground to go out and interview them and say here's -- is this your signature, what have you done here, right? And all of the programs where there's not oversight in-house, I owned a home health agency for many years.

Mrs. Harshbarger. Yeah.

Ms. Wootton. And there's a lot of trust goes into sending your staff into a home, getting a doctor's order from someone who's not in the home at the same time. So there are avenues that they can beat, and we try to study what's required in different types of healthcare so that we can figure out where could you commit fraud.

Mrs. Harshbarger. You could use AI models to kind of -- I mean, there's a million ways to do

it, but thank you.

Ms. Gay, what aspects of current telehealth regulations can be exploited by criminals to perpetrate Medicare or Medicaid fraud? Because we'll be controlling the -- you know, changing the rules on telehealth pretty soon and extending those things, so where do we need to look at for the loopholes?

Ms. Gay. Yeah. I think we reduced barriers to care during COVID, and I'm not sure that all of those went back up, and some of that is to the convenience of many of us. We've probably experienced telehealth and been pleased that we didn't have to go out for those services, but when we reduce those barriers, oftentimes we do open it back up to fraud.

Mrs. Harshbarger. Across state lines, you know, I think that was a big deal when we did that --

Ms. Gay. Absolutely.

Mrs. Harshbarger. -- for COVID and I can see how.

Ms. Gay. Absolutely. And if I may about rendering providers, you know, one of the things that when I was talking to my team about, like, the so many solutions that we'd like to bring up, we have often talked to rendering providers, and they have no idea that they are complicit in a particular scheme, and sometimes these are retired providers.

There is not any type of feedback looped to somebody with a current MPI saying that you've been billing under these TIMs, so when we look DME or labs or those such things, they really don't have any indication until they get a letter either from an organization like mine or Ms. Wootton to say what do you mean and how do you mean, and so that is absolutely like an area that's frustrating.

Mrs. Harshbarger. Totally. Well, my time is up, so I'll yield back, Mr. Chairman. Thank you guys.

Mr. Joyce. The gentlelady yields.

Votes have been called. We will recess the hearing and reconvene ten minutes after the last

vote. The subcommittee now stands in recess.

[Reces.]

RPTR MCGHEE

EDTR HUMKE

[12:12 p.m.]

Mr. Joyce. The committee will now come to order. The chair now recognizes the chairman of the entire committee -- oh, I'm sorry, Mr. Tonko for his five -- Mr. Tonko from New York, as soon as we let him get seated, from New York for his five minutes of questioning.

Mr. Tonko. Thank you, Mr. Chair, and sorry to be a little delayed here. Let me be clear. We all support rooting out fraud, but that's not what has been happening under this Trump administration. Instead, today Republicans are attempting to use fraud claims to legitimize the Trump administration's lawlessness in American cities.

While the resulting harm might be unprecedented, this strategy is not new. This whole Congress, Republicans have leaved massively over broad allegations of fraud to justify their deeply unpopular policies.

Republicans have stretched the word fraud beyond recognition. One way they have done so is by conflating things that routine administrative errors or improper payments with illegal and deceptive behavior. Professor Tillipman, can you walk us through the difference between improper payments and fraud, please.

Ms. Tillipman. Yes. Thank you for the question. Improper payments -- all fraudulent payments are improper, but not all improper payments are fraudulent.

In fact, when we see the data points, if you have over \$90 billion of improper payments, about 77 percent of that is administrative error and not actual intentional fraud.

Mr. Tonko. All right. Thank you for that. And in your testimony, you shared that treating improper payments as fraud, quote, distorts reality. Why is it important for Congress to treat improper payments as distinct from illegal fraud and what are the consequences of not treating the two separately?

Ms. Tillipman. One of the biggest consequences is that labels drive remedies, so if you label everything as fraud and you don't make the distinction, you'll be directing scarce resources towards the wrong conduct.

Mr. Tonko. And one consequence of distorting claims of fraud in Medicare and Medicaid is that it undermines the public's belief in the integrity of federal programs. How can using the term fraud as a catch-all mislead the public and why is that so damaging for public confidence in government programs?

Ms. Tillipman. So, again, ultimately you want to make sure you are crystal clear with the labels that you're using, because if the taxpayers are led to believe that 100 percent of their taxpayer dollars are going towards fraud, it causes them to lose confidence and faith in the government operations.

Mr. Tonko. And, professor, you also shared that oversight of federal programs must remain credible and durable across administrations and that failures can diminish public confidence in oversight findings. How can instability at agencies responsible for monitoring fraud undermine the public's confidence in the integrity of government programs and why is that indeed harmful?

Ms. Tillipman. Ultimately, we want to see stability in how federal programs are being operated, because it makes them credible, it makes them more capable, and it also ensures that they have the capacity to adequately address these issues.

If taxpayers believe that some of these things have been disrupted, that, again, would cause the belief that for them to lose confidence in their government operations and the spending of taxpayer dollars.

Mr. Tonko. Thank you for that. You know, I thank all of our witnesses. You know, we need to ensure that the public does not lose confidence in the ability of federal programs to help them and their families.

Obviously, these programs are rooted in a sense of mission that they are there to serve

people truly in need, and if we're to destroy that by lack of confidence or other dynamics, we, in fact, have lost the battle to do well to the program. That means preserving the mechanisms that ensure good governance and making certain that fraud allegations are indeed leveled accurately and responsibly.

With that, Mr. Chair, I yield back.

Mr. Joyce. The gentleman yields. The chair now recognizes the chairman of the entire committee, Mr. Guthrie, for his five minutes of questioning.

The Chair. Thank you. Wow. I was just sitting here trying to think. We're splitting hairs over the word fraud when what's going on in Minnesota, what's going on in Los Angeles -- gosh, if that doesn't undermine confidence in the system, nothing else does. And do we not call it fraud because it might undermine confidence in the system?

Fourteen billion dollars being taken, people's identity being stolen on Medicare -- our seniors, so when they go to get the product that they desire, that they deserve, they can't get it because somebody's gotten paid for it under their name. I mean, my goodness, if we're going to try to redefine the word fraud to not include that, I'm not sure why we're sitting here. It's just dumbfounding.

Ms. Gay, the things that you've seen that we're talking about in Minneapolis, that's happened in Minnesota, and what's happened in Los Angeles, would you define that as fraud? Aren't these people purposely setting up fake accounts so they can get money and not serving anyone? I think that would have to be fraud. I don't think that's improper.

Ms. Gay. Interestingly, so I can never -- we don't use the F word often is what I say in my line of work, because I'm not law enforcement or, you know, can't, you know, speak for the law. However, it is hard not to see fraud when there's very clear intent. Proving that intent is often what is difficult.

The Chair. So, Ms. Wootton, your organization, you have people that are police. You have

your law enforcement. So would you define these what you're seeing in Minneapolis and what we've seen with the Somali population particularly and in Los Angeles with domestic medical program, would you define that as fraud? Or is there some kind of law school term we need to use to try not to call people fraud when they're being fraudulent?

Ms. Wootton. Yeah. Given the information I have about those states is what I've read in the news, it's difficult to address those exact investigations. However, Medicaid fraud control units look at fraud and we call it fraud. We do not have authority to look at waste and abuse. We are specifically designated -- people refer to us a case and they say here's a credible allegation of fraud or we data mine and find what appears to be an outlier.

We only pursue investigations if we think they're credible. But we do learn from other states, and yes, the schemes that we see there we see schemes in our own states where it's definitely fraud. Companies, like I said before, set up with the sole purpose of committing fraud. Substance use disorder providers who never had a real provider provide services even though they're so desperately needed, but I think in this conversation we're fortunate that we focus on fraud, we call it fraud, we prosecute and litigate fraud.

The Chair. So, this is funny, I had a physician one time show me that he had Medicaid money, Medicare money reclaimed because he didn't put the time down he did the service although he did the service. Just didn't have the paperwork absolutely correct. That's not what we're talking about. That's absolutely not what we're talking about here, is it?

Ms. Wootton. Absolutely. I get --

The Chair. We're talking about foreign entities in some cases setting up dummy accounts to take money out of the Medicaid and Medicare system, which seems like everybody in this room would want to get rid of because it takes money away from people who really deserve it, and I don't understand why we're splitting hairs on a definition when we have this kind of crime going on, so would you like to talk about, Ms. Gay, too, as well, people setting up these entities just to take money

from the taxpayers?

Ms. Wootton. Yes, and I want to say absolutely we do see some of those frauds you're describing. We also see domestic individuals stepping in who are not appropriate. They're not providers and they're billing Medicaid and Medicare, so we see it across the gamut, but yes, it harms the system.

The Chair. So how do they set up systems to get money if they're not providing care?

Ms. Wootton. So they use --

The Chair. I mean, I ask that rhetorically, because I know they do it, so what are they doing?

Ms. Wootton. Okay. So they set up a company. You don't necessarily have to be a healthcare provider to own a company. Home health agency, substance use disorder clinic, nursing home, and then maybe -- and some of the people at the lower level are doing what they think they're supposed to do as services, but the reality is those lower level people don't know what the Medicaid regulations are and the Medicare regulations are, and so the people who are supposed to be billing and knowing the process and who signed the provider agreements, there are no therapists involved in some of these behavioral health schemes.

The Chair. If you're billing for therapy and you don't have therapists, would that be fraud?

Ms. Wootton. Absolutely is fraud.

The Chair. Ms. Gay, would you agree that would be fraud?

Ms. Gay. Absolutely.

The Chair. So what are you seeing? I mean, now it looks like that's what this hearing has turned into, trying to define what fraud is, and I think fraud should be prosecuted.

Ms. Gay. Absolutely. And so our role -- so most of the work that I do is directly for the MCOs and MA plans, and they work then with law enforcement to refer these and to get the official stamp of the fraud.

The Chair. Did you see more fraud in states in Medicaid particularly that don't have MCOs

or Medicaid managed -- it's just bill for service Medicaid or Medicare? Do you see more fraud in that versus when the private insurance market is trying to chase the --

Ms. Gay. I see a lot of MCO fraud, a lot.

The Chair. Across all of the --

Ms. Gay. Yeah, and not the plans committing the fraud, let me be clear, but we see a lot in the states that we're working with that is through the managed care organizations and the difficulty to stop those, but it is -- many of the cases that we are working now are with law enforcement and are being prosecuted for such things.

The Chair. Thank you. I see my time is expired, so thank you for your time. Appreciate it.

Mr. Joyce. Gentleman yields. The chair now recognizes the Ranking Member of the committee, Mr. Pallone, for his five minutes of questioning.

Mr. Pallone. Thank you, Mr. Chairman.

The terror and violence we're witnessing in Minneapolis is the extreme result of congressional Republicans' unwillingness to hold the Trump administration accountable, and the use of fraud as a justification for every cut to programs is really getting old.

Today's hearing is yet another attempt by Republicans to convince the public they're generally concerned about fighting fraud even though they've been silent while very -- the very individuals responsible for fighting fraud were fired, pushed out, or resigned in protest, but let me go to Ms. Tillipman.

You say in your testimony that overstating fraud has the potential to, quote, stigmatize program participants.

Could you talk about the risk to programs and program participants when fraud is overstated or action against fraud is taken preemptively.

Ms. Tillipman. Yes. Thank you for the question. First, I also want to just be clear, there is definitely a lot of fraud out there, but the reason that we want to be clear about our labels again is

because different things have different consequences. Fraud can result in imprisonment, false claims that can result in substantial liability financially, and then, of course, some of the other types of things, including improper payment, should have greater resources than directing -- being directed to oversee those processes to result in fewer improper payments.

So the risk to that and the risk to the integrity of the entire system happens when we are not appropriately directing the appropriate remedies to the appropriate act.

Mr. Pallone. And then when fraud is exaggerated or overstated, how might that impact the efforts of investigators and prosecutors who are trying to root out actual illegal fraud?

Ms. Tillipman. So, again, we have finite and scarce resources within the Federal Government, state governments, and of course, all the actors across the entire landscape, and so you want to make sure you're being efficient with taxpayer dollars and how you're directing those resources.

Mr. Pallone. And then -- well thank you. But in the case of Minnesota, the Trump administration is withholding as much as billions of dollars in funding that the state relies on to provide healthcare to residents and it appears poised to take similar action in many other states.

They're doing that despite the numerous improvements that Minnesota has been implementing to prevent and prosecute fraud across the board, and this is only going to end up hurting Americans who need care.

Already the White House has directed federal agents to review nearly all federal funding for 14 states and D.C. that supported Vice President Harris in the 2024 presidential election, so Ms. Tillipman, again, what are effective approaches that can be taken to prevent and prosecute fraud without unfairly punishing Americans who rely on those programs?

Ms. Tillipman. So, you know, ultimately what you want to do is look at things from an institutional level. We know that fraud occurs in all, you know, 50 states and then territories as well, and so the goal is to make sure that we're not seeing what's behind us.

We're so focused on some aspects that we don't look at the entire system as a whole, so that would be critical is to make sure we're accounting for all of these risk areas, which, by the way, are in all states so that, again, we're not misdirecting resources.

Mr. Pallone. Well, thank you.

Ms. Wootton, in your testimony, you refer to federal, state, and local partnerships as vital. Could you talk about how partnerships and collaboration rather than hostility between federal and state partners could help fight fraud? It's about a minute and a half you've got left.

Ms. Wootton. Okay. I can speak to partnerships. They're invaluable, and examples would be as fraudsters are no longer staying within one state, they're crossing state lines, we have limited jurisdiction as a state prosecutor, state investigator, and we rely on those federal partners, whether it's the FBI's healthcare task force, whether it's the HHS OIG. They are able to take what we can provide the resources we have, but they can also cross state lines and we can involve other states in that, so they are critical.

State partners are invaluable in the area of patient safety and protection, because they are the ones who get complaints of abuse, neglect, and exploitation, and we work those cases as well more at the state level.

Mr. Pallone. Well thank you. I just think we're at a dangerous moment in our country. The committee Republicans are amplifying the Trump administration's reckless rhetoric targeting Minnesota and Los Angeles, and I don't think fraud is a partisan issue.

It just doesn't happen in blue states. We should all want to go after actual fraudsters. However, using the facade of fraud prevention as a weapon to hurt people who did not vote for President Trump is really unconscionable and the Trump administration must be held accountable, and the Republican majority should not be providing the administration with excuses for harming even more Americans in my opinion, but I yield back, Mr. Chairman.

Mr. Joyce. The gentleman yields. The chair now recognizes Mr. Allen for his five minutes

of questioning.

Mr. Allen. Thank you, Chair Joyce, for holding this important hearing on fraud and Medicare and Medicaid. I thank the witnesses for being here to testify. It is critical we examine how bad actors use Medicare and Medicaid to manipulate the system and that it has negative impacts for beneficiaries and taxpayers alike. My hope is we can look for solutions on how to prevent this in the future.

Mr. Nuckolls, as an accountable care organization, you are incentivized to lower healthcare costs for Medicare patients. What impact do fraudulent claims have on an ACO's ability to make healthcare more affordable for seniors?

Mr. Nuckolls. Thank you, Representative Allen, for that question. So as an accountable care organization, you know, we are responsible for the costs. Medicare shares with us the claims that they pay on behalf of our patients that are assigned to us by the program, so if our spending overshoots the budget, we have to pay Medicare back.

In the current program they're at, we are at 100 percent at risk, so we talk about the risk in harm to the taxpayers and in this case the risk in harm is to provider groups like us that are trying to do the right thing. We're trying to, you know, give higher quality care and we're trying to reduce wasteful spending, and we work within our community to do that. And so if these fraudulent claims are paid out and we don't have control over it, we report it to the Federal Government, more of us are going to leave the program.

We have been able to reduce costs in our community by 25 percent over group from where we were in the past compared to the counterfactual. If these claims keep going out and we're held accountable for claims for fraud of which we have no control, then we'll have no choice but to leave the program, and cost for the overall entitlement programs are going to go up, and so we want to keep those costs low. Thank you.

Mr. Allen. Okay. Great. Thank you. Ms. Wootton, from my understanding, it's not

uncommon for fraudsters to target Medicaid to commit fraud to take advantage of vulnerable populations such as the homeless or those with substance abuse disorders. How does Medicaid fraud harm these patient populations?

Ms. Wootton. In so many ways. It's difficult for many of the patients in those populations to seek services for what can be a very difficult diagnosis to let people know that you're truly an addict. And when they don't receive the services they need, not only is Medicaid wasting money paying for them, but that person still needs the treatment at the end of that, so it becomes neglect as well. So it's a very difficult population to work with, and we have difficult laws federally that make it difficult to get some of the medical records without jumping through hoops, but we need to, because this population needs to be treated.

Mr. Allen. Good. Thank you.

Ms. Gay, in your experience, can fraud be prevented if the government and regulators lowered information barriers and increase scrutiny on certain providers?

Ms. Gay. Absolutely. Yeah. I think there's a gap in our credentialing process across the board as far as, you know, letting practitioners into programs and keeping up with the screening. It's a big job, but most organizations that I work with, they're screening their providers once every three years, and that's just not often enough to deter the bad players out there.

Mr. Allen. Well, obviously, we have news coming out on this every day and, you know, the public is really discouraged about the way people are using these programs in a fraudulent and abusive way, so we've got to get to the bottom of it, and I thank you for your work, and certainly Congress needs to help you in any way we can. Thank you, and I yield back.

Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from Texas, Mr. Crenshaw, for his five minutes of questioning.

Mr. Crenshaw. Thank you, Mr. Chairman. Thank you everyone for being here.

Ms. Gay, when we talk about Medicare and Medicaid, we're not talking about just paperwork

errors, right? We're talking about really actual people being harmed, whether it's seniors kids or the disabled. In your experience, when it comes to fraud and federal healthcare programs, it's not a victimless crime, is it? It directly harms beneficiaries. So drawing on your experience across Medicare and Medicaid and the commercial plans, why is it that Medicare and Medicaid are so much more vulnerable to fraud than private insurance? Look, fraud is a crime. Also waste. I like to differentiate between these two terms.

Ms. Gay. Sure. Yeah. I mean, I think, one, there's just scope and span. Medicaid in particular is difficult, because each plan has varying regulations and guidance as well as benefit coverage determination, so it gets more difficult at the state level. There's a saying, you know, if you've worked for one Medicaid plan, you've worked for one Medicaid plan, and so that certainly offers some challenges there.

I think there's also -- I don't know, personally I can say I don't often read my EOBs, but I think, you know, that goes down, too, in certain populations where whether they don't have access to a computer, they don't even mail these EOBs out. We talked a little about the homeless population. Where would that go? I'm not exactly sure. So do you even know what's being billed under your Medicaid or your Medicare number. It's just a difficult process to wrap around. It's complicated from a data standpoint.

Mr. Crenshaw. Yeah. I think the more we waste on people who really are not even eligible for it in the first place, the less space there is for people it's designed for. That doesn't get said enough. And I guess my next question, I mean, who really bears the brunt of the harm? You know, is it the system? I mean, yeah, a little bit, right? Because taxpayers are on the hook, so the system is hurt. But it's really the patients for all the reasons we just stated, right?

Ms. Gay. Absolutely.

Mr. Crenshaw. Can their care become delayed or we've heard of providers just won't even take Medicaid anymore. Now, you know, so what's the solution here? I mean, some argue

stronger oversight would actually threaten access to care, but based on your experience, what actually happens when to access when fraud is not controlled? That gets to, you know, again, who bears the brunt of this.

Ms. Gay. Yeah. I mean, I think there's certainly the patient harm attribute. You mentioned, you know, not getting the care that you need and Ms. Wootton brought up, you know, SUD treatment facilities and we dealt with some cases with ACA enrollments, and by the time we verified with CMS that those were eligible recipients, they -- the health plan was already on the hook for \$1, \$2, \$3 million. Were these patients even receiving the care? In some case, yes. In other cases, they had no idea that they were in a facility for such treatment. And I think to Ms. Wootton's point with having that stigma, now you have somebody that doesn't even have that challenge, but that is now on their record, and even worse, those that do that are getting subpar treatment at a very exorbitant rate and still not getting better.

Mr. Crenshaw. Yeah. This gets to in my time left, you know, asking what the solutions are. I mean, how do you tackle fraud, waste, and abuse in a way that helps the patients and the taxpayer? I guess anybody could answer that question. Maybe Ms. Wootton since given your role on the National Association of State Medicaid Fraud Control. What's -- what are some of the worst -- two questions. What are some of the worst examples you've seen, and again, how do we fix this? That goes to anybody.

Ms. Wootton. I think one example I would use as a nurse that was most shocking to me was Hospice fraud. You have individuals who need this care at the end of the life that is so valuable, but we see Hospice games where patients are enrolled. They may be in a facility enrolled. They don't even know they're put on Hospice, but Hospice is not just a billed service. Hospice declares that they are terminally ill. It discontinues the treatments they need for preventative care. And if they don't even know they're on Hospice, essentially their healthcare plan has been changed just because somebody's trying to defraud Medicaid. That is in my mind the most egregious.

But I worry a lot about nursing homes right now, because as we're all aging, especially me, the facilities are not operating in a way always that verifies that patients are going to get or residents in that situation are going to get the care they need, and it becomes terrifying, because people need care.

We need patients to feel safe going to their providers, and most providers are amazing. But we've got to be able to share these schemes so that somebody knows what's being billed on their behalf, and I think in Medicaid not having explanations of benefits makes it very difficult for them to be part of the conversation and solution.

Mr. Crenshaw. I'm out of time, but an explanation of benefits seems like a solution kind of rabbit hole that we should dive into at a later point. Thank you.

Mr. Joyce. The gentleman yields. Chair now recognizes the gentlewoman from Texas, Ms. Fletcher, for her five minutes of questioning.

Mrs. Fletcher. Well thank you, Chairman Joyce and Ranking Member Clarke, for holding today's hearing. Thank you to our witnesses for your time today. Like many of my colleagues, I'm also in two hearings at the same time, but I appreciate you being here and to follow along with several of the things I've heard, which I want to get into in just a minute, but I do want to note that this subcommittee has an important job, and our purpose on the Oversight and Investigation Subcommittee is to protect our communities, to protect the rights of our citizens, and to make sure that what we see in the executive branch and beyond is not overreaching and certainly is not violating the rights of Americans.

And I think it's fair to say in face of the lawlessness that we are seeing across the country right now that this Congress as a whole has failed to conduct necessary oversight over the last year ceding Congress's authority to the executive branch and rubber stamping the President's agenda, even when it's unlawful and even when it's unconstitutional.

And I'm concerned from some of the comments that I've heard from this hearing already

today as I've been following it that this hearing is designed to support the Trump administration's use of claims of fraud in state programs, including Medicaid and Medicare, to recklessly deploy ICE agents to cities and states, to cut necessary funding, and to make fraud prevention and detection more difficult rather than less difficult.

And there's a lot -- there's a lot to say there. There's a lot going on, but we have limited time, so certainly I understand that the Medicaid system in states and the Medicare system are not without real challenges, substantive challenges, and that there is opportunity for real fraud to occur, and certainly we know that it has occurred.

You know, in administration after administration, there have been professionals whose sole job it is to monitor, oversee, and root out fraud and abuse, to prosecute cases against those who are committing it.

And what we've seen is that early on in this administration, the Trump administration fired most of those people who are responsible for doing this work. So we know that to detect this fraud we really need experts in the field. We need responsible nonpartisan investigations, and that's just not happening in this administration and it's not happening in this Congress.

So we have limited time, of course, and I do want to get to a couple of questions for Ms. Tillipman. In your testimony, you mention the risk of resource management or mismanagement when we don't have reliable data to look at, when the incidents of fraud as it is defined are inflated, and so can you just talk a little bit more about how it leads to a misuse of resources and so that you can have just a long time to answer sort of the second part of, like, how does that interfere with our job here in terms of proper oversight and reform, and what are the things that we should be thinking about, looking at, and asking for so that we can properly utilize resources and properly conduct oversight?

Ms. Tillipman. Thank you for the question. So, you know, ultimately, oversight is only going to function well if it is, you know, independent, well resourced, highly capable, and then there's

a coordinated effort amongst all the individuals that are responsible for rooting out fraud, waste, and abuse in the system, so that's the baseline expectation.

The loss of data, data is everything. I think you've heard this already from several of the other witnesses today that data quality is a problem, and that's actually been something that's been highlighted by both the IG and GAO routinely, so that's an issue that needs to be addressed.

And the final thing I'll say is there's a very great starting point for Congress right now, which is all the many unimplemented GAO and IG recommendations, and so when necessary, even providing some sort of timeline to the agencies for completing some of those unimplemented recommendations, and so there's a whole long list, but there's an easy place for people to start, and it's written down and available right now.

Mrs. Fletcher. Well, thank you. I think that's extremely helpful, and we have limited time here, so the other thing I want to ask is one of the things we saw at the very beginning of this administration last year was the efforts from Elon Musk and others to go through and cut personnel.

Can you talk with the 15 seconds we have left about how those recommendations from GAO can be implemented if we're firing the people who are responsible for doing the work?

Ms. Tillipman. So, certainly. I think most of us can all get behind the idea of efficiency, but ideally, when we're dealing with oversight processes, we want to make strategic and more targeted cuts, and so since a lot of this was through buyouts, RIFs, and other mechanisms, incentivized retirements, I think if it's not as targeted as it could be, that necessarily doesn't reach the efficiency we would hope when we're dealing with employment issues involving the Federal Government.

Mrs. Fletcher. Thank you so much. I've gone over my time.

Mr. Chairman, I yield back.

Mr. Joyce. Gentelady yields. The chair now recognizes the gentleman from Alabama, Mr. Palmer, for his five minutes of questioning.

Mr. Palmer. Thank you, Mr. Chairman.

This is something that I've worked on almost from the first day in Congress on the Budget Committee working to get the Budget Committee to include in the budget accounting for improper payments and a reduction of that. I just looked at a report that indicates that the GAO says that the fraud could be between \$233 to \$521 billion annually. That's a stunning number, considering that we budget on 10-year windows.

You're talking \$2.3 trillion to \$5.2 trillion plus interest because we're operating in a deficit. We're borrowing that money to send it out improperly or in some cases fraudulently as we're seeing played out in states like Minnesota and California and other places.

One of the things on the Medicare side and the Medicaid side that should be, in my opinion, fairly easy to address and that is the failure to verify eligibility. That's one of the biggest reasons that payments are going out fraudulently. Director Wootton, is that something you think that we can -- that we can fix?

Ms. Wootton. So as I mentioned earlier, the Medicaid fraud control units only have authority to pursue provider fraud and fraud committed in collusion with the recipient, but we do partner when we have cases that involve that collusion, we work with the recipient fraud and try to solve that angle as well, but our primary focus is on provider fraud.

Mr. Palmer. Would that include making sure that terminated Medicaid providers no longer enrolled in multiple Medicaid programs across state lines?

Ms. Wootton. Absolutely. And a lot of that work is done through various state program integrity units where they're looking for waste, abuse, and whether or not they have a case to refer for fraud, so those efforts are going on and they're critical.

Mr. Palmer. How about authorizing state auditors to access certain personal data like taxpayer identification numbers to eliminate duplicative enrollments in Medicaid?

Ms. Wootton. There needs to be a system to identify duplication for sure, whether it's Medicaid numbers or other numbers, but for sure that needs to be done. Nobody benefits when

fraud is committed or when money is wasted.

Mr. Palmer. I do think, and I think we would have bipartisan agreement on this, that Congress could do a whole lot more in writing our laws and the guidance much better to help states ensure that they can manage the money without as much fraud and waste.

One of the other things that I've been focused on, and I've had many discussions with Gene Dodaro, the controller general about this, is antiquated data systems. We have federal agencies that their data system is so antiquated they don't communicate. That is another source of improper payments. What would you suggest on that?

Ms. Wootton. I would suggest that we need to find a way to be able to use all of the data as we're investigating and deciding whether fraud has occurred. An example of that, if a provider has submitted claims for services that exceed a 24-hour day, we call that an impossible day, but often we're limited to the Medicaid data we can get from our own states, and then we work with HHS OIG to get Medicare claims data, and that makes the day even more suspicious, but there's got to come a day where we can be able to use third party payers and private payers, because those impossible days would just be so blatant nobody would question that it's fraud.

Mr. Palmer. One of the suggestions that's been made is for the treasury department that operates that do not pay business center, for them to be able to do their prepayment verification and Medicaid and assist reducing the improper payments from fraudulent activities and to have some way to collaborate with the states on that. I don't know if the states have access or the training necessary to use a resource like the do not pay system.

Ms. Wootton. Right. And maybe access is even the bigger issue. We have separate systems. We do the best we can with personnel to tie those systems together, but I think as I said, anytime that we could have more access and more education on tools that would help us all combat fraud, it would be invaluable.

Mr. Palmer. We need to do audits on a more regular basis, and one of the suggestions I

made to General Dodaro is that rather than be punitive in our actions towards agencies with high improper payment rates that maybe we think about if they can reduce their improper rate that we use the savings to bring their data systems to the 21st century, which is kind of a novel idea. I yield back.

Mr. Joyce. The gentleman yields. The chair now recognizes the gentlelady from Massachusetts, Ms. Trahan, for her five minutes of questioning.

Mrs. Trahan. Thank you, Mr. Chair, and thank you to the witnesses today.

I have to say there is a perverse irony in today's hearing. Republicans tout their big bill as a fraud crackdown while President Trump quietly pardons major Medicare and nursing home fraudsters involving tens of millions of dollars stolen from taxpayers. Look, no one disputes that fraud, waste, and abuse exists in our healthcare system.

We see it in Medicare Advantage where insurers upcode diagnoses that don't exist to inflate payments and pad shareholder profits at taxpayer expense. But when it comes to the real fraudsters, this administration has granted impunity. Last May President Trump granted clemency to Lawrence Duran who stole \$87 million from Medicare. In November, the President pardoned a nursing home operator after just three months of a three-year sentence despite stealing from taxpayers while neglecting elderly residents in his care.

Professor Tillipman, what message is sent to fraudsters when the President of the United States pardons people convicted of serious Medicare and Medicaid fraud?

Ms. Tillipman. Thank you for your question. While I can't speak to any particular case, I can simply say that one of the features of enforcement is the importance of deterrence, and so certainly when individuals are considering whether or not they're going to commit fraud, they will look to whether or not the government is actively enforcing its laws and they will look to some of these cases, and it might be a factor in deciding whether or not the system could be credible or reliable, but again, I wouldn't speak to a specific case.

Mrs. Trahan. Thank you. I -- nope. I appreciate you stating the obvious. This claim that Republicans are serious about fighting fraud just doesn't appear to hold up in practice. The big ugly bill doesn't target fraud. It cuts healthcare for Americans while delivering tax breaks to the wealthiest in our country. Instead of going after large scale fraud schemes, Republicans imposed complex work reporting requirements that force states to build costly new infrastructures.

The Government Accountability Office has found states spending anywhere from \$10 million to more than \$270 million just to set up and run these systems. In Georgia, when the state imposed these red tape requirements on its residents, more than 80 percent of spending went to administration and system upgrades rather than patient care with enrollment falling and little to no impact on employment.

And the real winners I think are clear. I mean, just days after the bill was signed into law, the CEO of Equifax publicly celebrated as a profit opportunity. While eligible patients face new paperwork barriers, private data vendors stand to make millions administering requirements we already know don't work.

Professor Tillipman, rather than investing in fraud enforcement, Medicaid work requirements rely heavily on private companies to build and run verification systems. What oversight risks does this pose when the rules are vague and taxpayer dollars are flowing to contractors with limited public accountability?

Ms. Tillipman. Well, I think ultimately the whole goal of an entirely effective oversight system is to prioritize your money by risk, and that works not only for the federal government or state governments but also private entities who make risk based decisions, so ultimately I would recommend to anybody looking on how to reform a system to look where your biggest risks are and then focus your enforcement and attention activity there.

Mrs. Trahan. That seems logical. And -- you know, we've run this experiment. Work reporting requirements haven't reduced fraud, they haven't meaningfully increased employment,

and they've drained millions into administrative systems instead of care. If the goal is actually protecting taxpayer dollars, what guardrails would work without pushing eligible people off of their coverage?

Ms. Tillipman. So I think looking at it from an institutional perspective, again, I think one of the recommendations I had was the many unimplemented recommendations by GAO and the IG. One of the bigger areas we see, and especially it's been touched upon today with MCOs is the diffuse responsibility and ensuring that when weaknesses are identified, like lack of referrals or lack of feedback loops or lack of training at the state and local level, that we follow up on those recommendations to address some of those weak points within the system.

Mrs. Trahan. Thank you. I yield back.

Mr. Joyce. The gentlelady yields. The chair now recognizes the vice chairman of the committee, Mr. Balderson, for his five minutes of questioning.

Mr. Balderson. Thank you, Mr. Chairman. Thank you all for being here today.

My first question is for Mr. Nuckolls. Are Medicare and Medicaid beneficiaries provided with clear actionable information on how to detect and report suspected fraud?

Mr. Nuckolls. Not by organizations like us, but it is available, you know, online if they were to go to the right websites.

Mr. Balderson. Okay. What information can be shared with them that would allow for better detection and reporting of suspected fraud?

Mr. Nuckolls. I think the -- in my experience that Medicare beneficiaries have done a good job reporting fraud when they see it. The real question is what happens after they report it and see it and the actions that take place or don't take place.

Mr. Balderson. Thank you.

Next question is for Ms. Gay. My understanding is the timeline from the moment fraud occurs until it is identified and resolved is far too long. How long does it typically take for a fraud

examiner to identify suspected fraud in a post payment review?

Ms. Gay. We see an average case take about a year. By the time we do conduct the data analysis, your investigation, conduct member surveys, request records, review those records, and then give the appropriate appeal time frame, it's usually between nine months and a year before we have really credible allegations of fraud, at which point we can pull in our law enforcement partners. It can happen sooner than that. In a great case, sometimes it is as soon as we get it, it is glaring. Other times it takes even longer as we try and peel back the networks of who owns what and what is connected.

Mr. Balderson. That's what I was going to follow up with. How long does it take to then investigate the identified fraud?

Ms. Gay. Once it's identified as fraud, that goes to law enforcement and I back off.

Mr. Balderson. Thank you.

My next question is for Ms. Wootton. As the leader of the State Medicaid Fraud Control Unit, how quickly are you able to identify the instances of fraud? And then the follow up would be and how successful are these units at recovering fraudulent payments once they have gone out the door?

Ms. Wootton. The speed of an investigation and a prosecution depends on many issues, and if it's a -- say a patient calls in and they say my provider did not see me and I found out they billed, that can go very quickly if we're just looking at one provider.

In the scheme that I described in my written testimony with behavioral health, we don't want to just get the one patient, one provider situation. We're trying to find out are there related companies, how high in the organization does it go, because that's where the true fraud and a lot of money is there. Those can take a long time. And, I'm sorry, will you repeat the second --

Mr. Balderson. I can. And how successful are these units at recovering fraudulent payments once they have gone out the door?

Ms. Wootton. So we, of course, diligently try. Unfortunately, some of these fraudsters have spent the money or the money has gone elsewhere and it's difficult to track, but we work closely with our single state agencies, our Medicaid programs to let them know that if we no longer need say a law enforcement exception for payment suspension, if we think we're going to do some kind of an operation that could be jeopardized if the provider becomes aware of the investigation, then we ask them to give us a little time to do that.

But once the provider is aware we're looking at them or we've done everything we need to do, we can notify the Medicaid program that we no longer need that exception, and if they can suspend payments, those payments could come in much better. We can get much more back.

Mr. Balderson. Thank you. Well done. Follow up to also Mrs. Wootton, are fraudsters using emerging technology such as artificial intelligence to deal with these Medicaid fraud schemes?

Ms. Wootton. Yes. We see that evidence across the nation, and we've been bringing in speakers on that topic to try to educate us. It's frightening as you watch presentations on how quickly an MRI or an X-ray can be altered, and we need to be able to determine which is the correct one, so we're trying to combat fraud with tools, but we need more tools.

Mr. Balderson. It's a great point, and I mean, I will ask you, are you all doing anything to adapt to figuring out this AI piece and the fraudulent with that?

Ms. Wootton. Yes. It varies by state how much we've been able to use it, but these presentations are showing us how we could use them to look at medical records and at least identify that they're cookie cutter records, that everybody patient there has the same diagnoses, same treatment, and I think that will be able to be done sooner rather than later, but we may -- we're going to have to have more resources to be able to combat fraud where they're altering images or falsifying surgeries, or that kind of a thing. But our association, like I said, is committed to learning this and we've been bringing in speakers for about the last three years.

Mr. Balderson. Thank you very much.

Mr. Chairman, I yield back.

Mr. Joyce. The gentleman yields. The chair now recognizes the gentlelady from Washington, Dr. Schrier, for her five minutes of questioning.

Ms. Schrier. Thank you, Mr. Chairman, thank you, Madam Ranking Member, and thank you to all of the witnesses for being here today and for your work.

I'm really happy that this committee is taking on the issue of fraud, an issue that we all want to crack down on. Fraud and abuse hurts patients, honest providers, as we've heard a lot today, and the taxpayer, and this is not a partisan issue, but right now fraud is being weaponized by this administration only against blue states.

I'm sure you have noticed. It is being used as a pretext for cutting funding to 14 states, all of which happen to be run by Democrats. Criminals should be prosecuted whether they're in red states or blue states, and we have heard over and over again in this hearing from all of you that it happens everywhere.

It happens in red and blue states. And so I just want to say that I am tired of the weaponization. I am ready to work with my Republican colleagues on common sense ways to improve oversight so that we can truly root out fraud everywhere.

But other than when it's politically convenient, this administration's also made it harder to investigate Medicare and Medicaid fraud. Just four days into his presidency, President Trump illegally fired 18 inspectors generals we've talked about.

These are the very people responsible for rooting out fraud and abuse in federal programs, and they are independent nonpartisan officials, and President Trump fired them in favor of his highly political and highly ineffective DOGE which slash programs indiscriminately.

And one of the IGs that he fired was the highly respected, highly experienced HHS inspector general who oversaw and was in the process of doing a lot of crackdowns on this type of fraud. And then, of course, about a year later, he was replaced by Thomas Bell who himself has a very

concerning history of misuse of taxpayer dollars. This is hardly the right man for the job.

So if we want to root out fraud, I suggest for this committee that a great place to start is Medicare Advantage, because that is where a lot of the really big dollars are being wasted. Medicare Advantage is the type of Medicare plan that contracts with private insurance companies, as you know, to deliver care.

This is a public-private partnership that was initially championed by Republicans as a great way to use the private market to save money, to administer healthcare they thought more efficiently, but it turns out it just has not saved Americans money. It allows massive insurance companies, like UnitedHealth Group, to swindle the taxpayers by making their patients look sicker than they actually are so they can make more money per patient and we taxpayers end up footing the bill.

In fact, a 2024 inspector general report found that taxpayers spent billions of dollars in overpayments to Medicare Advantage companies each year based on unsupported diagnoses for MA enrollees. That was a quote.

Professor Tillipman, thank you for being here today, and I really appreciate your comments on the record of enforcement of rules being a great deterrent for other fraud. I think that's an important lesson and also a very obvious lesson for anybody in here who is a parent. What specifically more do you think HHS could be doing to strengthen accountability for managed care plans like Medicare Advantage?

Ms. Tillipman. Thank you for your question. So, again, I feel like I've said this a few times, there are some unimplemented recommendations from the GAO and IG that relate to that plan in particular. There's a long list. You can go online. They have an actual tracker that identifies them that I think would be the most useful in terms of oversight. There is one thing I will raise, though, particularly because so much of the recoveries from this year's false claims act were related to healthcare and a big priority has been managed care from FCA enforcement.

Right now there is an 11th circuit case on appeal challenging the constitutionality of the Qui

Tam components of the False Claims Act, which is a huge driver, \$5.3 billion of these False Claims Act recoveries, so Congress -- it would behoove Congress to pay close attention to the outcome, because if the Qui Tam relater whistleblower provisions and incentives go away, I think we're going to see significantly reduced antifraud -- not antifraud, but false claims activity.

Ms. Schrier. I really appreciate those comments. I will keep a very close eye on that case. It sounds like it will have gigantic ramifications.

Thank you. I'll yield back.

Mr. Joyce. The gentlelady yields. The chair now recognizes the gentleman from Georgia, Mr. Carter, for his five minutes of questioning.

Mr. Carter. Thank you, Mr. Chairman, and thank all of you for being here. I'll preface my remarks by telling you that professionally I'm a pharmacist, and I have dealt with Hospices in my career. In fact, one of my businesses was entirely dedicated to Hospices and nursing homes and personal care homes, so I've got a lot of knowledge, a lot of experience, and I will tell you, during the '90s, I serviced the only Hospice in Savannah, Georgia and it seemed like overnight they proliferated and exploded, and all of a sudden we had 12 and 13 and 14 and 15, and I always wondered what happened there, how did this happen.

Now, I'm not saying that they were all committing fraud, but what I am saying is that they caught on to the fact that they could make a lot of money and we saw the proliferation of it. And I'm concerned about what's happening, what I've heard is happening particularly in California where the state auditors have reported an unprecedented surge in home health and Hospice fraud.

My wife's a physical therapist and she worked home health as well, so this is why I ask, and I appreciate you letting me waive on to this committee, Mr. Chairman, so this is why I'm very interested in this.

But in a shocking example, auditors found that 112 Hospice providers operating out of a single physical address. 112. Holy cow! As a result, Hospice agencies in L.A. County alone likely

overbilled Medicare by \$155 million in just one year. Let me tell you, there's a special place in hell for people who commit fraud with Hospice. A special place.

This is something we've got to look at. It looks like it's not just an isolated problem. It looks like it's a problem in a lot of different places, and that's why I want to ask you, Ms. Wootton, have you seen instances of copycats where fraudsters see a successful fraud scheme happening in one location so they try to replicate it, the same fraud elsewhere?

Ms. Wootton. Absolutely. We definitely see replicated fraud schemes, and Hospice is an excellent example. I share your concerns about home health and Hospice, because I owned a home health agency for many years, and I didn't even choose to be a Hospice because those -- there were specialized agencies that could handle that part and we would refer to them under the right circumstances.

What we now see, though, Hospices who are admitting patients who are not terminally ill, patients who don't know they were put on Hospice. Patients who maybe aren't getting treatments that they need because the Hospice philosophy, as you know, is for comfort care, not for treating illnesses.

Mr. Carter. Palliative care.

Ms. Wootton. So in our state, we have seen the same thing in Utah, that the Hospices have exploded. Now, I'm not saying they're all fraudulent either, but absolutely, fraudsters learn from fraudsters, and it's an area we have to investigate.

Mr. Carter. Do you share this information with other states whenever you find out that there's, you know, a certain scheme going on?

Ms. Wootton. Absolutely. That is the value of NAMFCU, our national association. All 50 states and the three territories work together to share schemes, and we talk more openly than I think we had to even several years ago, because we need to know who are these people and how do we get on top of it, how do we collaborate. We teach training programs.

Right now we have a group over in our main office who are preparing our nursing home fraud, and they're creating a curriculum to teach MFCUs how to identify that fraud.

RPTR DEAN

EDTR HUMKE

[1:04 p.m.]

Mr. Carter of Georgia. I'm telling you special place in hell for these people.

Let me shift gears here, I want to talk about something else that I am interested in, that's skin substitute pricing and cost. Over the past 2 years alone Medicare part B expenditures for skin substitutes have skyrocketed from roughly 400 million in 2022 to more than 10 billion. Hear me 400 million in 2022 to more than 10 billion with a B in 2024. That is a staggering 640 percent. Again, they seeing this happening, man, like buzzards just coming together.

So I introduced the Skin Substitute Access and Reform Act. And this target has run away pricing and inappropriate prescribing through program integrity reforms that target the top 3 percent of providers generating nearly two-thirds of the Medicare skin substitute billing with program integrity reforms and setting a payment rate at a sustainable level that protects patient access.

I'm concerned and Mr. Nuckolls, I'm going to ask you this one, I'm concerned that the approach of setting a very low payment rate without specifically targeting problematic providers may be harming patients. From your perspective, does an artificially low reimbursement rate risk restricting access for legitimate patients and providers.

Mr. Nuckolls. Thank you very much for the question, Representative Carter. From where I sit on the business side of things, I can tell you that no one will give skin substitute patients will not receive skin substitutes based on the current regulations that were passed by the Secretary and HHS.

Mr. Carter of Georgia. That's what I'm hearing is happening.

Mr. Nuckolls. I couldn't tell you whether it is comparable or better than existing treatments. You would have to ask a physician.

Mr. Carter of Georgia. We don't want to swing the pendulum too far. I mean we got it corrected, but you've got to be careful not to swing it it too far. So would a more targeted program

integrity approach be a better way to do it?

Mr. Nuckolls. I don't know that I'm qualified to say that, because I don't know. I know the current program will cease almost all skin substitutes from being supplied

Mr. Carter of Georgia. Exactly. Again, I don't want that to happen, and I don't think anybody wants it to happen. We ought to be targeting those bad actors and how we can get to them.

Thank you, Mr. Chairman, again for letting me sign on to this. And thank y'all for being here and I yield back.

Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from California, Mr. Mullin, for his five questions -- 5 minutes of questioning.

Mr. Mullin. Thank you, Mr. Chair. Thank you all for being here today. At face value, fraud and government programs is an important topic for this subcommittee to consider. We have a responsibility to ensure Federal programs under our jurisdiction are being implemented as intended by Congress and that Federal dollars are going to communities that need assistance.

However, we cannot discuss healthcare fraud without discussing the deeply troubling actions by this administration in the name of addressing fraud. The Trump administration has deployed ICE agents to Minnesota under the guise of at least partially addressing Medicaid fraud. We have all seen with our own eyes that this mission is leading to the killing of American citizens and terrorizing innocent families. But what has the majority on this committee chosen to do? While American citizens are being executed by their own government on American soil they open an investigation on Minnesota's Medicaid program.

Ms. Wooton, CMS has specified in its comprehensive Medicaid integrity plan that individual States are empowered to best address program integrity challenges with CMS supporting. And yet the Federal Government is attempting to take the lead on fraud allegations in Minnesota out of nowhere.

Ms. Wooton, do you believe we can get better outcomes in Medicaid fraud investigations and enforcement actions when local State and Federal agencies closely collaborate and why would that be the case?

Ms. Wooton. That collaboration is critical because fraudsters are not just in one State doing one particular fraud, they travel from State to State. And the States don't have the tools to cross State boundaries. We don't have authority to prosecute or investigate in those States. We collaborate closely with Federal partners. They are integrally involved with us.

In fact, HHS OIG pays 75 percent of everything we do so we can collaborate. So we need to put all the tools we possibly can in this toolbox to combat fraud, that would include State, Federal and local partners.

Mr. Mullin. I do appreciate that.

In your experience leading fraud investigations, could you tell us does the Department of Homeland Security -- Department of Homeland Security typically play any role in investigating Medicaid fraud?

Ms. Wooton. No.

Mr. Mullin. Okay. So-called fraud is also being used by this administration as a catchall, it is used to cut healthcare spending and punish States that didn't vote for the President. In H.R. 1, the Republicans' big ugly bill they cut \$1 trillion in healthcare spending to supposedly address waste, fraud, and abuse. But when you look past their messaging, this bill is stripping 15 million Americans of their healthcare coverage and giving a tax break to corporations and billionaires. There are also countless examples of this administration freezing or canceling Federal dollars for political reasons.

Just a month ago the Department of -- the Department of Health and Human Services froze childcare and family assistance grants going to 5 States with Democratic governors, including my home State of California. They claim it was to ensure program integrity and fiscal responsibility, but families rely on these programs are hurt in the process.

So Ms. Tillipman, as you highlight in your testimony, fraud on some level is inevitable, but well-resourced oversight can successfully detect and address widespread issues. So my question is, is unilaterally freezing billions of dollars in assistance a smart targeted way to address fraud especially when it comes at the expense of ripping essential health services away from beneficiaries and what are some more effective approaches?

Ms. Tillipman. Thank you for your question. I haven't examined those specific States particularly in preparation for this hearing, but I will say this, ultimately once you are completely shutting down programs, whether it is cutting off contractor from their access to contracts, shutting down spending in certain areas in a kind of blanket way, it may be able to stop any type of fraud, but it can also harm innocent individuals as well. And so what we typically would say if you want to have a response that is proportional to what you're detecting.

And while I wouldn't be able to say without examining those particular States what is, generally when we see either fully excluding from a program, completely ceasing funding something or again kicking certain contractors or companies out of the system. Usually that is the nuclear option. And so ultimately again people I usually like to recommend a scalpel instead of a sledge hammer.

Mr. Mullin. Thank you for that. I just want to wrap by saying I'm deeply concerned about the weaponization of allegations of fraud to enact a political agenda. And I know that my colleagues on this side of the aisle and I will not stop calling out that hypocrisy.

Mr. Chair, I appreciate the time and I yield back.

Mr. Joyce. The gentleman yields.

Seeing there are no further members wishing to ask questions, I would like to thank our witnesses again for being here today.

I ask unanimous consent to insert in the record the documents included on the staff hearing documents list.

Without objection, so ordered.

[The statement of Mr. Joyce follows:]

***** COMMITTEE INSERT *****

Mr. Joyce. Pursuant to committee rules I remind members that they have ten business days to submit additional questions for the record.

I ask the witnesses to submit their response within ten business days upon receipt of the questions. Members should submit their questions by the close of business on Wednesday, February 18th.

Without objection, the subcommittee is adjourned.

[Whereupon, at 1:13 p.m., the subcommittee was adjourned.]