United Council on Welfare Fraud
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October 23, 2025
<Sent via e-mail>

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
c/o Stephanie Carlton, Chief of Staff

RE: Urgent Demand for Written Clarification Regarding Rescinded SMD #24-005

Dear Dr. Oz,

On behalf of the United Council on Welfare Fraud (UCOWF), a national organization representing state and local welfare fraud investigators, benefit recovery specialists, and program integrity professionals, we write to express our deep concern over the continuing confusion surrounding the rescission of CMS State Medicaid Director (SMD) letter #24-005, ("Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions"), issued on December 5, 2024, and formally rescinded on May 1, 2025.

This is the ***third formal letter*** UCOWF has submitted to CMS on behalf of state program integrity professionals across the nation.[1] While we appreciate the rescission of this flawed guidance – following our April 3rd correspondence - recent CMS communications have left states in deeper operation confusion, impeding their ability to uphold fiscal accountability and statutory integrity requirements.

CONTRADICTORY CMS MESSAGING

During the October 21, 2025, National Fraud Technical Advisory Group call, CMS staff reportedly stated that despite the memo's formal rescission, its restrictive policies "remain in effect." Specifically, your representatives asserted that:

- **States may <u>not</u> recover state-funded overpayments, including state capitation funds**, from beneficiaries found to have committed fraud;
- **All Medicaid beneficiary fraud cases must be referred to law enforcement** (i.e., Medicaid Fraud Control Units); and
- States could face **federal funding or FMAP penalties** for non-compliance if they attempt to recover their own state funds or follow state law vs CMS guidance.

Despite multiple requests for clarification from states, CMS representatives on the call restated that "while the memo was rescinded, the policy remains in place." This directly contradicts CMS's own rescission, undermines state authority, and undermines your commitment to transparency and cooperative federalism.

The effect has been chilling: states are now paralyzed in performing basic recovery actions they have lawfully conducted for decades.

[1] See April 9, 2025 UCOWF letter to Stephanie Carlton:
https://www.ucowf.net/assets/pdf/UCOWF+letter+to+CMS+re+5Dec2024+Memo/
and June 20, 2025 UCOWF letter requesting CMS clarifying guidance:
https://www.ucowf.net/assets/pdf/UCOWF+letter+to+CMS+re+Recission+of+5Dec2024+Memo/

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VIOLATION OF LAW, POLICY, AND COOPERATIVE FEDERALISM

In FY 2023, improper Medicaid payments exceeded $50 billion – much of it attributable to beneficiary error and fraud. Prohibiting states from recovering their own funds absent a criminal conviction – often delayed for years due to under-resourced law enforcement – guarantees unrecovered losses and only serves to reward those defrauding the government. Not only is this position fiscally indefensible and administratively unworkable, **the confusing and inconsistent guidance runs counter to**:

- **President Trump's June 6, 2025, directive** to HHS and CMS titled, "Eliminating Waste, Fraud, and Abuse in Medicaid"; and
- **Executive Order 14243**, "Stopping Waste, Fraud, and Abuse by Eliminating Information Silos."
- **The Medicaid Extenders Act of 2019**, which expressly conditions federal matching participation (FMAP) on states conducting eligibility verifications and recoveries to prevent and recoup improper payments.

CMS's position contravenes the **Tenth Amendment's anti-commandeering doctrine** and established cooperative federalism by attempting to bar states from enforcing their own laws and administratively recover their own funds. **The Supreme Court has clearly ruled on this prohibition**, yet CMS employees remain steadfast and in direct opposition to this Administration's priorities and directives.[2]

Furthermore, the rationale behind SMD #24-005, and the subsequent verbal guidance, demonstrates a fundamental lack of understanding of how states actually administer Medicaid, especially within Integrated Eligibility Systems that coordinate Medicaid applications with SNAP, TANF, and other programs. These systems rely on automation and data-driven verifications and analytics to identify fraud, waste, and abuse; they cannot function effectively under vague or contradictory federal instructions that penalize states for recovering fraudulently obtained taxpayer funds.

DUE PROCESS PROTECTIONS ALREADY EXIST

The purported justification for SMD #24-005 – to "protect beneficiary due process" – is wholly unnecessary. Due-process rights and protections under *Goldberg v. Kelly (1970)* and 42 CFR Part 431 already ensure fair hearings and advance notice – protections far exceeding those contemplated by SMD #24-005. The rescinded policy's additional constraints serve only to obstruct legitimate recovery efforts – not to strengthen fairness.

OPERATIONAL PARALYSIS AND FISCAL CONSEQUENCES

Following the October 21st TAG call, a second Beneficiary Fraud TAG call was held on October 22, 2025, during which states again raised concerns that the rescinded guidance from the former Administration was again being treated as active policy. CMS staff attending the call provided no clarification nor a single response to these questions, deepening the perception that states risk penalty for standard recovery operations and an internal division within CMS.

UCOWF members report widespread confusion among state and county agencies, policy staff, recovery units, and investigators – all now uncertain whether they can proceed with normal integrity functions, including recovery of state-funded capitation and administrative removal of

[2] The U.S. Supreme Court's ruling in *New York v. United States (1992), Printz v. United States (1997), and Murphy v. NCAA (2018)* affirm that the federal government cannot compel states to forgo enforcement of their own fiscal laws, such as recovering the 20-50% state share of capitation payments lost to beneficiary fraud.

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beneficiaries committing eligibility fraud. This confusion also has bled over to cases flagged through the Public Assistance Reporting Information System (PARIS), which identified over 3 million unique SSNs linked to over **6 million instances of duplicate participation** in the February 2025 Interstate Match. Preventing states from administratively addressing these findings and recoveries from Managed Medicaid Managed Care Organizations goes against GAO and HHS OIG audits and recommendations as well as undermining the intent of the **Payment Integrity Information Act of 2019**.

During the subsequent October 22nd Beneficiary Fraud Technical Advisory Group call, CMS representatives provided no clarification, opting to remain silent in the face of state questions. The absence of clear written guidance, as requested in our June 20th letter (see footnote #1), threatens fiscal accountability, administrative oversight, violates state laws, and only serves to embolden those defrauding this critical taxpayer funded program.

REQUEST FOR IMMEDIATE WRITTEN CLARIFICATION

UCOWF is actively working to obtain the recorded transcript of the October 21st call to confirm the CMS statements in question. (The TAG call agendas are appended to this letter.) However, regardless of transcription, the verbal guidance already issued has caused enough immediate operational and reputational harm.

To resolve this untenable situation and restore confidence in CMS leadership, UCOWF respectfully but urgently requests that the agency issue **formal written confirmation within 14 days,** explicitly confirming that:

1. The **rescission of SMD #24-005** is fully effective;
2. **All restrictions** on state administrative recovery of Medicaid overpayments and capitation funds **are void**;
3. States may continue to conduct **lawful administrative recoveries** and sanctions under existing federal and state law without fear of funding penalties; and
4. States may continue to **detect, deter, prosecute, and enforce** violations of the Medicaid program as detailed in their respective State Medicaid Plans.

If CMS believes new rulemaking or interpretive guidance is warranted, including establishing term limited administrative disqualifications for violations of the Medicaid program, UCOWF stands ready to assist in its development to ensure consistency with state and federal law and mission directives.

Thank you for your prompt attention to this critical matter. We appreciate your leadership and look forward to CMS's written clarification to resolve this issue and restore the integrity of Medicaid program oversight and reaffirm your Administration's commitment to combatting fraud, waste, and abuse.

We appreciate your prompt attention to this critical matter and look forward to your response.

Sincerely,

Keith Miskie, President
United Council on Welfare Fraud
www.ucowf.net

CC:
Dr. Caprice Knapp, Medicaid Counselor to U.S. Department of Health & Human Services
Darcie Johnston, Principal Deputy Director, U.S. Department of Health & Human Services
Alex Meyer, Director, White House Office of Intergovernmental Affairs

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Fraud, Waste, and Abuse Technical Advisory Group (TAG) Meeting
October 21, 2025 – 2:30 p.m. EST

Agenda

Region Representatives	**CMS Center for Program Integrity (CPI) Groups**
FWA TAG Chair – Anne Harvey (Nebraska) Region 1 - ME, NH, VT, MA, CT, RI - Joan Senatore, (MA) Region 2 - NY, NJ, Puerto Rico, Virgin Islands – Erin Ives (NY) Region 3 - PA, WV, MD, VA, DE, DC - Louis Elie (VA) Region 4 - FL, GA, KY, TN, NC, SC, MS, AL – Floyd Price (TN) Region 5 - IL, WI, MN, MI, OH, IN - Anthony Baize (WI) Region 6 - TX, NM, OK, AR, LA – Matthew Lyon (AR) Region 7 - NE, IA, KS, MO – Kimberly Pierson (IA) Region 8 - CO, UT, WY, MT, ND, SD – Andrew Chapin (WY) Region 9 - CA, NV, AZ, HI, Northern Marianas, Guam, American Samoa – Vanessa Templeman (AZ) Region 10 - WA, OR, ID, AK - Lori Stiles (ID) ***Send agenda topics to your Region Representative or to DeVera Ricks at devera.ricks@cms.hhs.gov.**	Fraud Investigations Group (FIG) Provider Enrollment and Oversight Group (PEOG) Audits and Vulnerabilities Group (AVG) Data Analytics & Systems Group (DASG) Center for Medicaid and CHIP Services (CMCS) Office of Financial Management (OFM) **Resource mailbox:** MIIResource@cms.hhs.gov **MII website:** https://www.cms.gov/medicaid-integrity-institute

1. **Welcome** – Anne Harvey, Administrator Program Integrity (Nebraska), TAG Chair

2. **Roll Call** – DeVera Ricks, TAG Lead CMS/CPI/AVG/Division of State Partnership (DSP)

3. **Medicaid Integrity Institute Update** - Stacy Downing, MII Business Function Lead, CMS/CPI/AVG/DSP
   - MII Update

4. **Voluntary Terminations and DEX Reporting** - Alexandra Wilcon, Social Science Research Analyst and Todd Alspach, Deputy Director CMS/CPI/PEOG/Division of Quality & Compliance

5. **Tax Project –** Debra Tubbs, Senior Health Insurance Specialist and Brent Person CMS/CPI/FIG/Division of Field Operations West

6. **Beneficiary Rescindment Memo –** Jennifer Sheer, Health Insurance Specialist, Marc Steinberg, Deputy Director, and Sarah Spector, Director CMS/OA/CMCS/CAHPG/DMEP

7. **Vetting the PERM sample for providers under investigation –** Floyd Price, PI Director (TN) and Alan Mahmuljin, Auditor CMS/OA/COO/OFM/PARG/DPERM

   - When a provider under active investigation is included in the PERM sample, states may be limited in what information can be supplied so as not to impact an ongoing investigation. This may lead to an immediate error. States would like an opportunity to vet the sample list to remove providers under investigation.

8. **Failure to Maintain Documentation** - Andrew Chapin, PI Section Manager (WY) State Discussion
    - In Wyoming, failure to maintain documentation has been a crime for about five years. Do any other states have a similar law?

9. **Reconciliation Bill –** State Discussion
    - *What questions do states have?*

10. **Other TAG Group Updates**

- **Beneficiary Fraud Update** - Michelle Dehn, Fraud Prevention Program Coordinator (Minnesota)

  Next Meeting – October 22, 2025; 3:00PM – 4:00PM EST

- **Provider Enrollment Update** - Todd Alspach, Deputy Director CMS/CPI/PEOG/Division of Quality & Compliance
    - *When is the next update to the MPEC anticipated?*

  Next Meeting - October 28, 2025; 1:00PM – 2:00PM EST

- **Data Analytics and Systems Group** - Altijani Hussin and Wendy Alexander, Deputy Division Director CMS/CPI/AVG/Data Analytics and Systems Group

  Next Meeting – December 16, 2025; 2:30PM – 3:30PM EST

- **Small States Call Update** - Anne Harvey Administrator Program Integrity (Nebraska)

  Next (quarterly) Meeting – January 14, 2026; 2:00PM – 3:00PM EST

11. **Open Discussion**

Next Meeting – November 18, 2025

Please contact the regional representatives listed above to have topics added to future agendas.

AGENDA
Beneficiary Fraud Tag Subgroup
Conference Call

Wednesday, October 22, 2025
1:00PM – 2:00PM (MST)
2:00PM – 3:00PM (CST)

Participant Dialing Instructions:

1. (608) 571-2209
2. Enter the PIN: 141076672#
3. Please mute your audio when you're not speaking.

Discussion Topics:

1. UCOWF
    a. Florida passed a state bill (SB 1227) requiring the State to submit a Section 1115 Waiver to stop doing redeterminations on Medicaid disabled enrollees. UCOWF is concerned as the state will not even conduct Exparte reviews on eligibility requirements. UCOWF has fraud/waste concerns and is currently contemplating an official letter in opposition.

2. Virginia
    a. The position of CMS on the letter dated 12/05/24, and rescinded 05/01/25 (#24-005)

3. New Hampshire
    a. I was wondering if any other states had a working definition of "abuse" as opposed to fraud, and if so, do any other states impose these fines to those they have found committed abuse? I cut out the section of the December 5th guidance (see attachment below) that talks about these fines. I understand that this guidance was rescinded, but I was wondering if these fines are something that other states already had in place and what methodology was used to determine the amount of the fine. Honestly, I wouldn't be surprised if no States had anything like this in place, but I won't know unless I ask.

4. Any other topics?

Next meeting will be **Wednesday, January 28, 2026**.

Please email future agenda topics to: michelle.dehn@state.mn.us

Item 2 Attachment

Permissible Sanctions for Beneficiary Abuse

Sanctions for beneficiary abuse may only be applied by a state Medicaid agency to a beneficiary *after* the completion of a full investigation by the state Medicaid agency that results in a determination that the beneficiary committed abuse.27 Any sanctions for beneficiary abuse other than a warning letter must be approved by CMS and documented in the state plan.28 Such sanctions cannot conflict with other federal statutory or regulatory requirements.

Fines

The state Medicaid agency may administratively impose fines on beneficiaries who commit eligibility abuse as an "other sanction," subject to the limitations explained below and provided that the state's policy for the circumstances under which fines may be imposed and the amount of such fines are documented in an approved Medicaid state plan amendment.30

Fines for abuse imposed administratively by the state Medicaid agency cannot equal or exceed the value of items and/or services provided to, or capitation payments made on behalf of, the beneficiary after the instance of abuse, as this would effectively constitute a recoupment of funds which, as discussed above, violates a beneficiary's due process rights.

To ensure that fines do not function as a *de facto* administrative recoupment, fines must be reasonable in amount and not be correlated with the value of items and services provided to the beneficiary after the instance of abuse. Any fine structure tied to the costs of medical assistance incurred by the state Medicaid agency would effectively serve as a retroactive determination of ineligibility, which, as discussed above, is not permitted. State Medicaid agencies considering fines as an administrative sanction for beneficiary abuse should contact their CMS state lead for technical assistance.

If a state Medicaid agency chooses to impose a fine as a sanction for beneficiary abuse and CMS approves a state plan amendment reflecting the agency's fine policy, any fine imposed effectively increases beneficiary liability. Because an increase in beneficiary liability is an adverse action, the state Medicaid agency must provide at least 10 days advance written notice to the beneficiary, including information regarding the beneficiary's fair hearing rights, prior to imposing a fine for abuse.31 As noted above, no reductions in the advance notice period are authorized for cases of beneficiary abuse.