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June 21, 2025

Committee on the Budget
US House of Representatives
c/o Ryan.Bailey@mail.house.gov

RE: "Reversing the Curse: Rooting Out Waste and Fraud and Restoring the Dignity of Work"

Dear Members of the House Budget Committee:

The United Council on Welfare Fraud (UCOWF) is writing to submit copies of two letters sent to the Centers for Medicare & Medicaid Services regarding Medicaid beneficiary program integrity. Both letters are included in this document to meet House formatting guidelines.

The letters reveal a startling deficiency in the attention to program integrity rules relating to Medicaid Beneficiaries that remain in the aftermath of the Affordable Care Act rollout that remain today. The lack of administrative sanctions and inability for states to recover improper payments are artifacts from the ACA that remain unaddressed.

While the House draft version of HR1, the "One Big Beautiful Bill Act" contain commonsense program integrity initiatives, much more is needed. We fully support directives that address fraud, waste, and abuse in public assistance programs as we testified to in front of the House Oversight and Government Reform DOGE Subcommittee. A copy of the UCOWF testimony can be found here: https://oversight.house.gov/wp-content/uploads/2025/02/Royal-Written-Testimony.pdf. Despite our initial encouragement that the solutions to these problems would be addressed, reform has been slow.

While HR1 Sec. 44103 requires CMS to build a centralized matching system to address dual enrollment, the Executive Branch Agencies have demonstrated they are not best qualified to build or maintain systems relating to fraud and waste in duplicate participation that wastes billions of taxpayer resources.

We urge the Committee to reconsider ceding control over such a critical dual enrollment program integrity function to federal bureaucrats who have already demonstrated an inability to implement efficient or effective safeguards. Consider the following:

- The Public Assistance reporting Information System (PARIS) was created in 1997 by the Administration for Children and Families (ACF) to detect dual enrollments across state Medicaid programs. Although it successfully identified costly duplications between Medicaid and TriCare, it has proven largely ineffective over the past two decades:
    - Matches are quarterly post-eligibility determinations that rely on the ineffective and inefficient "pay and chase" model to address dual enrollment in Medicaid, CHIP, SNAP, and TANF programs.
    - States routinely fail to upload the full Medicaid beneficiary enrollment as demonstrated by a simple review of the Interstate Match transaction counts posted on the PARIS website: https://acf.gov/paris/interstate-match-2025
    - PARIS was offline for an entire year – from February 2024 to February 2025 due to a data sharing agreement expiring between two federal agencies. This has resulted in millions of beneficiaries improperly enrolled in multiple programs in

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multiple states – resulting in billions of wasted taxpayer dollars every month in state and federal capitation payments. From February 2025 PARIS match:

- 68.2 million records were uploaded, yet Florida failed to report its 4.2 million enrollees, and approximately **10 million discrepancies remain**. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights
- The February match located **6.7 million duplicate enrollments – 10% of all records - including over 3.2 million active dual enrollees.** At an estimated $5,000 annual capitation rate, this equates to **$33.4 billion** in preventable waste still occurring.

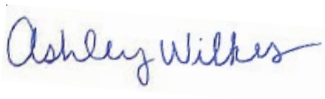
- The problem is not hypothetical. The failures of state and federal agencies to address this issue are shockingly detailed in a recent audit by the Oregon Secretary of State that found the state spent **$445 million** in duplicate payments to individuals living in other states. See October 2024 Report 2024-29, "Oregon Health Authority: Without Federal Action, States Will Continue to Pay Millions of Dollars in Duplicate Medicaid Payments" located at https://sos.oregon.gov/audits/Pages/audit-2024-29-OHA-Medicaid.aspx
- Acknowledging PARIS's shortcomings, Congress funded the **National Accuracy Clearinghouse (NAC)** in 2013 as a pilot to prevent duplicate SNAP participation across states. Independent evaluations confirmed its effectiveness in detecting and stopping dual enrollment, prompting Congress to mandate national expansion in the **2018 Farm Bill**. Despite this clear directive, **USDA Food and Nutrition Services failed to meet the deadline** and instead handed development to the **GSA's 18F team**, which rebuilt NAC on the same flawed, post-eligibility "pay-and-chase" model as PARIS—incapable of real-time prevention, identity resolution, or fraud deterrence. Making matters worse, USDA then issued **regulations prohibiting SNAP matches with other programs**—a restriction with no basis in law and directly opposed to Presidential Executive Order #14243, "Stopping Waste, Fraud, and Abuse by Eliminating Information Silos." https://www.govinfo.gov/content/pkg/DCPD-202500382/pdf/DCPD-202500382.pdf

It is clear that Congress must mandate, fund, and monitor another nation-wide "Unwinding" in Medicaid to remove duplicates, deceased, incarcerated, ineligible, and synthetic identities in all state beneficiary rolls to restore proper stewardship and oversight to the program.

This hearing is yet another opportunity for the Committee to ask tough questions, demand accountability, and restore public confidence in our government services.

Congress must not reward failure with more money and control. Instead, it must demand accountability from both federal and state agencies. Billions of taxpayer dollars are being squandered due to bureaucratic negligence and regulatory defiance. Strong, enforceable oversight is urgently needed to ensure these systems perform as intended, data silos are eliminated, and real-time eligibility checks are mandated across all means-tested programs. Taxpayers deserve better.

Respectfully submitted,



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April 3, 2025
<Sent via e-mail>

Stephanie Carlton
Chief of Staff and Deputy Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Stephanie.Carlton@cms.hhs.gov

RE: SMD #24-005 CMS Letter to State Medicaid Directors

Dear Ms. Carlton,

The United Council on Welfare Fraud (UCOWF) is writing to bring your attention to a CMS guidance letter we believe has caused great confusion and misunderstanding amongst State Medicaid Directors regarding Medicaid beneficiary fraud and overpayments.

What Is UCOWF?

For reference, UCOWF is the only national association singularly focused on the prevention, detection and prosecution of welfare fraud. For over fifty years, UCOWF has advocated for stronger policies to strengthen America's social safety net programs. As a 501(c)(3) nonprofit organization, UCOWF continues to ensure our nation's critical public assistance programs are safeguarded and that taxpayer resources reach society's vulnerable citizens while also connecting policymakers, fraud investigators, and key agency personnel to real world practices resulting in outcomes that reflect program purpose and intent. UCOWF members include county and state investigators conducting administrative and criminal investigations into recipient/beneficiary fraud, as well as the attempt to recover funds lost to fraud.

Background Information

On October 17, 2022, CMS issued Covid Pandemic Health Emergency (PHE) Frequently Asked Questions on Unwinding to all Medicaid agencies.[1] At issue was guidance on Fraud & Abuse/Recoupment:

Fraud & Abuse/Recoupment

Q31: Can a state recover or recoup the cost of services from a beneficiary who committed Medicaid fraud or abuse?

A: No. States cannot recover or recoup the cost of services from a beneficiary, even if they have been found after an administrative or criminal proceeding to have committed Medicaid beneficiary fraud or abuse. States must continue furnishing Medicaid to all beneficiaries until they are determined ineligible per 42 CFR § 435.930(b), and such recovery or recoupment would effectively represent a retroactive termination of Medicaid eligibility, which would violate a beneficiary's due process rights under section 1902(a)(3) of the Act, 42 CFR part 431 subpart E, and relevant Supreme Court due process jurisprudence (*see* Goldberg v. Kelly, 397 U.S. 254 (1970) and its progeny).

The only circumstances under which a state may recover funds from a beneficiary are those explicitly provided for in federal statute and regulation. These include: (1) liens placed on a beneficiary's property when a court judgment finds that Medicaid benefits were improperly paid under section 1917(a) of the Act and 42 CFR § 433.36(g)(1); (2) estate recovery proceedings required under section 1917(b)(1) of the Act; and (3) benefits provided pending the outcome of a fair hearing under 42 CFR § 431.230 (except that benefits provided pending the outcome of a fair hearing during the PHE may not be recouped, and states that do so risk losing enhanced match claimed pursuant to section 6008 of the FFCRA; *see* footnote 9 in the March 2022 SHO Letter # 22-001).

[1] https://www.medicaid.gov/sites/default/files/2022-10/covid-19-unwinding-faqs-oct-2022.pdf

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As a result of this guidance, many state agencies refrained from pursuing the recovery of improper payments or instances of beneficiary fraud—even in cases where the fraud occurred prior to the Public Health Emergency (PHE) or was the result of an enrollee's failure to report changes in circumstances, such as increases in income that would have rendered them ineligible for benefits. This FAQ guidance conflicts with numerous state laws, regulations, and agency policies that specifically address Medicaid beneficiary fraud and the recovery of improperly paid benefits.

The guidance also reflects a fundamental misunderstanding of how states administer public benefit programs, particularly those that involve both federal and state funding, such as Medicaid. CMS appears to assume that the responsibility for investigating and recovering beneficiary fraud rests solely with Medicaid Fraud Control Units (MFCUs). In practice, however, MFCUs primarily focus on provider and licensing fraud and are statutorily limited in their ability to investigate beneficiary fraud.

Most states rely on Integrated Eligibility Systems to streamline eligibility determinations across multiple programs, including Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF). The state and county agencies responsible for eligibility determinations also have well-established processes and authority to investigate, address, and recover overpayments related to beneficiary fraud. These activities often focus on the recovery of state funds, including Medicaid capitation payments made on behalf of ineligible individuals.

By disregarding these state processes and statutory authorities, the FAQ guidance undermines program integrity efforts at the state level and impedes the appropriate recovery of taxpayer-funded benefits that were improperly paid.

UCOWF even addressed this issue in response to a request for our subject matter expertise for the House Budget Committee and House Oversight and Accountability's Improper Payment Working Group.[2]

December 5, 2024 CMS Memo

During the "Lame Duck" period between the November election and January inauguration, CMS Deputy Administrator and Director Daniel Tsai doubled-down on the issue and published SMD#24-005, "Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions."[3]

This memo not only protects fraudsters and prohibits State's from common-sense program integrity measures and recoveries of taxpayer funds lost to eligibility fraud, it threatens to withhold FMAP funds, even if state investigators are following state law:

> As noted above, CMS expects state Medicaid agencies to promptly cease the use of any sanctions or penalties for beneficiary fraud and abuse that are inconsistent with this guidance, including administrative recoupment activities and lock-outs, unless expressly permitted in federal statute and/or regulations. State Medicaid agencies that continue such prohibited actions may be subject to compliance action, including the withholding of federal financial participation, per section 1904 of the Act and 42 CFR § 430.35.

[2] https://www.ucowf.net/assets/pdf/UCOWF+RFI+Response+on+Improper+Payments_FINAL/
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24005.pdf

This guidance also directly conflicts with President Donald J. Trump's priorities to eliminate fraud, waste, and abuse in government programs.

Closing

UCOWF respectfully requests CMS rescind the December 5, 2024 guidance letter and reissue helpful guidance that seeks to encourage agencies to address Medicaid beneficiary fraud, as well as helpful guidance and encouragement to recover both state and federal funds involved with eligibility payments lost to fraud in both administrative and criminal proceedings. Due process that affords beneficiaries the means to dispute state findings are well established and should remain in place.

UCOWF remains dedicated to improving program integrity, and we believe this administration has the opportunity to provide common sense guidance on this issue. We remain committed to assist you and your staff in promoting anti-fraud initiatives and restoring public trust in the effective stewardship of taxpayer funds.

We appreciate your consideration and stand ready to provide any additional information or assistance you may require in supporting these efforts.

Sincerely,

Ashley Wilkes, President
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June 20, 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: Recission of SMD #24-005 and Request for Clarification

Dear Dr. Oz,

The United Council on Welfare Fraud (UCOWF) is writing to request clarification for States on prior guidance regarding Medicaid beneficiary fraud and overpayment recoveries.

Recission of SMD #24-005
On behalf of the UCOWF members and welfare fraud investigators across the nation, we write to express our sincere appreciation to CMS for rescinding SMD #24-005, Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions on May 1, 2025. This action reflects recognition of the concerns we raised in our April 3, 2025, letter to CMS on behalf of state and county welfare fraud investigators and program integrity professionals nationwide, and we thank you for your responsiveness and leadership.

With the memo rescinded, we respectfully request CMS issue clarification to States on a couple of remaining areas of concern relating to Medicaid program integrity:

1. Clarification on CMS Guidance on Recovery of Medicaid Improper Payments
State Medicaid agencies must retain the ability—and indeed be *expected*—to recover overpayments made on behalf of ineligible beneficiaries, particularly when caused by intentional misrepresentation or failure to report changes in circumstances. On October 17, 2022, CMS issued a Covid Pandemic Health Emergency (PHE) Frequently Asked Questions on Unwinding to all Medicaid agencies.[4]

At issue was guidance on Fraud & Abuse/Recoupment (Question 31) that stated, "*States cannot recover or recoup the cost of services from a beneficiary, even if they have been found after an administrative or criminal proceeding to have committed Medicaid beneficiary fraud or abuse.*"

This FAQ comment preceded the rescinded guidance, remains a source of confusion amongst State investigators, recovery specialists, and policy/ program administrators. The guidance also conflicts with President Trump's Executive Orders, including a June 6, 2025, memo to HHS and CMS on "*Eliminating Waste, Fraud, and Abuse in Medicaid*" and Executive Order #14243, "Stopping Waste, Fraud, and Abuse by Eliminating Information Silos."[5]

[4] https://www.medicaid.gov/sites/default/files/2022-10/covid-19-unwinding-faqs-oct-2022.pdf
[5] https://www.whitehouse.gov/presidential-actions/2025/06/eliminating-waste-fraud-and-abuse-in-medicaid/ and https://www.whitehouse.gov/presidential-actions/2025/03/stopping-waste-fraud-and-abuse-by-eliminating-information-silos/

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2. Clarification on Repayment of Recoveries and Federal Share

There have been both HHS OIG and GAO reports/audits which outline States must remit to CMS the FMAP share of overpayment recoveries, not simply the establishment of a claim.[6] UCOWF believes that clear guidance from CMS, along with modifications of the CMS-64 Form, can clearly convey the expectation that States can and will establish Medicaid beneficiary overpayment claims based on state/federal share of payments (capitation rates), AND, remit the appropriate federal share once collected.

3. Clarification on Medicaid Fraud Control Units (MFCUs)

Both the rescinded SMD #24-005 and 2022 FAQ implied that State MFCUs are the sole entities responsible for investigating beneficiary fraud. This interpretation overlooks both statutory limitations and practical realities. MFCUs are primarily tasked with provider fraud and are often organizationally and physically separate from the eligibility offices that detect, prosecute, and recover recipient fraud. At least 35 States currently use an integrated eligibility system that processes Medicaid and other programs (such as SNAP, TANF, CHIP, etc) in a single platform for applicants.

State welfare fraud investigators—many of whom are UCOWF members—are embedded in the agencies responsible for eligibility determinations and are specifically trained to investigate, prevent, and pursue administrative or criminal remedies against recipients who commit fraud. These teams are best positioned to detect discrepancies at the point of application, during redeterminations, or through case monitoring.

To preserve effective program integrity functions, we respectfully request CMS formally clarify that:

- State program integrity units retain authority and responsibility to investigate beneficiary fraud, not just MFCUs.
- States must address this expectation in their respective State Plans.
- MFCUs should continue to focus primarily on provider fraud.
- States may utilize both administrative and criminal processes to pursue improper payments caused by beneficiary fraud.
- CMS will enforce the FMAP penalty provisions of the **Medicaid Extenders Act of 2019** (*Public Law 116-3, enacted January 24, 2019)* for States failing to conduct required eligibility verifications on all applications and redeterminations – including ex-parte reviews.

4. Administrative Sanctions and Recovery Options

Despite administrative Due Process procedures in place for States to address eligibility determinations, allegations of fraud/waste/abuse and improper payment claims in other safety-net programs, no administrative penalties exist to combat Medicaid beneficiary fraud,

[6] **GAO-23-106025**, "CMS Oversight and Guidance Could Improve Recovery Audit Contractor Program," June 2023: https://www.gao.gov/assets/gao-23-106025.pdf.
GAO #107710, "Recovery of Federal Share of Medicaid Overpayments," October 1978: https://www.gao.gov/assets/107710.pdf.
HHS OIG A-07-19-02816, "Colorado Did Not Report and Refund the Correct Federal Share of Medicaid-Related Overpayments for Some Cases Identified by the State's Program Integrity Section," May 2024: https://oig.hhs.gov/documents/audit/9888/A-07-19-02816.pdf
HHS OIG A-06-23-09002, "Twelve Selected States Did Not Accurately Calculate the Federal Share of Medicaid Collections Subject to the Increased Covid-19 Federal Medical Assistance Percentages," December 2024: https://oig.hhs.gov/documents/audit/10125/A-06-23-09002.pdf

such as temporary/term limited or permanent program disqualifications. No common strategy, fraud framework, or collections regulations satisfactorily address these shortcomings.

Administrative sanctions act as a deterrence to eligibility fraud in all other means-tested assistance programs using established due process procedures that protect recipients against unwarranted penalties. We encourage CMS to design regulations that update this deficiency in program rules to restore Medicaid program integrity.

To address the enforcement of improper payment recoveries, we respectfully request CMS to spearhead an initiative with the Department of Treasury to add Medicaid to the Treasury Offset Program and to provide fiscal incentives for States attempting to address recipient/beneficiary oversight and recovery efforts.

In Closing

UCOWF appreciates your leadership in rescinding SMD 24-005 and respectfully requests CMS to provide clear guidance and rulemaking to address the remaining concerns and inequitable state/county program integrity oversight and administration of the Medicaid program as outlined in this letter.

We appreciate the opportunity to work collaboratively with CMS to protect the integrity of Medicaid and other public assistance programs. We stand ready to assist your team in shaping future guidance that reflects the operational realities of State Medicaid administration and ensures taxpayer resources are safeguarded.

Thank you again for your leadership and support.

Sincerely,

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