

**Ranking Member Ron Wyden
Senator Elizabeth Warren
Senator Raphael Warnock
United States Senate Committee on Finance**

Paid to Process, Not to Protect Medicaid Contractors to Receive a Taxpayer-Funded Windfall While Millions of Americans Lose Coverage and Care

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Introduction

On October 10, 2025, Senate Finance Committee Ranking Member Ron Wyden, alongside fellow Finance Committee Senators Warren, Sanders, and Warnock, opened an investigation into four large contractors that build and operate state Medicaid Management Information Systems (MMIS) and Medicaid Eligibility & Enrollment (E&E) systems across the country.¹ Earlier that year, on June 9, 2025, Senators Wyden and Warren had written to the CEO of Maximus, another large Medicaid support contractor, about its lobbying activity and its potential to profit from the implementation of new Medicaid eligibility requirements that would subsequently be enacted by Congressional Republicans in the One Big Beautiful Bill Act of 2025 (OBBBA or H.R.1).²

The core concern of this investigation is that a small handful of companies—some whose technology has a history of grievous errors—will be in charge of implementing historically harsh Medicaid work reporting requirements that never should have been enacted in the first place. Administrative errors in this line of work are not like errors in other fields—there are life-and-death consequences for sick Americans who seek care only to find that their Medicaid coverage has been terminated. The ongoing and well-documented errors made by contractors’ E&E support systems will only be magnified as OBBBA’s new Medicaid work reporting requirements create significant new work for the contractors. As Ranking Member Wyden has said, “[t]hey’re essentially health care middlemen that are in the business of red tape, and they profit when Americans don’t get health care... [w]ithout stronger oversight and real accountability, these contractors are just going to get a jumbo windfall for creating systems that actually harm Americans trying to get health care.”³ The newly enacted Medicaid work reporting requirements take effect on January 1, 2027. When they do, Medicaid enrollees will face a two-pronged threat to coverage: the draconian requirements of the law itself, and the shoddy performance record of the contractors processing new mountains of paperwork.

The market failure that this investigation exposes is not partisan and it did not begin with OBBBA, but Congressional Republicans and the Trump administration have dramatically deepened it. For decades, a small and concentrated group of contractors has dominated the market for Medicaid E&E systems – accumulating federal certifications, entrenched relationships with the Centers for Medicare and Medicaid Services (CMS), and proprietary system architectures that make it prohibitively expensive and operationally risky for states to switch vendors. These

¹ Letter from Ranking Member Wyden and Sens. Warren, Sanders, and Warnock to Conduent, Deloitte, General Dynamics Information Technology, and Gainwell Technologies (Oct. 10, 2025), <https://www.finance.senate.gov/ranking-members-news/wyden-warren-sanders-warnock-probe-medicaid-contractors-on-faulty-eligibility-and-enrollment-systems>

² Letter from Ranking Member Wyden and Sen. Warren to Maximus President and Chief Executive Officer Bruce Caswell (June 9, 2025), https://www.warren.senate.gov/wp-content/uploads/media/doc/letter_to_maximus_on_medicaid_work_requirements1.pdf

³ Rachana Pradhan and Samantha Liss, *Senators Press Deloitte, Other Contractors on Errors in Medicaid Eligibility Systems*, KFF Health News, Oct. 10, 2025, <https://kffhealthnews.org/health-industry/deloitte-contractors-medicaid-eligibility-system-errors-senators/>

dynamics effectively bar smaller or newer competitors from entering the market. States did not build this market and they did not choose it; they inherited it. The systems they rely on today have been built up, patched, and Frankensteined for decades.

On June 1, 2026, the Trump Administration released an Interim Final Rule (IFR) that makes plain how much these Medicaid work reporting requirements will harm Americans and how much they will cost states. In this interim period before January 1, 2027, states are spending millions and racing to become compliant with a law that is both cruel and unworkable. Twenty-five states and the District of Columbia are currently challenging the law in federal court.⁴ Senate Finance Committee Democrats share these interim findings today in order to sound the alarm about what comes next.

State governments working overtime to implement federal eligibility rules need more support than they get from CMS, and OBBBA's work reporting requirements only exacerbate this problem. While the federal government subsidizes the majority of system design and development costs, CMS has yet to establish mandatory performance standards, model contract terms, or meaningful penalties for contractor error. This leaves states largely on their own to manage vendors that "are running circles around states' capacity" to check their work.⁵ The result is a market in which the same contractors repeatedly win bids despite documented track records of harm. Many states are locked into agreements they cannot easily exit, and CMS does not collect the performance data that would allow Congress or the public to track how often these systems fail. Congressional Republicans and the Trump Administration turned a blind eye to these market failures. Now working against the clock to implement a terrible law, states are sending a wave of new business to contractors, often without rigorous vendor due diligence or adequate performance oversight.

⁴ *Massachusetts v. Oz*, No. 1:26-cv-12962 (D. Mass. June 29, 2026).

⁵ Samantha Liss and Rachana Pradhan, *Errors in Deloitte-Run Medicaid Systems Can Cost Millions and Take Years To Fix*, KFF Health News, Sept. 5, 2024, <https://kffhealthnews.org/health-industry/deloitte-run-medicaid-systems-errors-cost-millions-take-years-to-fix/>; see also Medicaid and CHIP Payment and Access Commission (MACPAC), *Issue Brief: State Medicaid Enterprise Systems* (July 2026), <https://www.macpac.gov/wp-content/uploads/2026/07/Issue-Brief-State-Medicaid-Enterprise-Systems-FINAL.pdf> (documenting structural concentration in the E&E and MMIS vendor market and the barriers to entry for smaller competitors).

Investigation Background

The Medicaid program is a cornerstone of the U.S. health care system, and it provides health insurance coverage to more than one in five Americans.⁶ Medicaid covers 40% of U.S. births, provides 20% of hospital funding, and is the single largest payer of long-term services and supports, including nursing home care.⁷ Yet for years, thousands of eligible Medicaid beneficiaries have erroneously been denied or stripped of their Medicaid coverage due to errors in contractors' eligibility systems.⁸ These errors became so widespread that the National Health Law Program (NHeLP), together with the Electronic Privacy Information Center (EPIC) and Upturn, filed a complaint with the Federal Trade Commission in 2024, alleging among other things that Medicaid contractor Deloitte and its Texas system *failed “to accurately automate the relevant eligibility rules”* and that these failures have resulted in *“loss of critical health care coverage and inability to access necessary medical care”* for hundreds of thousands of Texans.⁹ Investigations have also found errors in Deloitte-built systems that led to wrongful termination of coverage for new mothers in Florida, cuts to home care services for people with disabilities in Arkansas, and confusing notices that left beneficiaries in Missouri uncertain whether they had coverage at all.¹⁰ Patient groups in several states are taking legal action against state Medicaid systems and their support contractors.¹¹

It was against this backdrop in 2025 that Congressional Republicans enacted the largest cuts in Medicaid's history with the passage of OBBBA. The Congressional Budget Office (CBO) projects that the law will cut federal Medicaid spending by \$911 billion over 10 years, and that \$326 billion of these cuts will be a result of the new work reporting requirements, forcing 5.3

⁶ KFF, *Health Insurance Coverage of the Total Population* (last accessed Oct. 9, 2026) <https://www.kff.org/state-health-policy-data/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁷ Hannah Grabenstein, *A closer look at who relies on Medicaid*, PBS News, March 26, 2025, <https://www.pbs.org/newshour/health/a-closer-look-at-who-relies-on-medicaid>

⁸ See, e.g. Rachana Pradhan and Samantha Liss, *Senators Press Deloitte, Other Contractors on Errors in Medicaid Eligibility Systems*, KFF Health News, Oct. 10, 2025, <https://kffhealthnews.org/health-industry/deloitte-contractors-medicaid-eligibility-system-errors-senators/> (Florida's E&E system run by Deloitte erroneously slashed Medicaid benefits for new mothers); Rachana Pradhan and Samantha Liss, *Medicaid for Millions in America Hinges on Deloitte-Run Systems Plagued by Errors*, KFF Health News, June 24, 2024, <https://kffhealthnews.org/health-industry/medicaid-deloitte-run-eligibility-systems-plagued-by-errors/> (systems send beneficiaries' paperwork to incorrect addresses, and administrative errors of this sort can take months to fix).

⁹ In re Deloitte Consulting LLP, *Complaint and request for investigation, injunction, and other relief submitted by National Health Law Program, Electronic Privacy Information Center, and Upturn, Inc.* (F.T.C. filed Jan. 31, 2024) <https://healthlaw.org/wp-content/uploads/2024/01/NHeLP-EPIC-Upturn-FTC-Deloitte-Complaint.pdf>

¹⁰ Daniel Chang and Samantha Liss, *Florida's Deloitte-Run Computer System Cut Off New Moms Entitled to Medicaid*, KFF Health News, Nov. 26, 2024, <https://kffhealthnews.org/health-care-costs/florida-deloitte-medicaid-computer-system-women-pregnancy-disenroll/>.

¹¹ See, e.g. Samantha Liss and Rachana Pradhan, *supra* note 5 (discussing litigation in Florida and Tennessee).

million Medicaid enrollees to become uninsured.¹² It is important to acknowledge how this will happen in practice: these new work reporting requirements will strip coverage from millions of enrollees — either by requiring them to work when they cannot, or by requiring mountains of paperwork for eligibility checks that set enrollees up to fail.

Currently, 92% of adults covered by Medicaid are working, going to school, caregiving, or navigating an illness or disability that prevents them from working. While Republicans continue to lie about these cuts — downplaying their importance or denying that they even exist at all¹³ — Democrats will continue to tell Americans the truth: work reporting requirements will strip health insurance coverage from millions of Americans, one at a time. They will do this by making patients jump through a never-ending series of bureaucratic hoops and ending their Medicaid coverage whenever they reach a hoop they struggle to clear. State governments do not have the capacity to monitor the daily activities of each and every person enrolled in the Medicaid expansion group or to keep track of when they are working for pay, working in service of the community, caregiving, looking for work, traveling to treatment, receiving treatment, or navigating other realities of daily life. But OBBBA asks states to do just that, and so the states enlist third party contractors to do it for them.¹⁴

Federal law places the administrative burden of implementing work reporting requirements on states, while the majority of implementation costs are financed by the federal government. Congress has authorized the federal government to cover up to 90% of costs for designing, developing, and installing Medicaid Enterprise Systems (MES), as well as up to 75% of costs for operating and maintaining them.¹⁵ Earlier this year, CMS announced an agreement with ten technology companies, including the five named in this investigation, to offer an alleged \$600

¹² Congressional Budget Office, *Distributional Effects of Public Law 119-21*, Aug. 11, 2025, <https://www.cbo.gov/publication/61367>; see also KFF, *Tracking Implementation of the 2025 Reconciliation Law: Medicaid Work Requirements*, Jun. 29, 2026, <https://www.kff.org/medicaid/medicaid-work-requirements-tracker-overview/>; Samantha Liss and Rachana Pradhan, *States Pay Deloitte, Others Millions To Comply With Trump Law To Cut Medicaid Rolls*, KFF Health News, March 31, 2026, <https://kffhealthnews.org/insurance/state-medicaid-work-requirements-eligibility-systems-deloitte-accenture-optum/>

¹³ See, e.g. Ali Swenson, *FACT FOCUS: RFK Jr. misleads on Medicaid cuts*, Associated Press, Apr. 23, 2026, <https://apnews.com/article/rfk-jr-medicaid-cuts-trump-congress-320d81927079712b3e802d4e93d9f73e> (Secretary Kennedy repeatedly testifying “*There are no cuts to Medicaid.*”)

¹⁴ See Letter from Oregon Gov. Tina Kotek, Maine Gov. Janet Mills, Michigan Gov. Gretchen Whitmer, New York Gov. Kathy Hochul, New Mexico Gov. Michelle Lujan Grisham, and Washington Gov. Bob Ferguson to Health and Human Services Sec. Robert F. Kennedy May 29, 2026, <https://apps.oregon.gov/oregon-newsroom/OR/GOV/Posts/Post/governor-kotek-organizes-multi-state-pushback-against-chaotic-federal-medicaid-mandate> (“*This challenge is compounded by a structural reality of Medicaid administration that CMS understands well: many states do not build or maintain their own IT systems. These systems are built, maintained, and modified by third-party vendors operating under multi-year contracts representing tens – and in many cases hundreds – of millions of dollars in state and federal expenditures.*”)

¹⁵ See MACPAC, *supra* note 5

million worth of discounted support services to states that need to implement new systems.¹⁶ In this niche marketplace where work is concentrated among a handful of large contractors, states have limited options. This is not a market that rewards competition or innovation. It is a market structured around incumbency, and CMS has failed to establish oversight or accountability mechanisms that would give states leverage to demand better vendor performance.

Three months after OBBBA became law, Senators Wyden, Warren, Warnock, and Sanders opened this investigation into the contractors who will earn millions helping states operate the systems they will use to screen individual Medicaid enrollees for compliance with work reporting requirements. Four of the five contractors named in this investigation were selected because they are dominant players in the E&E and MMIS market. Maximus was separately identified based on its public statements regarding its financial interest in OBBBA's passage. All five of these companies are publicly known to hold existing E&E systems contracts with states, and all five have committed to support states in implementing OBBBA's work reporting requirements.¹⁷ The Democratic staff of the Committee notes that these five contractors are not the only entities active in this market, and future investigations may probe the work of additional companies.¹⁸ Initial findings reveal that these companies are preparing for a major windfall of new work without having solved the systemic problems that previously resulted in thousands of eligible individuals being denied coverage.

This investigation probes the historical performance of these contractors. It seeks to answer whether the systems they are building for states are capable of accurately making eligibility determinations. Each company was asked to respond to questions about pay-for-performance incentive structures, the frequency of erroneous coverage terminations, testing protocols, lobbying activity, CEO compensation, and plans to compete for OBBBA implementation contracts. The answers, and more revealingly, the refusals to answer, are detailed in this report.

The companies that are likely tasked with building and operating Medicaid's eligibility and enrollment infrastructure have a documented track record of errors that have wrongly stripped coverage from eligible Americans. In light of these prior errors detailed in the October 2025 letters, Senate Finance Committee Democrats fear that the problems of past performance will only be exacerbated by the bureaucratic complexities of new Medicaid work reporting requirements.

¹⁶ Centers for Medicare & Medicaid Services, *Medicaid Technology Companies Pledge \$600M in Savings to Support Community Engagement and Related State Medicaid System Improvements*, Jan. 29, 2026, <https://www.cms.gov/newsroom/press-releases/medicaid-technology-companies-pledge-600m-savings-support-community-engagement-related-state>. The announcement listed all five contractors named in this investigation.

¹⁷ *Id.*

¹⁸ See, e.g. National Health Law Program, *Medicaid Eligibility System Vendor Map* (last accessed Oct. 6, 2026) <https://healthlaw.org/medicaid-eligibility-system-vendor-map/?state=MO&tab=documents> (listing Accenture, Optum, and RedMane as currently holding vendor contracts with one of more states for E&E or MMIS systems work)

All of the contractors named in this investigation are large, well resourced, and powerful. They will be paid for this work with millions of taxpayer dollars, and they have the capacity to build better systems that put Medicaid applicants and beneficiaries first. It is their responsibility to build systems that make error-free eligibility determinations in accordance with state and federal requirements.

- **Maximus** holds approximately 60% of the market for Medicaid eligibility contractor work and, as of 2019, had earned \$1.7 billion to implement means-testing in Medicaid and the Children’s Health Insurance Program (CHIP) across 28 states and the District of Columbia.¹⁹ Maximus’s role may differ from the other four contractors named in this investigation as it has historically operated call centers, assisted beneficiaries in choosing Medicaid managed care plans as an enrollment broker, and provided other Medicaid member-support services. Further clarification will be necessary, because while Maximus has represented to the Committee that it **does “not build, deploy, or operate MMIS or E&E systems,”** the company’s own website promotes a suite of services related to the implementation of Medicaid work reporting requirements, and claims: “*Maximus connects people to coverage and care through technology-enabled Medicaid eligibility and enrollment, community engagement, fair hearings, clinical services, and provider support for state agencies.*”²⁰
- **Gainwell** is one of the largest MMIS vendors in the country, serving more than 30 states and territories, and more than 50 when including adjacent or modular options.²¹
- **General Dynamics Information Technology (GDIT)** processed 366 million Medicaid claims in 2023 through New York’s eMedNY system alone, representing approximately \$94 billion in authorized payments.²² GDIT also operates North Carolina’s NCTracks system, which processed more than 57 million claims and \$34 billion in payments in state fiscal year 2025.²³

¹⁹ Tracie McMillan, “How One Company Is Making Millions Off Trump’s War on the Poor,” Mother Jones, January/February 2019, <https://www.motherjones.com/politics/2018/12/how-one-company-is-making-millions-off-trumps-war-on-the-poor/>.

²⁰ Maximus, *Medicaid Solutions for State Agencies* (last accessed Oct. 6, 2026), <https://maximus.com/state-and-local-government/medicaid>.

²¹ Gainwell Technologies, *Our History* (last accessed Oct. 9, 2026), <https://www.gainwelltechnologies.com/our-history/>; Fitch Ratings, *Fitch Rates Gainwell's New Other Secured Debt 'B+'/'RR2'* (Aug. 7, 2026), <https://www.fitchratings.com/research/corporate-finance/fitch-rates-gainwell-new-other-secured-debt-b-rr2-07-08-2026>.

²² General Dynamics Information Technology, *eMedNY System Elevates Medicaid Payment Efficiency, Providing Healthcare Access to Millions of New Yorkers* (last accessed Oct. 9, 2026), <https://www.gdit.com/perspectives/case-studies/emedny-system-elevates-medicaid-payment-efficiency-providing-healthcare/>.

²³ State of North Carolina, *North Carolina Medicaid Annual Report for State Fiscal Year 2025*, <https://medicaid.ncdhhs.gov/medicaid-state-fiscal-year-2025-report/download?attachment>; North Carolina Dept. of Health and Human Services, *Annual Report Tables Dashboard* (last accessed Oct. 9, 2026), <https://medicaid.ncdhhs.gov/reports/dashboards/annual-report-tables-dashboard>.

- **Conduent** currently holds MMIS contracts in seven states and the District of Columbia; it holds eligibility and enrollment contracts in ten additional states.²⁴
- **Deloitte**, though it declined to disclose its full contract list, holds contracts across at least 25 states, including Oregon, worth a combined \$6 billion or more.²⁵

This report is an interim finding, and the investigation is ongoing. The five contractors named herein are not the only entities that hold contracts with states for E&E or MMIS work, and the Committee will continue to monitor vendors' work across all fifty states as work reporting requirements take effect.

This investigation began by asking contractors a series of questions to determine whether they are up to the task of implementing Medicaid work reporting requirements on behalf of states, and the Committee's interim findings show that we cannot conclude they are. Senate Finance Committee Democrats are releasing this report, and making the companies' written responses public, to show the American people the flippancy with which these companies responded to critical Congressional oversight. The interim recommendations in this report are also actionable now regardless of which vendors ultimately hold OBBBA implementation contracts. The responses submitted to this Committee should serve as a warning for what lies ahead — the companies who stand to profit from new Medicaid work reporting requirements evaded hard questions about past performance, current process, and the potential for errors that cause widespread harm. Their written responses give the Committee no confidence that their systems will be error-free by January 1, 2027. The contractors named here, and those not yet reached, should expect further inquiry.

The Road to January 2027: The IFR and a Record of Failure Prior to Implementation

The chaos of implementing OBBBA's work reporting requirements did not begin with these contractors. Before a single state could issue new or amended vendor contracts or begin reconfiguring its systems, the Trump administration had already set the stage for policy failures that would cascade down from Congress to the U.S. Department of Health and Human Services (HHS) to state governments to contractors to families across the country. From December 2025 through May 2026, CMS issued interim guidance, held calls with state officials, and provided

²⁴ Written responses submitted to Senate Finance Committee staff by Michael Krawitz, EVP and General Counsel, Conduent Incorporated, October 30, 2025. (See Appendix).

²⁵ Rachana Pradhan and Samantha Liss, *Senators Press Deloitte, Other Contractors on Errors in Medicaid Eligibility Systems*, KFF Health News, Oct. 10, 2025, <https://kffhealthnews.org/health-industry/deloitte-contractors-medicare-eligibility-system-errors-senators/>

agency slide decks with implementation guidance. CMS abruptly reversed itself in June, and as is often the case with Republican policy failures, Americans will pay the price.

Congressional Republicans knew all along that this timing would cause chaos and harm. They laid this groundwork as they established the implementation timeframes in OBBBA, purposefully choosing to implement Medicaid work reporting requirements *immediately after the mid-term elections*. They tried to side-step the political ramifications of their policy choices, significantly compounding the challenges states face as they race to set up reliable eligibility systems. This in turn contributed to states' reliance on a consolidated market of enrollment contractors and middlemen.

On June 1, 2026, CMS issued its IFR, a regulation that was supposed to provide clarity but instead delivered a last-minute policy reversal and upended months of implementation planning based on prior guidance.²⁶ Congress had set two deadlines: 1) states must begin sending notices to Medicaid members about the new requirements by August 31, 2026, and 2) the requirements themselves must take full effect on or before January 1, 2027.²⁷ The IFR arrived with three months remaining before the first of those deadlines. The IFR also arrived at a moment when states were already mid-construction on systems they had been building based on preliminary CMS guidance – guidance that the IFR abruptly reversed.²⁸

Together, OBBBA and the IFR impose a new burden on Medicaid enrollees in the expansion group that they have never before faced: documenting 80 hours per month of qualifying work, education, job training, or community service as a condition of keeping their coverage.²⁹ For the many Medicaid enrollees who are shift workers, gig workers, agricultural laborers, informal caregivers, or people whose hours fluctuate and whose employment is not reflected in tidy payroll records, satisfying this requirement is not a simple administrative step. It presents a recurring monthly gauntlet. The statute and the IFR require states to verify compliance primarily through “reliable information available to the State” such as electronic data sources, payroll records, and claims data from the preceding twelve months before they may ask members for additional documentation.³⁰ When such data is unavailable, which will be common for new applicants and those earning their livelihood across several jobs, states must request documentation from the individual, compounding the burden on the people least equipped to shoulder it.

²⁶ Medicaid Program; Community Engagement Requirement for Certain Individuals, 91 Fed. Reg. 33348 (June 3, 2026).

²⁷ Pub. L. No. 119-21, § 71119, 139 Stat. 72, 306-315 (2025) (codified at 42 U.S.C. § 1396a(xx)).

²⁸ See e.g., State of North Carolina Office of Governor Stein, *Governor Stein, NCDHHS Call on CMS to Protect Medicaid for People with Cancer and Severe Illnesses*, July 30, 2026, <https://governor.nc.gov/news/press-releases/2026/07/30/governor-stein-ncdhhs-call-cms-protect-medicaid-people-cancer-and-severe-illnesses>.

²⁹ 42 U.S.C. § 1396a(xx)(1).

³⁰ 91 Fed. Reg. 33474-75.

The IFR's most contested provision arbitrarily narrows who is exempt from work reporting. OBBA established categorical exemptions from the work reporting requirements for individuals who are “medically frail or otherwise have special medical needs,” defining that category to include people who are blind or disabled, who have a substance use disorder, who have a disabling mental disorder, who have a physical or developmental disability that significantly impairs their daily activities, or who have a “serious or complex medical condition.”³¹ Congressional Republicans applied a functional impairment test – which asks whether the condition impairs the ability to perform activities of daily living – to only one of those five subcategories, **but the IFR applies it to all of them**, requiring that an individual's condition “significantly impair” their ability to comply with work reporting requirements in order to receive any exemption.³²

In other words, having a serious chronic condition is not enough to qualify for an exemption from the new work reporting requirements; a person must have a serious chronic condition and also have documented proof or an arbitrary combination of medical claims that the condition inhibits their ability to work in order to meet the “significantly impair[ed]” standard.³³ Therefore, a person managing cancer whose treatment is working, a person living with a serious mental illness who is stable on medication, or a person living with diabetes whose condition fluctuates may all be found ineligible for the exemption – not because they are well, but because they must prove their condition is bad enough on the day they are evaluated to satisfy an undefined threshold that CMS has offered states no guidance for applying.³⁴ In yet another example of CMS’s arbitrary interpretation, the IFR separately invented a restriction Congress never wrote: individuals with substance use disorders who have been in recovery for five or more years are excluded from the exemption entirely, on the theory that long-term recovery means their disorder no longer significantly impairs their ability to work.³⁵

Beginning in 2028, individuals may self-attest to qualifying as medically frail only once per period of enrollment, creating a perverse incentive to cycle through coverage losses in order to reset the clock and preserve the ability to access an exemption, the opposite of continuity of care.³⁶ Critically, CMS's own regulatory impact analysis concedes that **seven percent of individuals who are fully compliant with work reporting requirements or who qualify for an**

³¹ 42 U.S.C. § 1396a(xx)(9)(A)(ii)(V).

³² 91 Fed. Reg. 33472.

³³ Centers for Medicare & Medicaid Services, *Implementing Medical Frailty Under Community Engagement (Section 71119 of WFTC Legislation)* (last accessed Oct. 13, 2026), <https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement/ImplementingMedicalFrailtyDeck.pdf>.

³⁴ 91 Fed. Reg. 33373-74; see also Sara Rosenbaum et al., *Medical Frailty Rule Contravenes HR 1, Burdens the Health Care System, and Threatens Public Health*, Health Affs. Forefront (June 12, 2026), <https://www.healthaffairs.org/content/forefront/medical-frailty-rule-contravenes-hr-1-burdens-health-care-system-and-threatens-public>.

³⁵ 91 Fed. Reg. at 33374.

³⁶ *Id.* at 33476.

exemption will lose coverage anyway due to administrative and procedural failures.³⁷ The CBO projects that half of the 5.3 million people who will lose Medicaid coverage under OBBBA's work reporting requirements by 2034 will do so because the verification process will be too difficult for them to navigate (approximately 2.8 million people).³⁸ CBO also projects an additional 700,000 losing coverage from the six-month redetermination requirement, and of those, 70% will lose coverage for procedural reasons.³⁹ These are not people who failed to qualify – they are eligible Americans who will be stripped of coverage because they could not navigate a system designed to pile on paperwork, not to protect care.

The operational demands of this system fall on state Medicaid agencies and on the contractors—including those named in this investigation—that build and operate their eligibility systems. Some states develop these systems in-house; most rely on private vendors. Verifying which enrollees are subject to work reporting requirements, determining individuals' eligibility for exemptions, navigating the unworkable medical frailty exemption, identifying individuals who have not documented sufficient hours, triggering the required notice process, and generating new member notices – all of it must be built into, or layered on top of, existing E&E systems. Those changes must be specified in writing, memorialized in contracts with vendors, tested and submitted for CMS certification, independently validated, and implemented. States that already had implementation plans underway, built based on CMS guidance the IFR reversed, must now rebuild on even more compressed timelines. The consequences of that compression will not be borne by the contractors or CMS. When the January 2027 deadline arrives, states whose systems are not yet updated to reflect the new requirements will face an impossible choice: delay enforcement and risk federal penalties, or proceed with systems that are not ready and guarantee wrongful disenrollments of eligible people. The states implementing these systems are not passive actors, but they are operating under constraints that Congressional Republicans, the Trump administration, and decades of federal inaction on contractor oversight have imposed on them.

Congressional Republicans enacted a fundamentally cruel law with an unworkable implementation timeline and no accountability mechanism for wrongful disenrollment. The Trump administration invented eligibility restrictions it had no statutory authority to impose. States are scrambling to comply with these arbitrary terms, often without the technical capacity, the contract leverage, or the CMS guidance they would need to do so reliably; and the vendors building the

³⁷ *Id.* at 33460.

³⁸ Letter from Congressional Budget Office to Hon. Ron Wyden, Hon. Frank Pallone Jr., and Hon. Richard E. Neal Re: Estimated Effects on the Number of Uninsured People in 2034 Resulting from Policies Incorporated Within CBO's Baseline Projections and H.R. 1, the One Big Beautiful Bill Act (June 4, 2025), https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf; Congressional Budget Office, *Supplemental Cost Estimate* (Oct. 28, 2025) <https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%200.pdf>.

³⁹ Congressional Budget Office, *Supplemental Cost Estimate* (Oct. 28, 2025), <https://www.cbo.gov/system/files/2025-10/PL-119-21-Medicaid%200.pdf>.

systems have a documented track record of producing errors that strip eligible people of coverage even under ordinary conditions.

State Snapshot: Georgia as Cautionary Tale

The state of Georgia provides an informative case study. Georgia did not wait for Congress and OBBBA to impose its own work reporting requirements on Medicaid enrollees. In July 2023, Governor Brian Kemp launched "Pathways to Coverage" (Georgia Pathways) making Georgia the first state to sustain a Medicaid work reporting requirement under a Section 1115 demonstration waiver.⁴⁰ Georgia Pathways covers low-income Georgians earning up to 100% of the federal poverty level who document 80 hours per month of qualifying activities.⁴¹ The state projected 25,000 enrollees in the first year.⁴² After two years, as of June 2025, approximately 8,077 Georgians were actively enrolled, no more than seven percent of the 180,000 to 200,000 uninsured, low-income adults.⁴³

The cost of building and administering this system has been staggering. A Government Accountability Office (GAO) review found the state spent more than twice as much on administration as on health care for enrollees, with over \$54 million going to administration and roughly \$26 million to benefits.⁴⁴ Total program costs exceeded \$80 million, with \$27 million going to consultants.⁴⁵ The state's own independent evaluation, commissioned by the Kemp administration, reportedly confirms the program failed to meet its two primary goals: enrolling people in health care and increasing employment.⁴⁶ A peer-reviewed study reached the same conclusion.⁴⁷ The tracking system built to verify compliance cost \$91 million in taxpayer funds, translating to \$13,000 per enrollee in administrative costs, nearly five times total spending on actual health care benefits for those enrolled.⁴⁸ Notably, Deloitte, one of the companies implicated

⁴⁰ Leah Chan, *Georgia's Pathways to Coverage Program: The First Year in Review*, GBPI (Oct. 29, 2024), <https://gbpi.org/georgias-pathways-to-coverage-program-the-first-year-in-review/>.

⁴¹ Ga. Dep't of Cmty. Health, *Georgia Pathways to Coverage: Eligibility*, (last visited Aug. 24, 2026) <https://pathways.georgia.gov/eligibility>.

⁴² Margaret Coker, *Georgia Touts Its Medicaid Experiment as a Success. The Numbers Tell a Different Story*, ProPublica/The Current (Feb. 19, 2025), <https://www.propublica.org/article/georgia-medicaid-work-requirement-pathways-to-coverage-hurdles>.

⁴³ Ellie Pourbohloul, *What Three Years of Georgia's Medicaid Work Requirement Show as the Policy Goes National*, Emory Rollins Sch. of Pub. Health (July 29, 2026), <https://sph.emory.edu/news/what-three-years-georgias-medicaid-work-requirement-show-policy-goes-national>.

⁴⁴ U.S. Gov't Accountability Off., GAO-25-108160, *Medicaid Demonstrations: Information on Administrative Spending for Georgia Work Requirements* (Sept. 3, 2025), <https://www.gao.gov/assets/gao-25-108160.pdf>.

⁴⁵ Margaret Coker, *Georgia's Medicaid work requirement program spent twice as much on administrative costs as on health care, GAO says*, The Current (Sept. 24, 2025), <https://thecurrentga.org/2025/09/24/georgia-pathways-medicaid-work-requirement-gao-report/>.

⁴⁶ Margaret Coker, *supra* note 42.

⁴⁷ Daniel Y. Johnson et al., *Insurance Coverage and Employment After Medicaid Expansion with Work Requirements: Quasi-Experimental Difference-in-Differences Study*, BMJ (Sept. 5, 2025), <https://www.bmj.com/content/390/bmj-2025-086792>.

⁴⁸ Margaret Coker, *supra* note 45.

in this investigation, built Georgia's eligibility system and serves as the primary consultant for Georgia Pathways.⁴⁹

On August 14, 2026, just months before OBBBA's national work reporting requirement framework was set to take effect, the Georgia Department of Community Health filed documents warning that Georgia Pathways is "unsustainable" and threatening to shut it down entirely unless the federal government increases its financial support from the current two-thirds match to the 90% match rate available to states that fully expanded Medicaid.⁵⁰ Georgia, which chose not to fully expand Medicaid, does not legally qualify for that rate. Having to shut down Pathways is a vivid illustration of what happens when the administrative cost of work reporting requirements outpaces the benefits they are deemed to deliver. Governor Kemp spent years defending work reporting requirements as a national model, and that model may now collapse under the weight of the very federal law he supported.⁵¹ Meanwhile, the contractors who built Georgia's system are among those now positioning themselves to bid on implementation contracts with other state agencies across the country.

Georgia's experience is not an implementation failure that better technology could fix. **It is evidence of what work reporting requirements actually do: they consume resources that could fund care, and they strip coverage from people who cannot navigate administrative complexity, regardless of whether those people are eligible.** When Arkansas attempted to implement Medicaid work reporting requirements in 2018, 17,000 people lost coverage in four months because they lacked internet access, never received notices, or could not navigate a glitchy website.⁵² Michigan paused similar plans after projecting that 80,000 enrollees, fully one third of program participants, would lose coverage.⁵³

⁴⁹ Margaret Coker, *The Firm Running Georgia's Struggling Medicaid Experiment Was Also Paid Millions to Sell It to the Public*, ProPublica/The Current (May 14, 2025), <https://www.propublica.org/article/deloitte-georgia-medicaid-work-requirement-pathways-campaign>; *Broken Pathways: How the nation's only Medicaid work requirement policy fails Georgians*, The Current, (May 15, 2025), <https://thecurrentga.org/2025/05/15/series-medicaid-georgia-pathways-work-deloitte/>.

⁵⁰ Ariel Hart, *Would Gov. Brian Kemp Really Shut Down His Pathways Medicaid Program?*, WABE/Georgia Recorder (Aug. 20, 2026), <https://www.wabe.org/would-gov-brian-kemp-really-shut-down-his-pathways-medicaid-program/>.

⁵¹ *Id.*; Laura Harker, *CMS Extends Georgia's Medicaid Waiver Program, Despite GAO Report Raising Concerns with Costs*, Center on Budget & Policy Priorities (Sept. 23, 2025), <https://www.cbpp.org/research/federal-budget/executive-action-watch?item=30362>.

⁵² Pamela Herd & Donald Moynihan, *Health Policy Brief: How Administrative Burdens Can Harm Health*, HealthAffairs (Oct. 2, 2020), <https://www.healthaffairs.org/doi/10.1377/hpb20200904.405159/>.

⁵³ Jesse Cross-Call, *Michigan Nearing Large Medicaid Coverage Losses Due to Work Requirements*, Center on Budget & Policy Priorities (Mar. 4, 2020), <https://www.cbpp.org/blog/michigan-nearing-large-medicaid-coverage-losses-due-to-work-requirements>.

Companies' Responses

The Committee received a written response from all companies named in this investigation.⁵⁴ While the Committee appreciates the vendors' written responses, they leave most of the investigation's questions unanswered. They reveal a pattern of evasion, incomplete disclosure, and disregard for Congressional oversight.

Several notable patterns emerge across the companies' responses:

- **All five vendors deny having any kind of “pay for performance” provision in their E&E and MMIS contracts with state agencies.** Deloitte writes, for example, *“None of Deloitte’s state Medicaid-related contracts include pay-for-performance clauses that tie payments or revenue to the number of individuals removed from Medicaid.”* Conduent elaborates: *“No. First, the decision to remove [a] Medicaid recipient from eligibility is reserved for the State agency. Second, since Conduent’s compensation is generally based on a per member per month basis, the removal of a Medicaid recipient reduces our compensation.”* Maximus confirmed its compensation is based on per-call pricing, per-transaction fees, or fixed fees, with service level agreement remedies tied to accurate execution of state policy, timeliness, and call quality. Maximus also noted that states may assess liquidated damages, withhold payments, impose service level penalties, and require corrective action when it fails to meet those standards.
 - The responses on this point raise questions for further investigation. Deloitte wrote in its response: *“It is common for systems contracts to include service levels, holdbacks/retainages, performance measures, or other similar structures requested by our clients. The specifics of such clauses vary across projects and clients based on the state client’s priorities and needs. None of these clauses or structures in our Medicaid contracts are tied to removal of individuals from Medicaid.”* It is vital that taxpayers know what kind of “performance measures” are being written into these contracts and whether they are designed to optimize for benefits delivered, benefits denied, patient outcomes, or some other kind of “savings” or “efficiency” benchmarks.
 - Furthermore, what Deloitte and other vendor responses do not address is whether they in practice classify their own system errors as billable “enhancements” rather than no-cost “defects.” This uncertainty allows for scenarios where contractors

⁵⁴ The October 10, 2025 letters to Deloitte, Conduent, GDIT, and Gainwell requested responses by October 31, 2025; each of these four companies responded in a timely manner on or before that deadline. Maximus first received a letter from Senators Wyden and Warren on June 9, 2025, and the company transmitted an initial response on June 16, 2025. After the investigation expanded to include additional companies, Senators Wyden, Warren, and Sanders sent a private letter to Maximus on October 31, 2025 in order to comport with the broader investigation and to align the questions posed to Maximus with the questions posed to the other four companies. Maximus responded to this second letter on November 24, 2025.

effectively charge states and taxpayers twice: once for a system that produces errors, and again for “enhancements” that fix the errors.

- **No vendor provided historical data on the number of individuals their systems have referred to state Medicaid offices as ineligible or potentially ineligible for coverage.** Similarly, no vendor provided data on how many of those referrals were for administrative reasons (e.g., missing a paperwork deadline) versus substantive eligibility failures (e.g., earning income over the relevant threshold).
- Throughout their written responses, all of the vendors leaned heavily on the argument that eligibility determinations are ultimately made by state agencies. Maximus was the most explicit on this point, stating that it “*does not decide who qualifies for Medicaid coverage in these programs; only the state does*” and that its systems “*receive and use eligibility data transmitted by the state*” rather than making independent eligibility determinations. This posture downplays the crucial importance of the contractors’ work and deflects responsibility for getting it right. While it is true that state agencies are tasked with implementing the federal regulations and setting Medicaid eligibility parameters accordingly, the contractors are tasked with **operationalizing** these parameters. They build systems that act as the front line and the first clearinghouse for Americans seeking Medicaid coverage. Their posture in the written responses also reflects a dynamic that runs throughout this market: vendors use the formal legal responsibility of state agencies as a shield against accountability for operational failures that are, in practice, theirs. States set the parameters; contractors build and run the systems. When the systems produce wrong answers, states bear the legal and political consequences while vendors collect their fees and move on to the next contract.
- **No vendor provided their Medicaid E&E and MMIS contracts as requested.** A question for further investigation, therefore, is what these contracts say. Americans need to know whether these contracts provide adequate incentives for vendors to provide error-free analysis and administrative support. They also deserve to know whether the contract language drives companies to err on the side of preventing coverage denials and interruptions in any borderline or ambiguous cases.
- **None of the vendors provided information about the documents they collect and review to assess an individual’s Medicaid eligibility.** While it is true that the ultimate responsibility for eligibility determinations rests with state governments, the contractors do important front-line work in compiling and processing documentation that supports state agencies’ decisions. The companies failed to adequately answer questions about how they do this work, and they repeatedly denied responsibility for its consequences.
- **None of the vendors disclosed their CEO’s annual compensation.**

- **None of the vendors provided meaningful detail on how they test and monitor E&E systems for accuracy.** Moreover, Deloitte, which holds contracts across at least 25 states, also sells auditing and advisory services, creating a structural conflict of interest if it were permitted to audit its own or its competitors' Medicaid support services.
- **No vendor provided planning documents for OBBBA implementation bids, despite several companies confirming that they intend to compete for these contracts.**

In addition to these topline takeaways, the written responses received by each company are briefly summarized below. The companies' written responses to the Committee are also included as an appendix to this report.

Deloitte

Question to Contractor	Contractor's Response
Any “pay-for-performance” provisions that tie your payment with the number of individuals removed from Medicaid?	ANSWERED <i>“None of Deloitte’s state Medicaid-related contracts include pay-for-performance clauses that tie payments or revenue to the number of individuals removed from Medicaid.”⁵⁵</i>
What documentation do you require to determine an individual’s eligibility?	NOT ANSWERED
Penalties for wrongly terminating an individual’s Medicaid eligibility?	NOT ANSWERED
Have CMS or state agencies brought any compliance actions against you?	NOT ANSWERED
Over the past 5 years: how many people have you referred to state Medicaid offices as ineligible for Medicaid coverage?	NOT ANSWERED
Do you administer work requirements in TANF or SNAP? If yes, what is the process for hardship exemptions?	PARTIALLY ANSWERED <i>“While state systems maintained and enhanced by Deloitte may be used by state staff or other vendors who implement welfare-to-work programs for Federal assistance programs such as TANF or SNAP, we do not provide welfare-to-work program placement services.”</i>
Do you have processes for dispute resolution or appeals when beneficiaries seek to appeal an eligibility decision?	ANSWERED <i>“Deloitte does not determine the processing or denial of hardship exemptions. In addition, we are not the initial arbiter of Medicaid eligibility, and do not decide appeals of initial determinations, as the government retains responsibility for determining eligibility.”</i>

⁵⁵ Letter from Lindsay Hough (Principal, Deloitte Consulting LLP) to Sens. Wyden, Sanders, Warnock, & Warren (Oct .31, 2025) (See Appendix).

Question to Contractor	Contractor's Response
Do you plan to compete for state contracts to implement the new Medicaid work requirements enacted in H.R.1?	ANSWERED <i>"We are not aware of any competitive requests for proposals (RFPs) to implement the new Medicaid eligibility requirements related to community engagement. If such RFPs are issued, depending on the scope and vendor requirements, we would consider responding and would then plan accordingly."</i> ⁵⁶
Federal law requires states to inform individuals on how to access ACA marketplace coverage when they lose Medicaid coverage. Do your contracts require you to share this information with individuals or assist them in finding marketplace coverage?	PARTIALLY ANSWERED <i>"State systems supported by Deloitte <u>may</u> process notices to individuals when they lose Medicaid coverage. The processing of notices to individuals by vendors performing these services is carried out in accordance with the state's direction."</i>
Are there any states where you hold contracts related to both Medicaid and ACA enrollment and eligibility?	NOT ANSWERED
What are your annual and total lobbying expenditures over the past 5 years?	NOT ANSWERED
What are your annual and total lobbying expenditures over the past 5 years, specifically related to Medicaid work requirements?	ANSWERED <i>"Deloitte has not incurred federal, state, or local lobbying expenditures in the past five years to advocate for or against the creation of work requirements for Medicaid."</i>
What is your CEO's annual total compensation?	NOT ANSWERED
How do you test and monitor the MMIS and E&E systems for accuracy?	NOT ANSWERED

⁵⁶ While this may have been true when Deloitte transmitted its response to the Committee on October 31, 2025, public reporting has since revealed at least one state where Deloitte's contracts for Medicaid work have significantly expanded since OBBBA was signed into law. See Vaughn Golden, *How Kathy Hochul's admin handed firm a \$1B Medicaid contract without competitive bidding*, New York Post, Sept. 27, 2026, <https://nypost.com/2026/09/27/us-news/how-kathy-hochuls-admin-handed-firm-a-1b-medicaid-contract-without-competitive-bidding/> (New York's Department of Health expanded its contract with Deloitte for "Medicaid Eligibility and Client Management (MECM)" and signed an \$866 million contract amendment in August 2026).

Question to Contractor	Contractor's Response
Do you share code and collaborate with other vendors in other states, or do you keep systems proprietary?	ANSWERED Code is sometimes (but not always) shared.
Do you collaborate with CMS to share code or other IT resources related to MMIS and E&E systems?	ANSWERED Code is sometimes (but not always) shared.
How do you staff the teams that manage these contracts?	NOT ANSWERED
List all MMIS and E&E contracts you received from 2014 to present. Provide all contracts and Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.	NOT ANSWERED

Conduent

Question to Contractor	Contractor's Response
Any “pay-for-performance” provisions that tie your payment with the number of individuals removed from Medicaid?	ANSWERED <i>“No. First, the decision to remove Medicaid recipients from eligibility is reserved for the State agency. Second, since Conduent’s compensation is generally based on a per member per month basis, the removal of a Medicaid recipient reduces our compensation.”</i>
What documentation do you require to determine an individual’s eligibility?	NOT ANSWERED The company responded that eligibility decisions are reserved for state agencies and provided no detail on Conduent’s role; its written response provides no examples of documentation collected.
Penalties for wrongly terminating an individual’s Medicaid eligibility?	NOT ANSWERED
Have CMS or state agencies brought any compliance actions against you?	ANSWERED <i>“Conduent has not been the subject of adverse compliance actions by CMS or any State Medicaid agencies.”</i>
Over the past 5 years: how many people did you refer to state Medicaid offices as ineligible for Medicaid coverage?	NOT ANSWERED The company responded that eligibility decisions are reserved for state agencies.
Do you administer work requirements in TANF or SNAP? If yes, what is the process for hardship exemptions?	ANSWERED <i>“Work requirement programs relative to TANF and SNAP are administered directly by the State agencies. Conduent does not operate any welfare-to-work program for any other programs.”</i>
Do you have processes for dispute resolution or appeals when beneficiaries seek to appeal an eligibility decision?	ANSWERED <i>“No; we understand that as a general rule, contractors such as Maximus have independent review organization (IRO) contracts with States and CMS. Conduent’s role in an eligibility dispute process would normally be limited to producing records from the system requested by the State agency.”</i>

Question to Contractor	Contractor's Response
Do you plan to compete for state contracts to implement the new Medicaid work requirements enacted in H.R.1?	ANSWERED Unknown at time of writing.
Federal law requires states to inform individuals on how to access ACA marketplace coverage when they lose Medicaid coverage. Do your contracts require you to share this information with individuals or assist them in finding marketplace coverage?	PARTIALLY ANSWERED <i>“Conduent does not assist the applicant,” but “when a state agency makes an ineligibility decision, it may provide Conduent with a template to mail to ineligible Medicaid applicants containing general information on how to apply for Qualified Health Plans (QHPs) through the ACA marketplace and/or a State-based marketplace.”</i> In their written response, Conduent declined to say whether they are contractually required to provide notice and whether they do so uniformly to all affected individuals.
Are there any states where you hold contracts related to both Medicaid and ACA enrollment and eligibility?	ANSWERED Yes, in Kentucky. Conduent “provides eligibility services” for both ACA and Medicaid programs under one contract in Kentucky.
What are your annual and total lobbying expenditures over the past 5 years?	NOT ANSWERED
What are your annual and total lobbying expenditures over the past 5 years, specifically related to Medicaid work requirements?	ANSWERED <i>“Conduent has not engaged in any lobbying activity advocating for the creation of work requirements for Medicaid.”</i>
What is your CEO’s annual total compensation?	NOT ANSWERED
How do you test and monitor the MMIS and E&E systems for accuracy?	PARTIALLY ANSWERED The written response lists some names of testing types but provides no detail about how the testing was carried out or what types of issues the testing identified.

Question to Contractor	Contractor's Response
Do you share code and collaborate with other vendors in other states, or do you keep systems proprietary?	ANSWERED Occasionally. <i>“On a case-by-case basis, and in response to a particular MMIS or E&E RFP, Conduent will enter into teaming agreements with other companies in order [to] bring together skill sets, experiences, and technologies that allow us to submit a responsive and competitive proposal.”</i>
Do you collaborate with CMS to share code or other IT resources related to MMIS and E&E systems?	ANSWERED <i>“It is Conduent’s experience that CMS encourages transfer systems and approves State contracts with transfer systems. The collaboration is actually done between States.”</i>
How do you staff the teams that manage these contracts?	ANSWERED <i>“This information is not tracked and reported. The cost of Key Personnel is usually not individually billed under a contract; rather their cost is wrapped into a monthly support fee or cost per member fee.”</i>
List all MMIS and E&E contracts you received from 2014 to present. Provide all contracts and Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.	PARTIALLY ANSWERED Conduent did not share any of its contracts with the Committee but responded that it currently holds MMIS contracts in seven states and the District of Columbia; it currently holds E&E contracts in ten states.⁵⁷

⁵⁷ Written responses submitted to Senate Finance Committee staff by Michael Krawitz, EVP and General Counsel, Conduent Incorporated, October 30, 2025. (See Appendix).

Gainwell

Question to Contractor	Contractor's Response
Any “pay-for-performance” provisions that tie your payment with the number of individuals removed from Medicaid?	ANSWERED <i>“[N]o Gainwell contract includes pay-for-performance clauses or other mechanisms that tie payment to the number of individuals removed from Medicaid.”⁵⁸</i>
What documentation do you require to determine an individual's eligibility?	NOT ANSWERED
Penalties for wrongly terminating an individual's Medicaid eligibility?	NOT ANSWERED
Have CMS or state agencies brought any compliance actions against you for failure to deliver on contract terms?	PARTIALLY ANSWERED <i>“Gainwell has not been the subject of any compliance actions by CMS,” but the company did not answer whether any state agencies have brought compliance actions.</i>
Over the past 5 years: how many people did you refer to state Medicaid offices as ineligible for Medicaid coverage?	NOT ANSWERED <i>“Gainwell does not have any active contracts with any state agency to provide Medicaid eligibility determinations or the removal of individuals from Medicaid. Moreover, we do not have data on individuals referred to state Medicaid offices as ineligible for coverage, nor do we receive the justifications for such determinations.”</i>
Do you administer requirements in TANF or SNAP? If yes, what is the process for hardship exemptions?	ANSWERED No.
Do you have processes for dispute resolution or appeals when beneficiaries seek to appeal an eligibility decision?	ANSWERED No.

⁵⁸ Letter from Mark Knickrehm, Chairman and CEO, Gainwell Technologies, to Sens. Wyden, Sanders, Warren, and Warnock, October 31, 2025. (See Appendix).

Question to Contractor	Contractor's Response
Do you plan to compete for state contracts to implement the new Medicaid work requirements enacted in H.R.1?	ANSWERED Yes. <i>"While Gainwell has not begun to do so, we plan to compete for contracts to implement the new Medicaid eligibility requirements stemming from H.R. 1 using Gainwell's proprietary Community Engagement Verification (CEV) solution. Gainwell's CEV will be a comprehensive technology and services solution designed to help states' Medicaid programs meet H.R.1 Community Engagement requirements while maintaining eligible member enrollment through a seamless member experience."</i>
Federal law requires states to inform individuals on how to access ACA marketplace coverage when they lose Medicaid coverage. Do your contracts require you to share this information with individuals or assist them in finding marketplace coverage?	NOT ANSWERED
Are there any states where you hold contracts related to both Medicaid and ACA enrollment and eligibility?	ANSWERED No.
What are your annual and total lobbying expenditures over the past 5 years?	ANSWERED Annually, Gainwell spends approximately \$3.6 million on state and federal lobbying efforts.
What are your annual and total lobbying expenditures over the past 5 years, specifically related to Medicaid work requirements?	ANSWERED <i>"Gainwell has not directed any federal or state lobbying efforts advocating for work requirements in Medicaid."</i>
What is your CEO's annual total compensation?	NOT ANSWERED
How do you test and monitor the MMIS and E&E systems for accuracy?	ANSWERED Brief description of MMIS testing methodology.

Question to Contractor	Contractor's Response
Do you share code and collaborate with other vendors in other states, or do you keep systems proprietary?	ANSWERED Sometimes. Critically, Gainwell's systems are built on proprietary technology and offered to states in a SaaS model, meaning that upon contract termination, states would need to procure a similar solution from Gainwell or another vendor, creating the potential for vendor lock-in.
Do you collaborate with CMS to share code or other IT resources related to MMIS and E&E systems?	ANSWERED Sometimes.
How do you staff the teams that manage these contracts?	PARTIALLY ANSWERED It depends on the contract.
List all MMIS and E&E contracts you received from 2014 to present. Provide all contracts and Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.	NOT ANSWERED

General Dynamics Information Technology (GDIT)

Question to Contractor	Contractor's Response
Any “pay-for-performance” provisions that tie your payment with the number of individuals removed from Medicaid?	ANSWERED <i>“GDIT’s contracts with these customers do not contain pay-for-performance incentives to reduce eligible Medicaid enrollment.”</i>
What documentation do you require to determine an individual’s eligibility?	PARTIALLY ANSWERED At the time of response, GDIT had two state contracts to manage MMIS systems—in New York and North Carolina. GDIT stated that its North Carolina system “<i>provide[s] a real-time processing environment for online eligibility verification,</i>” but did not list categories of documents collected for eligibility verification. The company also stated that its New York system “<i>makes limited eligibility determinations for those who qualify for health insurance under the Modified Adjusted Gross Income calculation,</i>” but again provided no examples of documents collected or reviewed to support these eligibility determinations.
Penalties for wrongly terminating an individual’s Medicaid eligibility?	PARTIALLY ANSWERED GDIT stated that it “<i>has consistently met the Service Level Agreements</i>” in its contracts with states but declined to say whether these minimum required levels of service and performance included error-free document verification and eligibility analysis.
Have CMS or state agencies brought any compliance actions against you?	PARTIALLY ANSWERED GDIT did not directly answer this question in its written response. In an October 2025 meeting with the Democratic staff of the Committee, GDIT stated that CMS has not brought any compliance actions against the company related to its MMIS work.
Over the past 5 years: how many people did you refer to state Medicaid offices as ineligible for Medicaid coverage?	NOT ANSWERED

Question to Contractor	Contractor's Response
Do you administer requirements in TANF or SNAP? If yes, what is the process for hardship exemptions?	ANSWERED <i>"GDIT does not administer or manage any systems related to TANF or SNAP."</i>
Do you have processes for dispute resolution or appeals when beneficiaries seek to appeal an eligibility decision?	PARTIALLY ANSWERED GDIT stated that under its New York contract, it <i>"plays no role in dispute resolution or appeals processes for individuals denied eligibility."</i> The company did not directly answer this question with respect to its work in North Carolina.
Do you plan to compete for state contracts to implement the new Medicaid work requirements enacted in H.R.1?	NOT ANSWERED
Federal law requires states to inform individuals on how to access ACA marketplace coverage when they lose Medicaid coverage. Do your contracts require you to share this information with individuals or assist them in finding marketplace coverage?	NOT ANSWERED
Are there any states where you hold contracts related to both Medicaid and ACA enrollment and eligibility?	ANSWERED GDIT holds contracts in New York for both the MMIS and the state's ACA Marketplace (NYOSH).
What are your annual and total lobbying expenditures over the past 5 years?	NOT ANSWERED
What are your annual and total lobbying expenditures over the past 5 years, specifically related to Medicaid work requirements?	NOT ANSWERED
What is your CEO's annual total compensation?	NOT ANSWERED

Question to Contractor	Contractor's Response
How do you test and monitor the MMIS and E&E systems for accuracy?	PARTIALLY ANSWERED GDIT wrote that it “<i>adheres to industry best practices and applicable CMS guidance in developing, maintaining and testing each system it manages.</i>” It did not elaborate further on its testing methodology.
Do you share code and collaborate with other vendors in other states, or do you keep systems proprietary?	PARTIALLY ANSWERED “<i>Software code developed by GDIT for these contracts is owned by the State customer.</i>”
Do you collaborate with CMS to share code or other IT resources related to MMIS and E&E systems?	PARTIALLY ANSWERED “<i>Software code developed by GDIT for these contracts is owned by the State customer.</i>”
How do you staff the teams that manage these contracts?	NOT ANSWERED
List all MMIS and E&E contracts you received from 2014 to present. Provide all contracts and Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.	NOT ANSWERED⁵⁹

⁵⁹ Memo to United States Senate Committee on Finance from General Dynamics Information Technology (GDIT), October 31, 2025. (See Appendix).

Maximus

Question to Contractor	Contractor's Response
Any “pay-for-performance” provisions that tie your payment with the number of individuals removed from Medicaid?	ANSWERED <i>“Maximus does not have any state Medicaid contracts that tie payment or revenue to the disenrollment of individuals.”⁶⁰</i> <i>“Maximus’ payment structure in state Medicaid contracts is based on transaction volume and service delivery — such as per-call pricing, per-transaction fees, or fixed fees — and on meeting agreed standards for accuracy and timeliness. It is not tied to enrollment or disenrollment outcomes. Most contracts include service level agreements that hold us accountable for measures of accuracy, timeliness, call handling, and similar operational metrics. Where we do not meet those standards, states may assess liquidated damages, withhold payments, and require corrective action.”⁶¹</i>

⁶⁰ Letter from Bruce E. Caswell, CEO, Maximus to Sens. Wyden & Warren, June 16, 2025. (See Appendix).

⁶¹ Letter from John T. Martinez, Chief Legal Officer, Maximus, to Sens. Wyden, Warren, and Sanders, November 24, 2025 (See Appendix).

Question to Contractor	Contractor's Response
Do you plan to compete for state contracts to implement the new Medicaid work requirements enacted in H.R.1?	PARTIALLY ANSWERED <i>“[W]ithout addressing whether we have submitted proposals for any specific opportunities, we can share that Maximus has a long-standing history of competing for government procurement opportunities when they align with our capabilities, expertise, and professional standards...If future contracts related to Medicaid eligibility requirements are a good fit for our services, we will evaluate and participate in those procurements in accordance with applicable laws and regulations.”</i> While Maximus declined to disclose whether it had already submitted proposals in any states, despite the direct nature of the question, Maximus’s CEO told investors in May 2025 that H.R.1 creates “multiple pathways to profit,” suggesting considerably more than a wait-and-see posture. Additionally, less than two months after sending this response, on January 29, 2026, Maximus was publicly listed by CMS as one of ten companies holding existing Medicaid E&E contracts with states to have voluntarily pledged to offer states discounted services to support work reporting requirement implementation and related state Medicaid system improvements under OBBBA. Maximus's decision to publicly position itself as a leading implementation partner for the very law it declined to discuss with this Committee raises serious questions about the candor of its November 2025 submission.
Do you have any state contracts to help states with ACA marketplace enrollment?	ANSWERED As of November 2025, Maximus had work related to ACA state marketplaces in eight jurisdictions, including seven states and the District of Columbia.

Question to Contractor	Contractor's Response
What documentation do you require to determine an individual's eligibility?	PARTIALLY ANSWERED <i>"We do not set documentation requirements. Those are determined by federal and state policy makers. If policymakers require additional documentation of eligibility, we execute those requirements, as directed by our government clients."</i> While Maximus thus acknowledged that it "executes" on document collection for purposes of assessing eligibility, it has declined to provide any information on the specific documentation it collects, reviews, or reports. Maximus's second written response repeatedly states that it "does not build, deploy, or operate E&E or MMIS systems." This claim contradicts what the company says on its own public website: ● Maximus maintains a Medicaid Solutions page that states: <i>"Maximus connects people to coverage and care through technology-enabled Medicaid eligibility and enrollment, community engagement, fair hearings, clinical services, and provider support for state agencies."</i> It promotes a trademarked product named "Accuracy Assistant" that <i>"moves quality reviews earlier in the eligibility process by embedding policy guidance, discrepancy detection, and risk-based review into existing workflows."</i> Maximus claims that with the "Accuracy Assistant" technology, <i>"[s]taff can identify verification issues, resolve discrepancies, and focus reviews on higher risk cases before determinations are finalized. The solution supports human decision-making, improves decision quality, strengthens program integrity, and reduces avoidable coverage disruptions."</i>⁶² ● On this same webpage, Maximus promotes a suite of "Community engagement implementation" services: <i>"Maximus provides program implementation support, reporting and verification tools, outreach and education, compliance reporting, contact center operations, and self-service digital experiences, including a job board and digital health risk assessment to help members find work and identify needed health and social supports. These capabilities integrate with existing state Medicaid eligibility processes."</i>

Question to Contractor	Contractor's Response
Penalties for wrongly terminating an individual's Medicaid eligibility?	PARTIALLY ANSWERED <i>"States never bear the cost of correcting errors that result from Maximus' performance...Our contracts generally allow states to impose remedies such as liquidated damages, payment withholds, or service level credits when we fail to meet agreed performance requirements. States do not pay us additional fees to correct errors that result from our performance."</i> While Maximus stated it is subject to contractual remedies, the company declined to say whether the terms of its contracts require error-free document verification and eligibility analysis. It also declined to provide copies of those provisions and declined to specify whether performance failures have triggered liquidated damages or payment holds in practice.
Have CMS or state agencies brought any compliance actions against you?	PARTIALLY ANSWERED <i>"We are not aware of the context you are using the term "censure" but if we understand your question correctly, we have not been censured by CMS."</i>
Over the past 5 years: how many people did you refer to state Medicaid offices as ineligible for Medicaid coverage?	NOT ANSWERED
Do you have contracts where you help states determine Medicaid eligibility and do you help to administer dispute resolution or appeals for beneficiaries to review the eligibility determination?	PARTIALLY ANSWERED Maximus confirmed it does not make final eligibility determinations. Regarding appeals, the November 2025 response does not directly address whether Maximus holds concurrent eligibility and appeals contracts.

⁶² Maximus, *Medicaid Solutions for State Agencies*, (last accessed Oct. 5, 2026), <https://maximus.com/state-and-local-government/medicaid#tabs-ace9994ced-item-e39a65cd1d-tab>

Question to Contractor	Contractor's Response
When you previously implemented welfare-to-work programs (TANF and SNAP), what percentage of participants were placed in jobs that count as full-time employment? What percentage of beneficiaries were determined by Maximus to be eligible for a hardship exception from the "work requirements?"	PARTIALLY ANSWERED <i>"Maximus does not make hardship determinations for federal or state work requirements in Medicaid, SNAP, or TANF. Those determinations are made by state agencies."</i> Maximus continued that in some programs, it may assist with <i>"gathering information from beneficiaries, scheduling assessments, or processing documentation under the state's rules."</i> Maximus did not answer the question about placement rates in full-time employment.
When Medicaid eligibility or renewal rules change, how (and how fast) do you update your systems?	PARTIALLY ANSWERED <i>"Each state has its own system as the Medicaid eligibility system of record; Maximus does not own any state's Medicaid eligibility system nor have we developed and deployed any Medicaid eligibility systems on behalf of states. If any Maximus systems need to be updated due to eligibility or renewal rules changes, we make those updates at the direction of the state."</i> While this may address downstream systems, it does not provide the average timeline for system updates or describe the change management process the Committee asked about.
Federal law requires states to inform individuals on how to access ACA marketplace coverage when they lose Medicaid coverage. Do your contracts require you to share this information with individuals or assist them in finding marketplace coverage?	PARTIALLY ANSWERED As of November 2025, Maximus confirmed it holds ACA marketplace contracts in eight jurisdictions, and that in integrated environments, it operates a single customer service center for both Medicaid and ACA enrollment. The Committee notes that Maximus's disclosure of its ACA marketplace contracts, combined with its Medicaid enrollment broker contracts, raises the precise conflict of interest the Committee's question was designed to probe: Maximus may profit twice from a beneficiary who loses Medicaid and is redirected to the ACA marketplace, where Maximus also processes enrollment. Maximus did not address this dynamic.

Question to Contractor	Contractor's Response
Are there any states where you hold contracts related to both Medicaid and ACA enrollment and eligibility?	PARTIALLY ANSWERED <i>“Maximus does not have organizational conflicts of interest in the Medicaid and ACA contracts that are the subject of this inquiry.”</i> Maximus states that in most jurisdictions, its Medicaid and ACA-related work is “structurally separated,” and that in “a smaller number of integrated environments,” a state has chosen to use a single customer service center for both programs. Maximus declined to identify which specific states have integrated environments, making it impossible to assess whether conflicts of interest exist in practice.
What are your annual and total lobbying expenditures over the past 5 years?	NOT ANSWERED
What are your annual and total lobbying expenditures over the past 5 years, specifically related to Medicaid work requirements?	ANSWERED <i>“Maximus does not lobby to influence Medicaid eligibility rules.”</i>
What is your CEO’s annual total compensation?	NOT ANSWERED
How do you test and monitor the MMIS and E&E systems for accuracy?	PARTIALLY ANSWERED <i>“Maximus does not build, deploy, or operate E&E or MMIS systems.”</i> Maximus states it is responsible for testing its own downstream systems “to ensure they correctly interpret and apply the data” received from state systems, and that it monitors those systems post-deployment. However, the question of how Maximus tests and monitors its own enrollment broker and member-support platforms for accuracy remains relevant and was not substantively answered.
Do you share code and collaborate with other vendors in other states, or do you keep systems proprietary?	PARTIALLY ANSWERED <i>“Our Medicaid-related applications and tools include proprietary components, but states own their program data and, in many cases, have rights to configuration artifacts, documentation, and interface specifications developed under their contracts. Our contracts do not restrict states from coordinating with one another, sharing their own implementation experience, or procuring services from other vendors...When a state selects a new vendor to perform services that Maximus previously provided, we support transition planning and knowledge transfer as directed by the state.”</i>

Question to Contractor	Contractor's Response
Do you collaborate with CMS to share code or other IT resources related to MMIS and E&E systems?	PARTIALLY ANSWERED <i>“Maximus does not build, deploy or operate MMIS or E&E systems. Our contracts do not contain licensing terms that prevent us from providing CMS with the information it requires.”</i>
How do you staff the teams that manage these contracts?	NOT ANSWERED
List all MMIS and E&E contracts you received from 2014 to present. Provide all contracts and Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.	ANSWERED Maximus stated it did not hold E&E or MMIS contracts (at the time of writing).

Preliminary Findings

As these contractors' written responses demonstrate, many of the investigation's central questions remain unanswered. Donald Trump and Congressional Republicans enacted a draconian law that will strip Medicaid coverage from vulnerable Americans at moments they most need it—moments when they are too sick to work, or too deeply buried in working and caregiving to complete mountains of paperwork. As Minnesota State Senator Matt Klein, a physician, has said: ***"The reason [OBBA] saves money on Medicaid is because they know we'll be kicking people off health care...And when people don't have health care coverage, they will come in sicker, and they'll come in later. Hospitals will be burdened with caring for them, regardless, and they'll be uncompensated."***⁶³

But while Republicans bear the responsibility for making these policy choices, the companies named in this investigation will bear responsibility for executing them. States, too, are caught in the middle, forced to rush implementation and potentially use vendors they cannot easily replace to run systems that have never worked as well as they should. The shared responsibility for what follows is real and distributed, but when the companies named herein had the ability to disclose their contract terms and their performance records to this Committee, they refused. Their written responses give zero confidence that they understand the gravity of this work; indeed, not one response makes mention of the human harm that results from a denial of coverage or care. These are evasive responses — plain and simple, and they underscore the need for further investigation.

Preliminary Recommendations and Conclusion

The investigation's preliminary findings compel further action. The contractors who will build and operate the systems implementing OBBA's work reporting requirements have demonstrated, through both their track records and their responses to this Committee, that more oversight and accountability are necessary. The following recommendations will be supplemented as this investigation continues and additional evidence is gathered.

- 1. Establish federal model contract terms for vendors in a mandatory checklist.** A consistent finding of this investigation is that the harms caused by contractor errors flow in significant part from weak and inconsistent contract terms that fail to hold vendors accountable for wrongful disenrollments. CMS currently maintains a checklist of mandatory elements for Medicaid managed care organization risk contracts that states must satisfy before CMS will approve federal matching funds – a framework that, while

⁶³ Robert King & Alice Miranda Ollstein, *States balk at the high price of Medicaid work requirements amid budget crunch*, POLITICO (May 31, 2026), <https://www.politico.com/news/2026/05/31/states-medicaid-work-requirements-high-costs-budgets-00943360>.

imperfect and itself in need of stronger enforcement, at least establishes a minimum accountability floor that does not exist for E&E and MMIS vendor contracts. CMS should develop and publish one with public model contract language for states to use when procuring E&E and MMIS system modifications. Any state contract with an E&E or MMIS vendor that does not contain the mandatory elements should be ineligible for federal administrative matching funds until it is brought into compliance.

Those mandatory terms should include, at a minimum:

- Quarterly disclosure of system error rates to CMS and state agencies, disaggregated by type of error and reason for ineligibility determination;
- Standardized financial penalties for wrongful disenrollments caused by system errors that states may not waive below a minimum floor;
- Explicit prohibition on the same vendor holding both eligibility determination and appeals or fair hearing contracts for the same state;
- Clear data ownership terms to ensure that states, not vendors, own the systems and code built with federal and state funds; and
- Classification of any system failure resulting in incorrect termination of an eligible beneficiary's coverage as a vendor-remediated defect at no additional cost to the state, not a billable enhancement to the system.

2. **Direct CMS to make public all vendor contracts and amendments.** There should be full public transparency about which vendors are contracting with which states and what their contracts require. CMS approves all state contracts and contract amendments with E&E and MMIS vendors before federal administrative matching funds are released. CMS therefore has access to the contract terms, payment structures, and performance requirements that the contractors named in this investigation refused to provide to the Committee.

The Committee calls on CMS to:

- Publicly identify all vendors currently under contract with state Medicaid agencies for E&E and MMIS system development, maintenance, and operations;
- Disclose what those vendors are being paid under their contracts and amendments;
- Provide copies of all contracts and amendments it has approved;
- Publish the minimum elements a contract must contain to obtain CMS approval as previously described;
- Resume and expand the public listing of state E&E and MMIS contracts that CMS previously maintained, updated on a quarterly basis and with sufficient detail to allow state-to-state and vendor-to-vendor comparison.

3. **Require CMS to establish and enforce standardized, publicly disclosed contractor performance metrics.** CMS currently lacks consistent, publicly disclosed performance standards for E&E and MMIS contractors, and no contractor named in this investigation was willing to provide data on how many individuals their systems have referred to state Medicaid offices as potentially ineligible for coverage. CMS should establish standardized quantitative performance metrics for all Medicaid eligibility contractors that are outcome-oriented, not process-oriented. Thin metrics such as website load time or the percentage of change requests processed within a defined timeframe are insufficient proxies for whether the system is accurately determining and describing eligibility. States should also report contractor performance against these metrics to CMS on a quarterly basis, and CMS should publish the results.
4. **Require public disclosure of all E&E and MMIS contractor performance data, design documents, and change orders.** Because CMS is not itself a party to state E&E and MMIS vendor contracts, the most direct mechanism for transparency is to require states, as a condition of receiving federal administrative matching funds, to publicly disclose comprehensive contractor performance data and transmit it to CMS. CMS should, in turn, be required to publish that data in a centralized, comparable format. Such data should include error rates for incorrect terminations of coverage, corrective action plans, and contractor performance ratings under state oversight processes. States and beneficiaries have a right to know how these contractors have performed when they are given authority over millions of eligibility determinations and millions of taxpayer dollars.

Design documents and change orders associated with E&E and MMIS contracts should also be made publicly available, including the number and nature of changes in each vendor's backlog, how the vendor prioritizes among pending changes, and whether changes driven by policy or guidance requirements, such as OBBBA implementation, are being prioritized over pre-existing error corrections. Any known system errors and associated workarounds should be publicly disclosed, including temporary workarounds that states or vendors are using while permanent fixes are pending.

5. **Mandate independent audits.** All E&E and MMIS vendors that receive federal administrative matching funds should be required to submit to independent audits of system accuracy, error rates, and disenrollment outcomes, with results reported to CMS and Congress. This audit mandate should cover not just new state contracts awarded to implement Medicaid work reporting requirements, but also existing system maintenance and operations contracts that may predate OBBBA and are being expanded through amendments. These audits must specifically track the number of individuals who lose coverage for administrative or procedural reasons versus substantive eligibility failures, and must identify the share of coverage losses that occurred among individuals who were

in fact compliant with or exempt from the work reporting requirements. CMS should explicitly prohibit vendors that also sell auditing services from auditing their own contracts or the contracts of competitors in the same state. Lastly, CMS should disclose all audits of state E&E and MMIS systems it has conducted or received in the past five years, including any audits that were completed but not published.

6. **Bar contractors from holding concurrent eligibility determination and appeals contracts.** Congress and CMS should prohibit contractors from simultaneously holding Medicaid eligibility determination contracts and contracts to administer appeals or fair hearing processes for the same state. A contractor that profits from finding individuals ineligible should not also be the entity that reviews those individuals' appeals, a conflict of interest that Maximus itself flagged in its June 16, 2025 response when discussing the parallel problem in Medicaid managed care. This prohibition should be incorporated as a mandatory term in the CMS contract checklist described in Recommendation 1 so that it applies to all state E&E and MMIS contracts as a condition of federal matching funds.
7. **Direct CMS to pilot and promote outcome-based contracting standards for E&E and MMIS procurements.** No contractor named in this investigation provided data on incorrect termination rates or error remediation timelines. Deloitte acknowledged that its contracts include unspecified “performance measures” whose optimization targets are unknown to the public. Several vendors disclosed service level agreements tied to thin process metrics such as website load times and whether notices were generated, rather than to whether eligible beneficiaries kept their coverage. Notice generation is illustrative of the problem as vendors may satisfy a contractual obligation by generating a notice that is sent to a wrong address, written in a language the beneficiary does not read, includes no explanation as to why a beneficiary's Medicaid is being terminated, or sent with a compliance deadline that gives the beneficiary insufficient time to respond. The absence of outcome-based standards means that a vendor can meet every contractual obligation while its system wrongly terminates thousands of eligible beneficiaries, with no financial consequence. Current Medicaid E&E and MMIS procurement rewards inputs, and vendors are paid for delivering systems that meet technical specifications, regardless of whether those systems produce accurate eligibility determinations or protect eligible beneficiaries from wrongful coverage loss. CMS should therefore develop and pilot outcome-based contracting standards under which vendors are paid for functional, working software that meets defined eligibility accuracy requirements at each stage, not for deliverable milestones like plans, documentation, and implementation reports that can be satisfied without the system actually working for beneficiaries.
8. **Direct CMS to prioritize open-source or state-owned architectures for OBBBA implementation systems.** Historically, Medicaid E&E and MMIS systems have been procured through large, single-vendor contracts that are slow to execute, difficult to exit,

and structured in ways that concentrate risk and give substantial leverage to vendors.⁶⁴ This structure is a root cause of the accountability failures documented in this investigation: when a state cannot practically exit a vendor relationship, it cannot effectively discipline a vendor for poor performance. To prevent the vendor lock-in that, for example, Gainwell's proprietary CEV model creates, CMS should require that systems built to implement OBBBA work reporting requirements use open-source or state-owned architectures consistent with existing CMS regulations requiring modular, interoperable Medicaid systems so that states can transition between vendors without being held hostage to proprietary technology or prohibitive switching costs. Prioritizing approaches that break large single-vendor contracts into smaller components can reduce both dollar value and vendor lock-in, open competition to a wider pool of vendors including smaller firms, and give states the flexibility to adapt to changing guidance without rebuilding from scratch.

The companies examined in this investigation are not passive actors in a policy landscape they did not shape. At least one of them, Maximus, has lobbied for the law from which they now stand to gain a new wave of lucrative contracts.⁶⁵ When this Committee asked them to be accountable – to disclose their error rates for incorrect terminations, their incentive structures, and the number of people their systems have flagged as ineligible – they refused. The states that will implement these requirements, by contrast, did not lobby for this law. Many of them fought it.

The millions of Medicaid enrollees who will be required to prove their eligibility every six months, to document every hour of work on a glitchy portal, to find a doctor willing to certify that their cancer or their chronic condition is bad enough to qualify for an exemption – deserve contractors who are accountable for what happens when the system fails them. That failure belongs to the contractors who profit from OBBBA's work reporting requirements, the Republicans in Congress who voted for them, and the Trump administration that cruelly touted them as an accomplishment. This report is an interim finding. The investigation is not over. Committee Democrats will continue pressing these companies for the answers they have refused to provide, and they will use every oversight tool available to ensure that the new Medicaid work reporting requirements do not strip coverage from low-income Americans in order to line the pockets of rich corporations.

⁶⁴ Tuyen Tran, *Building Nimble Procurement Approaches for State Medicaid Tech Systems*, Ctr. for Health Care Strategies (Apr. 2026), <https://www.chcs.org/media/Building-Nimble-Procurement-Approaches-for-State-Medicaid-Tech-Systems.pdf>.

⁶⁵ OpenSecrets, *Client Profile: Maximus Inc.* (2024-2026) (last accessed Oct. 13, 2026), https://www.opensecrets.org/federal-lobbying/clients/maximus-inc/agencies?client_id=179220&cycle=2025; see also Letter from Sens. Wyden & Warren to Bruce Caswell, President & CEO of Maximus, *supra* note 2.

Appendix

October 31, 2025

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Bernard Sanders
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Raphael Warnock
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Elizabeth Warren
Committee on Finance
United States Senate
Washington, DC 20510

Dear Ranking Member Wyden, Senator Sanders, Senator Warnock, and Senator Warren:

On behalf of Deloitte, I write in response to your letter dated October 10, 2025, regarding Medicaid systems.

Over the past four decades, Deloitte has collaborated with states to implement their eligibility and enrollment systems, and we continue to maintain, enhance and modernize systems that annually serve millions of people, delivering critical Medicaid, SNAP and TANF benefits. We take these responsibilities very seriously.

While industry analysts consistently rank Deloitte as a leader in system integration and business transformation, we are most proud of the longstanding relationships we have with our state clients. They choose us to support them in providing these benefits based on the quality of our work, our record of innovative digital service delivery, and our deep understanding of the health and human services programs they administer.

From the implementation of the Affordable Care Act through the unwinding of the COVID-19 Public Health Emergency – as technologies evolved and policies changed – Deloitte worked closely with states to minimize the challenges for those going through the Medicaid redetermination process. The innovations and human-centered design processes we helped our state clients implement enhanced the digital experience for their constituents and made it easier for caseworkers, staff, and community partners to support the individuals and families in their care.

When the Centers for Medicare and Medicaid Services (CMS) in 2024 clarified ex parte guidance to help reduce paperwork and improve continuity of coverage, Deloitte supported rapid system turnaround for our state clients that requested system changes based on that guidance. We also demonstrated our ability to help states quickly implement new communication options such as iterative text, e-mail, and notice campaigns to keep constituents, providers and other stakeholders informed.

KFF’s reporting about our work, which was cited in your letter, has been based on innuendo and supposition, rather than facts. Our state clients know that health and human services systems are complex due to the vast programs they support, and that all information technology systems require ongoing maintenance, periodic enhancements and upgrades to software and hardware, and database management. That is why so many of them continue to select Deloitte to help them maintain their mission-critical systems.

Data from KFF regarding the recent unwinding of the Public Health Emergency provides evidence of the positive impact our work has had on the states we serve. Deloitte supports three of the five states that had the lowest Medicaid disenrollment rates and five of the ten states that had the highest ex parte rates.¹

We are proud of our work serving individuals and families across the U.S. Our responses to your questions are provided below.

Deloitte’s Contract Performance with States

None of Deloitte’s state Medicaid-related contracts include pay-for-performance clauses that tie payments or revenue to the number of individuals removed from Medicaid.

It is common for systems contracts to include service levels, holdbacks/retainages, performance measures, or other similar structures requested by our clients. The specifics of such clauses vary across projects and clients based on the state client’s priorities and needs. None of these clauses or structures in our Medicaid contracts are tied to removal of individuals from Medicaid.

¹ [Medicaid Enrollment and Unwinding Tracker - Overview | KFF](#)

Deloitte's compensation under its state government contracts is not tied to disenrolling individuals from Medicaid.

Medicaid Eligibility Determination and Community Engagement Requirements

Deloitte does not determine an individual's eligibility for Medicaid or the documentation required to determine such eligibility. The Social Security Act (§1902(a)(5)) requires each state to designate a single state agency that has final authority for Medicaid eligibility decisions. This means a government official must approve or deny eligibility — not a private contractor or an automated system acting alone.

Each state determines the documentation it requires for Medicaid in accordance with Federal and state statutes. While the details may vary slightly by state and at times are clarified through CMS guidance, the common eligibility requirements for Medicaid include, but are not limited to, income limits, categorical or demographic requirements, citizenship and residency, and, for some categories, asset tests. We operate our projects in compliance with the state's requirements and specifications.

Regarding community engagement documentation requirements, CMS will be issuing implementation guidance in the coming months that will likely provide important direction to states on this issue.

We are not aware of any competitive requests for proposals (RFPs) to implement the new Medicaid eligibility requirements related to community engagement. If such RFPs are issued, depending on the scope and vendor requirements, we would consider responding and would then plan accordingly. Deloitte routinely works with existing state clients, at their request, to plan for Medicaid eligibility changes on an ongoing, project-by-project basis.

Deloitte does not determine the processing or denial of hardship exemptions. In addition, we are not the initial arbiter of Medicaid eligibility, and do not decide appeals of initial determinations, as the government retains responsibility for determining eligibility.

State systems supported by Deloitte may process notices to individuals when they lose Medicaid coverage. The processing of notices to individuals by vendors performing these services is carried out in accordance with the state's direction.

ACA Enrollment, SNAP & TANF

Many states operate Medicaid and 'ACA' enrollment on the same and/or integrated platforms to provide individuals a more integrated, customer-friendly experience in securing high-quality health care. States select their vendors for the various contracts for services supporting these platforms, which are then, as required, also approved by the applicable Federal authorities; that selection process accounts for any applicable conflict of interest laws and regulations.

While Deloitte has supported states by providing staff, at the state's direction, to perform activities that may support enrollment efforts, Deloitte is not currently under contract with any states to provide 'navigator-type' services to directly assist individuals in selecting health care coverage.

While state systems maintained and enhanced by Deloitte may be used by state staff or other vendors who implement welfare-to-work programs for Federal assistance programs such as TANF or SNAP, we do not provide welfare-to-work program placement services.

Lobbying

Deloitte has not incurred federal, state, or local lobbying expenditures in the past five years to advocate for or against the creation of work requirements for Medicaid.

Testing and System Changes

Deloitte performs all pre-deployment testing and post-deployment monitoring in accordance with its applicable state contracts, including the testing plans the state and Deloitte developed and agreed to for that system. In some cases, the system must then be certified by CMS. Certification often includes the use of an independent verification and validation (IV&V) vendor.

When Medicaid eligibility or renewal rules change, states may request Deloitte's assistance to make any needed updates to their Medicaid systems pursuant to their processes and timelines as reflected in the vendor's contract and agreed-upon project plans.

The protocols to address defects in a system during testing and after the system is in use are based on the applicable state's requirements for warranty and maintenance and operations, which vary among the states for all systems vendors. The states often have multi-vendor environments with significant engagement of state staff, so the root cause of an issue first needs to be determined.

System Code-Sharing

When appropriate, Deloitte supports states in their code-sharing with CMS and other states. Deloitte's contracts do not contain restrictive licenses that prevent Deloitte from supporting states in such collaboration. As with the other vendors, Deloitte offers to bring a variety of its own tools and technologies to a project and maintains its rights to them so that it can continue to provide their benefits and broad usage rights to all its clients.

Deloitte also collaborates with state clients to support compliance with CMS's modularity requirements by using a modular, flexible architecture with open Application Programming Interfaces (APIs) and clearly defined interfaces, and by ensuring the separation of business rules from core programming through the use of configurable rules engines. Eligibility logic derived from Federal and state policy is captured in both human-readable decision tables and machine-readable rule sets, typically maintained in a centralized state-owned repository and traceable to governing regulations. These rules are deployed as independent decision services that can be updated without re-coding core applications, enabling states to rapidly implement policy changes

while maintaining compliance, transparency, and auditability in accordance with 42 C.F.R. § 433.112(b).

Staffing

Deloitte staffs MMIS and E&E teams based on the requests and needs of each state client and requirements of the applicable contract. We continuously invest in staff training, knowledge sharing, and professional development so that our teams have the most relevant technology skills and industry knowledge.

Contract Documentation

MMIS and E&E contracts are generally subject to Federal approval provided to the states. Contracts are typically confidential to the client. It has not been our experience that CPARS are applicable to state MMIS and E&E contracts or if they are, they are not visible to Deloitte.

Deloitte does not have access to the APDs which are between states and the Federal government. The RFPs are put forth by the states.

Thank you for your consideration of our response. Should you or your staff require additional information or wish to discuss this matter further, please do not hesitate to contact me at 717-695-5367.

Sincerely,



Lindsay Hough

Clients & Sectors Leader, Government & Public Services Practice
Principal, Deloitte Consulting LLP

1) Do any of Conduent's state Medicaid contracts include pay-for-performance clauses or other payment structures that tie payments or revenue to the number of individuals your company removes from Medicaid? No. First, the decision to remove Medicaid recipient from eligibility is reserved for the State agency. Second, since Conduent's compensation is generally based on a per member per month basis, the removal of a Medicaid recipient reduces our compensation.

- a) If so, how many of your contracts include these provisions? N/A
- b) What do the provisions entail? N/A
- c) Please provide a copy of the contract provisions. N/A
- d) Specifically, when conducting enrollment assessments, does your company earn more for disenrolling beneficiaries than it does by retaining their enrollment? No

2) Do any of Conduent's state Medicaid contracts include pay-for-performance clauses or other payment structures that tie payments or revenues to other factors? The contracts frequently have service-level expectations (e.g., uptime or call answer time), and in many cases, there are penalties if the metrics are not met.

a) If so, list all factors for which you receive bonus payments by contract. As a general rule, there are no provisions for bonus payments.

b) If so, list all factors for which you receive payment reductions by contract. As a general rule, penalties may apply if a specific performance standard is not achieved under the particular contract. These vary from contract to contract but may include penalties for things such as system availability, timely processing of Medicaid application and claims, the timely delivery of reports, or call center performance (e.g., call answer time).

c) Please provide a copy of any such contract provisions. To ensure compliance with the public disclosure restrictions imposed under our State contracts, your request for copies of certain State contract provisions should be directed to the individual State Medicaid agencies.

3) Please provide a detailed summary of the documentation Conduent may require to determine an individual's eligibility for Medicaid, including the frequency with which such documentation is updated. The Medicaid eligibility and ineligibility decisions are reserved for each State agency. State case workers make the final decision. To the extent Conduent is involved in the administrative process, Conduent does so in accordance with statement of work requirements as set forth in each particular State contract. Conduent supports the technology that receives, stores, and makes available the documentation submitted by applicants to the State case workers for their review and determination.

Furthermore, based on Conduent's experience in the industry, please state whether the company believes such documentation would be sufficient to enact the so-called "community engagement" requirements contemplated by current Republican policy. It is Conduent's understanding that CMS and the States, not contractors, will establish the "community engagement" and documentation requirements. At this writing, it is our understanding that neither CMS nor the States have published any draft or final community

engagement and documentation requirements. If not, please identify additional categories of documents that may be necessary. N/A

4) Is Conduent penalized under any of its contracts for any of the following reasons:

a) Wrongly terminating the Medicaid eligibility of any individual; N/A. The Medicaid eligibility and ineligibility decisions, including decisions to terminate eligibility, are reserved for each State agency.

b) If applicable to your operations, failing to meet federal requirements concerning call center wait times or language accessibility requirements; Yes, as a general rule, if a contract includes a call center wait time or language accessibility requirement performance standard with associated penalties and those standards are not met. subject to other contract provisions (e.g., force majeure, State errors or omissions, etc.

c) If applicable to your operations, failing to comply with any other federal or state law regarding call center operations, government service providers, or other germane regulations or laws? As a general rule, Conduent may have liability as set forth in the particular contract to the extent of its failure subject to other contract provisions (e.g., force majeure, State errors or omissions, etc.)

d) If so, what do those provisions entail? Examples may include call center handle times, system availability, reporting, document ingestion and processing etc.

5) Has Conduent recently been the subject of a compliance action by the Centers for Medicare & Medicaid Services (CMS) or any state agencies for failing to adequately deliver on contract terms? Conduent has not been the subject of adverse compliance actions by CMS or any State Medicaid agencies. As is customary with complex programs, we maintain consistent communications with our State agency partners to address and collaboratively resolve any contract clarifications or issues promptly through the established communications channels.

If yes, please provide any written communication pertaining to contract violations or concerns raised by the government agencies about Conduent's service delivery and follow through. N/A.

6) For each of the last five years, please provide complete data on the number of people Conduent has referred to state Medicaid offices as ineligible for coverage, with the justifications for these determinations. Medicaid eligibility and ineligibility decisions are reserved to the State Medicaid agencies. To the extent Conduent is involved in supporting the administrative process related to determining an individual's Medicaid eligibility, Conduent does so in accordance with statement of work requirements as set forth in each particular State contract and in accordance with CMS regulations.

a) How many of these individuals were deemed ineligible for failing to follow administrative steps? The decision to determine ineligibility is made by each State in accordance with their rules. Such data is generally considered State data under our contracts and if it exists, it is stored separately for each State system. Accordingly, requests for the data should be directed to the individual State Medicaid agencies and CMS.

b) How many of these individuals were deemed ineligible for failing to meet substantive eligibility requirements? **Such data is generally considered State data under our contracts and if it exists, it is stored separately for each State system. Accordingly, requests for the data should be directed to the individual State Medicaid agencies and CMS.**

c) For those individuals deemed ineligible, describe if and how Conduent continued to process the individuals' cases in dispute resolution or other appeals processes. **Conduent does not make the eligibility determination. If an applicant submits data, we pass it along to the State to process per the State's own guidelines and rules.**

d) For those individuals deemed ineligible, describe if and how Conduent continued to process the individuals in their application and eligibility determination for state health insurance exchanges or marketplaces. **See the answer immediately above.**

e) Does Conduent currently administer so-called "work requirements" in TANF or SNAP? **It is our understanding that work requirement programs relative to TANF and SNAP are administered directly by the State agencies.**

i) If so, does Conduent process any requests for hardship exemptions? **N/A**

(1) If so, what share of hardship exemptions did Conduent recommend providing? **N/A.**

(2) Does Conduent generate more revenue by denying hardship exemptions, because, for example, such denials allow Conduent to engage in workforce development and training? **N/A.**

7) Does Conduent have any contracts wherein it both helps states determine or recommend when Medicaid eligibility requirements are not met, and also helps to administer dispute resolution, fair hearings, or other appeals processes when beneficiaries seek to appeal the eligibility decisions? **No; we understand that as a general rule, contractors such as Maximus have independent review organization (IRO) contracts with States and CMS. Conduent's role in an eligibility dispute process would normally be limited to producing records from the system requested by the State agency.**

a) If so, does Conduent's role as both the initial arbiter of eligibility and the appellate reviewer of the initial decision create a conflict of interest? If not, why not? **N/A. Conduent is neither an initial arbiter nor appellate reviewer.**

8) Does Conduent plan to compete for contracts to implement the new Medicaid eligibility requirements stemming from Trump and Congressional Republicans' new law? **The answer will depend on the content of final "community engagement" requirements to established by CMS and the States. At this writing, it is our understanding that neither CMS nor the States have published any draft or final community engagement requirements; and that neither CMS nor the States have issued any Requests for Proposals (RFPs) to that effect.**

a) If so, has Conduent begun the proposal process in any states? **Since no RFPs have been issued by the States, Conduent has not initiated its proposal process. If yes, which states? N/A.**

b) Please provide a copy of any planning materials Conduent made in anticipation of

competing for these new contracts. It is still unclear what the final “community engagement” requirements will be and how those requirements will be described in RFPs. That will drive the planning process.

9) Federal law requires states to inform individuals on how to access the Affordable Care Act (ACA) marketplace in the event they lose Medicaid coverage. [Footnote 15] Do Conduent’s active state contracts require your company to disclose this information or otherwise assist individuals in accessing private plans through the ACA marketplace? As a general rule, when a State agency makes an ineligibility decision, it may provide Conduent with a template to mail to ineligible Medicaid applicants containing general information on how to apply for Qualified Health Plans (QHPs) through the ACA marketplace and/or a State-based marketplace. Except Conduent does not assist the applicant. It is a very limited information provider role.

a) If so, what percentage of individuals that Conduent deemed ineligible for Medicaid coverage enrolled in a private health plan through the ACA? Please provide complete data for each of the last five years. Conduent does not make the eligibility determinations. To the extent this data exists, such information would be considered State data, and the best sources would be the State Medicaid agencies, the ACA marketplace, or State-based marketplace.

10) Does Conduent have any contracts wherein it helps states process or secure ACA enrollment? One contract.

a) If so, which states? The Kentucky Cabinet for Health and Family Services (CHFS) Contact Center as a Service contract.

11) Are there any states where Conduent holds contracts related to both Medicaid and ACA enrollment and eligibility? One contract.

a) If so, which states? The Kentucky Cabinet for Health and Family Services (CHFS) Contact Center contract, but Conduent does not operate the ACA or Medicaid systems under that contract. Rather, Conduent provides eligibility services for both programs, but does not provide any systems support. Deloitte provides the Integrated Eligibility System (IES) for both ACA and Medicaid in the Commonwealth of Kentucky.

b) If so, is Conduent required to reconcile any conflicts of interest related to these coinciding contracts? No. The ACA and Medicaid eligibility services are provided under one contract. They are not coinciding contracts.

c) How does Conduent navigate holding these two types of contracts concurrently? Please produce any written materials or guidance related to this. These are not two types of contracts held concurrently. Rather, the ACA and Medicaid eligibility services are provided under one contract.

12) Has Conduent previously implemented federal welfare-to-work for programs like TANF or SNAP? Work requirement programs relative to TANF and SNAP are administered

directly by the State agencies. Conduent does not operate any welfare-to-work program for any other programs.

a) If so, what share of participants were placed in jobs that qualify as full-time employment? **N/A.**

b) If so, what percentage of workers placed in a job through Conduent's welfare-to work programs were unemployed again within one month, three months, and six months? **N/A.**

c) If so, does Conduent have internal guidelines or presentations that incentivize placement of such workers in short-term or unstable employment? **N/A.**

Please provide any internal guidance to Conduent employees on job placements for workers. **N/A.**

d) If so, what percentage of beneficiaries are determined by Conduent to be eligible for a hardship exception from the so-called "work requirements"? **N/A.**

13) What are the annual and total lobbying expenditures by Conduent in the past five years of federal, state, and local governments? More specifically, what are the annual and total lobbying expenditures by Conduent in the past five years of federal, state, and local governments on the subject of so-called "work requirements" in Medicaid? **Conduent has not engaged in any lobbying activity advocating for the creation of work requirements for Medicaid.**

14) What has your annual total compensation been for the past five years? **Conduent is a subsidiary of Conduent Incorporated, which is a publicly traded corporation that publishes its consolidated financial results for all business activities quarterly. See <https://conduent.com>.**

a) What is your projected annual total compensation for FY 2025? **FY 2025 final consolidated results will be publicly reported in or about the first quarter of CY 2026.**

b) Is your projected compensation this year contingent on any bonuses or incentives tied, directly or indirectly, to disenrolling individuals from Medicaid? **No.**

c) Do "pay-for-performance" clauses in Conduent's contracts with states generate higher revenues or profits for the company that impact your total compensation? **As a general rule, the pay-for-performance clauses Conduent is familiar with, such as performance standard penalties, do not generate higher revenues. Rather, to the extent a contractual performance standard is not met, any associated contractual financial penalty would result in a revenue decrease.**

15) What pre-deployment testing and post-deployment monitoring does Conduent perform to ensure the accuracy and robustness of the MMIS and E&E systems being created for states? **As a general rule, specific pre-deployment testing and acceptance requirements and post-deployment monitoring requirements are contract specific and often include Unit Testing, Functional Testing, System Integration testing (SIT), Regression Testing, Performance testing, User Acceptance Testing (UAT), and CMS certification. Conduent also performs Post-Production**

validation after deployment of changes. As directed by the contract, Conduent may also do automated and/or manual system monitoring for accuracy and robustness.

Please describe the testing that occurred, how the testing was carried out, and the types of issues, if any, that Conduent identified through these processes. Testing often takes the form of Unit Testing, Functional Testing, System Integration testing (SIT), Regression Testing, Performance Testing, User Acceptance Testing (UAT). Specific areas that are usually tested include: Eligibility and Enrollment, Claims Processing, Decision Support/Data Warehouse, Encounter Processing, Long-Term Services and Supports (LTSS), Program Integrity, Provider Management, and Federal Reporting. The purpose is to determine compliance with contract performance requirements and identify any software issues.

16) When Medicaid eligibility or renewal rules change, what is the process and average timeline by which Conduent updates its systems? This information is not formally tracked and reported. CMS and the States define the changes. The process and timeline depend on a variety of factors, such as when the policy or regulation is published, State and Conduent agreement on the statement of work, implementation time, testing standards, testing timeline, and other terms of the change order or amendment to the contract, and the effective date of any policy or regulatory implementation.

a) What role do states play in this process? See answer immediately above.

17) What protocols are in place to address change request issues that are the result of Conduent? As a general rule, each State contract will include a specific clause that prescribes a process for the State to issue a change request or for the contractor to submit a change request.

a) In what instances do states bear the costs associated with Conduent-related errors? As a general rule, and subject to other contract provisions (e.g., force majeure, State errors or omissions, etc.), Conduent may have liability to the extent it was the cause of an error.

b) Please describe how these protocols and protections vary across contracts. See answers immediately above.

18) How many states have amended their original contract with Conduent to address change request issues beyond the original scope of the state's contract? This information is not formally tracked and reported. However, our contracts tend to have a change request at some point in time. The State contracts tend to be very complex and change requests may be issued by a State customer for a variety of reasons, but usually associated with new or additional requirements imposed by changes in policies, laws, and regulations related to who and what is covered, and for how long, or for a desire to incorporate new technologies, enhancements, reporting standards, etc.

a) Please describe what contract amendments frequently entail. See answer immediately above.

b) What are the minimum, maximum, and average costs associated with amendments to original contracts for change requests that Conduent has done

since 2014? This information is not tracked and reported. The costs of an amendment for a change request will vary depending on any number of factors, including but not limited to the scope, implementation schedule, staffing requirements, testing requirements, inspection time, acceptance requirements, supplier costs, software license costs, etc.

19) To what extent does Conduent collaborate with other Conduent teams, or other companies, in other states to share code or other information technology resources related to MMIS and E&E systems? Each State tends to have its own unique requirements and Medicaid Delivery systems such that it causes each State-owned MMIS System to be coded specific to that State. On a case-by-case basis, and in response to a particular MMIS or E&E RFP, Conduent will enter into teaming agreements with other companies in order bring together skill sets, experiences, and technologies that allow us to submit a responsive and competitive proposal. Changes directed by CMS typically require a global change across all affected contracts, which tends to reduce the cost share for each State.

a) Are Conduent MMIS and E&E systems proprietary? The MMIS Systems that Conduent operates today are State owned but operated by Conduent. The new generation of modular improvements to MMIS Systems that are in the process of implementation are proprietary to Conduent. Title to customized software is usually with the State customer. The Mississippi Eligibility System is also State owned but operated by Conduent; however, the Self Service Portal (SSP) module is Conduent proprietary. Conduent has deployed only one E&E System. It is called BenePath and is proprietary.

b) Do Conduent contracts contain any restrictive licenses that would prevent teams from coordinating across states? As indicated earlier, each State tends to have its own unique requirements such that it causes each State-owned MMIS System to be quite coded and specific to that State. However, in the case of MMIS systems and E&E Systems, Conduent is not aware of any restrictions on coordinating across States. Conduent has worked with States that “lift and shift” a system from another state as a base model that is then customized for that particular state.

c) Do Conduent contracts contain any restrictive licenses that would lock in Conduent by making it prohibitively difficult for states to switch vendors? The current MMIS Systems in operation and operated by Conduent are State-owned. States are free to and often do issue RFPs which invite new contractors to take over and operate their systems. Recently, CMS’ MMIS system modernization initiative invited contractors to propose proprietary incremental modular improvements to components of an existing MMIS System rather than conduct a procurement to completely replace the entire MMIS system. Even with new proprietary components, we are not aware of any restrictions on State agencies when it comes to recompeting the program and inviting other contractors to take over and operate the MMIS System. The same understanding would apply to E&E systems.

d) Should a state award another vendor a subsequent MMIS or E&E system, can the states build this from Conduent’s MMIS and E&E system, or would the new vendor need to build the MMIS and E&E system from scratch? Where a State agency owns the MMIS or E&E System, they can choose Conduent or another contractor to access the source code and build

upon their existing system or seek to build a brand-new system. For modules that are proprietary to a contractor, usually any contractor can operate the module as long as the state renews their term license.

20) To what extent does Conduent collaborate with CMS to share code or other information technology resources related to MMIS and E&E systems? It is Conduent's experience that CMS encourages transfer systems and approves State contracts with transfer systems. The collaboration is actually done between States. When a State RFP specification seems to be based on or is similar to an existing State customer's MMIS system, we can propose a transfer of that system. Typically, the new State must ask the old State for a copy of the old State's system. Once formal permission is obtained by the new State from the old State, then Conduent could do the actual work of copying it over.

a) Do Conduent contracts contain any restrictive licenses that would prevent Conduent from doing so? For State-owned MMIS or E&E Systems, there would be no such restrictive license. To the extent the new State would want to use a contractor-owned module, then the new State would need a license to use that feature.

21) Under CMS regulations, Medicaid systems must use a "modular, flexible approach to systems development," including "the separation of business rules from core programming." Please describe how Conduent systems comply with this requirement and translate eligibility rules into executable computer code, including through the use of rules engines, where applicable. Generally speaking, Conduent receives eligibility and business rules/requirements from the State, those requirements are confirmed, Conduent system architects use those requirements to design the change/solution, the design is confirmed by the State, and development and testing take place before moving the changes to production.

a) Please describe how Conduent ensures that it continuously implements the latest technology and industry best practices throughout the duration of the contract lifecycle. In accordance with the terms of a State operations and maintenance agreement, Conduent keeps the technology stack of the MMIS and Eligibility Systems updated.

22) Please describe how Conduent staffs MMIS and E&E RFP teams and contracts, including the number of staff, their education level, their area(s) of expertise, their title, the aggregate billed number of hours per month, and the contract's monthly full-time equivalence. This information is not tracked and reported. As a general rule, State RFPs often require bidders to include a list of Key Personnel and their education level, education, and title and each State sets its own requirements for staffing. The resulting contract sometimes requires the State to consent to any changes in Key Personnel. The cost of Key Personnel is usually not individually billed under a contract; rather their cost is wrapped into a monthly support fee or cost per member fee.

23) Please list all Conduent MMIS and E&E contracts dating back to 2014 and denote which contracts were and were not re-awarded. This information is not formally tracked and reported. Conduent currently holds MMIS contracts in the following States: Virginia, New

Mexico, Montana, Hawaii (only operations but no systems), District of Columbia, North Dakota, Alaska and New Hampshire. Conduent currently holds the E&E contracts for the following States: Kentucky, Indiana, Mississippi, South Carolina, Connecticut, Iowa, Kansas, New Jersey, Alabama, and Louisiana.

a) Please provide any and all Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives. It is our understanding that CPARS collects information on federal contracts with federal agencies and is available for viewing. Our MMIS and E&E contracts tend to be with State government agencies. However, for information purposes, we have attached two recent CPARS from the Social Security Administration related to the contract performance of our affiliate Conduent Federal Solutions, LLC.

24) Please provide all Conduent MMIS and E&E contracts dating back to 2014, as well as the most recent APDs and RFPs associated with those contracts. Conduent is not privy to State APDs. So the request for APDs would need to be submitted to the cognizant State agencies. CMS should also have a record of the APDs.



October 31, 2025

The Honorable Ron Wyden
United States Senator
Ranking Member, Committee of Finance

The Honorable Bernard Sanders
United States Senator

The Honorable Raphael Warnock
United States Senator

The Honorable Elizabeth Warren
United States Senator

Dear Senators Wyden, Sanders, Warnock, and Warren:

We write in response to your October 10, 2025, letter, which requested information about our role within Medicaid eligibility systems and the implementation of new eligibility requirements. Gainwell Technologies LLC (Gainwell) is a strategic partner and solutions provider enabling public health programs to elevate patient outcomes, cost savings, and provider experiences. We take seriously the issues raised in your letter and appreciate the opportunity to address your questions.

Background

At Gainwell, we are on a mission to help those most vulnerable get the quality healthcare they need to live healthier lives. Since its formation, Gainwell has continued to build on its legacy of innovation and operational excellence by providing, among other things, advanced technology solutions and services tailored to the unique needs of government health programs across the nation. With experience delivering digital and cloud-enabled solutions across 50 states, U.S. territories, and Washington D.C., our 12,000 experts, practitioners, and clinicians, are uniquely positioned at the intersection of technology and healthcare. We solve our clients' most complex challenges through our suite of innovative products and solutions.

Gainwell is a time-tested and trusted partner of state Medicaid agencies. Gainwell has no active contract with any state agency to provide Medicaid eligibility determinations or the removal of individuals from Medicaid. In terms of Gainwell's corporate history,

in April 2017, Hewlett Packard Enterprise spun off and merged its Enterprise Services business with Computer Sciences Corporation to create a global information technology services company called DXC Technology (DXC). DXC subsequently sold its State and Local Health and Human Services division which led to the creation of Gainwell, a private company that launched on October 1, 2020. This transaction enabled Gainwell to focus exclusively on supporting health and human services programs, and brought decades of industry expertise and a dedicated workforce to its clients.

We service all U.S. states and their respective state agencies by offering proven methodologies, scalable technologies, and a commitment to excellence in delivering Medicaid solutions. Gainwell typically contracts with state health and human services and state Medicaid agencies to create and maintain Medicaid enterprise systems, pharmacy solutions, and data and analytics platforms. Our services include Medicaid Management Information Systems (MMIS), fiscal agent operations, coordination of benefits, payment integrity, provider enrollment systems, and care quality improvement. Gainwell also supports states with systems integration and intelligent analytics to enhance program efficiency. We recognize the critical, life-saving care that we facilitate through our partnership with state agencies and take seriously our role in ensuring these systems function effectively.

While Gainwell has not begun to do so, we plan to compete for contracts to implement the new Medicaid eligibility requirements stemming from H.R. 1 using Gainwell's proprietary Community Engagement Verification (CEV) solution. Gainwell's CEV will be a comprehensive technology and services solution designed to help states' Medicaid programs meet H.R.1 Community Engagement requirements while maintaining eligible member enrollment through a seamless member experience.

The Gainwell approach is rooted in a deep understanding of Medicaid program requirements, regulatory compliance, and the unique needs of each state. We have successfully implemented large-scale technology platforms and operational solutions tailored to the evolving landscape of Medicaid by leveraging our knowledge to help states achieve policy goals, improve program efficacy, and enhance the provider experience. Gainwell also helps state agencies execute system transitions, address federal and state compliance mandates, and adapt to ongoing changes in Medicaid policy and funding.

Gainwell's Contracts & Services

Gainwell contracts with state agencies to support the administration, modernization, and enhancement of their MMIS; provider enrollment platforms; and related program

operations. Gainwell obtains state Medicaid contracts through a competitive procurement process. Each request for proposal includes concrete evaluation criteria and specific requirements for technical and financial submissions. The scope of work in our contracts with state agencies varies widely and can range from comprehensive, statewide modernization initiatives to targeted system enhancements and maintenance agreements.

Our personnel decisions for each Medicaid contract are tailored to the contract's size, scope, complexity, deliverable schedule, and client expectations. Gainwell's staff includes subject matter experts in healthcare IT, project management, compliance, and solution architecture, which allows us to assemble teams that align with the demands of a given project. A larger, more complex contract (*e.g.*, system modernization) might require the support of hundreds of individuals, while more targeted initiatives (*e.g.*, discrete system enhancements) will require smaller teams with specialized skill sets. To the extent permitted by law and contractual terms, Gainwell employees will collaborate across teams and share information technology resources.

This flexible staffing approach, combined with the depth of our team's expertise, enables Gainwell to efficiently allocate resources, maintain high-quality deliverables, and respond rapidly to evolving client needs throughout the contract lifecycle.

The compensation structure for Gainwell's Medicaid contracts varies depending on the nature of the underlying project. However, no Gainwell contract includes pay-for-performance clauses or other mechanisms that tie payment to the number of individuals removed from Medicaid. Gainwell also does not process, secure, or otherwise determine Affordable Care Act eligibility or enrollment, implement federal welfare-to-work requirements for programs like TANF or SNAP, nor does Gainwell administer dispute resolution, fair hearings, or other appeals processes to eligibility decisions.

Gainwell does not have any active contracts with any state agency to provide Medicaid eligibility determinations or the removal of individuals from Medicaid. Moreover, we do not have data on individuals referred to state Medicaid offices as ineligible for coverage, nor do we receive the justifications for such determinations. Gainwell has one current contract with a state to implement and maintain the environment and infrastructure for its online enrollment and eligibility system. This system interfaces with the state's MMIS and is designed and maintained in accordance with state-prescribed requirements and specifications, including eligibility requirements. Per the terms of our contract, Gainwell's role is limited to developing and implementing software changes and testing system updates. The state agency itself defines and manages all enrollment and eligibility decisions.

Gainwell is committed to ongoing innovation and the continuous adoption of the latest technologies and industry best practices throughout the contract lifecycle. Centers for Medicare and Medicaid Services (CMS) regulations require Medicaid systems to be developed using a modular architecture to enable flexibility, scalability, and ease of maintenance. Each module within our Medicaid solutions is designed to perform distinct functions such as claims processing or provider management while seamlessly integrating with other modules through secure, standards-based interfaces. Central to our architecture compliance is the explicit separation of business rules from core programming logic. This means that business rules, such as eligibility determinations, are developed separate from the foundational software code provided by Gainwell. Further, by leveraging these technologies, our solutions remain adaptable to evolving policy requirements and regulatory changes, while minimizing operational risk and maximizing transparency.

Gainwell's adoption of advanced rules engines and highly configurable system architecture reflects industry best practices in Medicaid system modernization. Gainwell's modular solutions are built on Gainwell and third party proprietary technology. Gainwell offers these solutions, and the state contracts for these solutions, in a Software as a Service (SaaS) or commercial model. Under both of scenarios, the state utilizes the solution, while Gainwell manages the infrastructure, maintenance, and updates and owns the underlying solution granting a license to the state for a certain contracted period. Upon termination, the state would procure a similar solution from Gainwell or another vendor.

In other instances, the state may contract for a bespoke solution funded by federal or state money. States have broad rights to use software and technology developed with state or federal funds, especially in the context of MMIS systems. States are typically able to utilize, reproduce, modify, and share the system and its code with other states and agencies. As a result, states can and often do build upon government-funded software, whether for maintenance, upgrades, or transitioning to a new vendor, without having to start from scratch. This flexibility supports innovation, cost-effectiveness, and compliance with federal regulations that require modular, interoperable system architectures.

We note that Gainwell is not compensated under its MMIS contracts through a pay-for-performance methodology. Annually, Gainwell spends approximately \$3.6 million on state and federal lobbying efforts. Gainwell has not directed any federal or state lobbying efforts advocating for work requirements in Medicaid.

Testing, Monitoring, & System Updates

Gainwell follows a structured and comprehensive testing methodology for aligning end-to-end testing of MMIS systems with the Medicaid Information Technology Architecture (MITA) initiative.¹ We conduct tests throughout a system's lifecycle, from conception to deployment, and engage in ongoing testing and defect management once launched.

Post-deployment, Gainwell employs a comprehensive monitoring strategy at both the component and system-wide level to allow for oversight of key modules, while maintaining visibility into the overall health of the system. All Gainwell systems are equipped with automatic notifications that enable the timely triage and resolution of anomalies by an account team and minimize the impact felt by patients and providers. Our monitoring processes align with widely adopted infrastructure standards, thereby ensuring that they operate with maximum efficiency, interoperability, and reliability.

In addition to Gainwell's own monitoring and review processes, state agencies also provide oversight of Gainwell's solutions. Most Gainwell contracts with state agencies include service level agreements (SLAs) outlining the specific standards of service that the provided solution must meet. SLAs typically consist of measurable performance standards, such as response times, resolution times, software code quality, and staffing and reporting requirements. The SLAs also often provide for corrective action plans, credits, or payment reductions if Gainwell fails to meet the agreed-upon standards, as well as procedures for monitoring continued compliance and resolving disputes. Gainwell has not been the subject of any compliance actions by CMS.

Once a product is live, a state to submit a change request for any number of reasons, such as updates to state policies, amendments to state or federal regulatory or Medicaid rules, shifts in project scope, or the emergence of unforeseen technical challenges. Gainwell also offers states system updates as part of our commitment to continuous improvement. In general, Gainwell deploys a standard change management process that captures, assesses, and approves changes through a structured approach. Our process is aligned to industry standards, which emphasize thorough impact analysis, risk assessment, controlled implementation, and post-initiation monitoring processes that harmonize modifications with program objectives and minimize disruptions to ongoing operations.

Our integrated approach enables states to manage changes effectively during both

¹ The MITA initiative is a national framework to support improved systems development and health care management for the Medicaid enterprise.

implementation and operational phases, resulting in consistent delivery of high-quality solutions tailored to meet the states' needs.

Conclusion

Gainwell is a leading provider of MMIS solutions, which support a broad portfolio of state agencies and contracts across the United States. While the precise number of clients and contracts may vary over time due to new awards and contract completions, Gainwell consistently serves a significant portion of state Medicaid agencies, which reflect its deep experience and trusted partnership in the MMIS space. Our teams are dedicated to the implementation, modernization, and ongoing support of MMIS platforms for numerous state clients, with contract scopes ranging from comprehensive, statewide modernization initiatives to targeted system enhancements and maintenance agreements. This extensive engagement base enables Gainwell to leverage best practices and innovative solutions across a diverse set of Medicaid programs, ensuring high-quality service delivery and compliance with evolving federal and state requirements.

Gainwell appreciates the opportunity to address your concerns regarding the development and implementation of Medicaid eligibility systems and to explain our role within the Medicaid marketplace.

Sincerely,



Mark Knickrehm
Chairman and Chief Executive Officer
Gainwell Technologies



Memo

Date October 31, 2025

To United States Senate Committee on Finance

From General Dynamics Information Technology, Inc. (GDIT)

cc Senators Ron Wyden, Elizabeth Warren, Bernard Sanders, and Raphael Warnock

Re October 10, 2025 letter to General Dynamics

In a letter dated October 10, 2025, Senators Ron Wyden, Elizabeth Warren, Bernard Sanders and Raphael Warnock requested information regarding information technology systems operated by General Dynamics Information Technology, Inc. (GDIT) that process Medicaid claims and determine Medicaid eligibility and coverage, known as Medicaid Management Information Systems (MMIS) and Eligibility & Enrollment (E&E) systems. GDIT provides this response to outline the work we perform in this area. We would be pleased to discuss these matters further with you and your staff.

Overview

GDIT operates three State systems that are relevant to the topic of the letter: two MMIS systems (one for New York and one for North Carolina) and the State of New York's Affordable Care Act (ACA) Marketplace that's referred to as the New York State of Health (or NYSOH).

A description of the systems and the work that GDIT performs for its State customers is provided below, but as a general matter the following statements apply to all three of these systems and their related contracts with our State customers:

- GDIT does not operate any E&E systems or provide any E&E call center services. However, the NYSOH system operated by GDIT makes limited eligibility determinations using rules provided by our New York State customer; we discuss this functionality below.
- GDIT's contracts with these customers do not contain pay-for-performance incentives to reduce eligible Medicaid enrollment.
- Each contract contains minimum required levels of service that the system must meet (referred to as Service Level Agreements, or SLAs); under these terms, GDIT is financially penalized for failing to meet our State customers' required levels of performance.
- GDIT adheres to industry best practices and applicable CMS guidance in developing, maintaining and testing each system it manages. System changes are made in close partnership with, and are subject to the approval of, our customers based on documented requirements. All system changes are monitored after implementation to ensure they conform with our customers' requirements and contractual SLAs.
- Software code developed by GDIT for these contracts is owned by the State customer.
- GDIT does not administer or manage any systems related to TANF or SNAP.



Discussion of MMIS Contracts

GDIT operates two contracts to manage MMIS systems, one for the State of New York and the other for the State of North Carolina. Both systems receive eligibility information from external systems that are not managed by GDIT. GDIT has consistently met the SLAs in these contracts.

New York MMIS.

Under this contract, referred to as “electronic Medicaid of New York” (or eMedNY), GDIT provides information systems for processing Medicaid claims and managing data for one of the largest and most technically sophisticated MMIS systems in the United States. GDIT’s systems are available 24x7x365 and provide a real-time processing environment for online eligibility verification, claims submission, status verification and review of transactions. GDIT’s work under this contract includes claims receipt, data conversion, claims processing and payment, data center operations, call center operations, systems development and quality assurance services.

GDIT has a long and successful history of supporting our eMedNY customer, with three decades of providing mission-critical operational excellence that has consistently seen 100% system availability. During eMedNY’s most recently completed contract year, 411 million Medicaid claims were processed by the MMIS system, resulting in authorized Medicaid payments of approximately \$110 billion.

North Carolina MMIS.

GDIT provides information systems for processing Medicaid claims and “capitation” payments to Managed Care Organizations for the North Carolina Medicaid program, referred to as NC Tracks. GDIT’s systems are available 24x7x365 and provide a real-time processing environment for online eligibility verification, claims submission, status verification and review of transactions. GDIT’s work under this contract includes claims receipt, claims processing and payment, data center operations, call center operations, systems development, prior authorizations and quality assurance services.

GDIT has supported our North Carolina customer on this program since 2009. The NC Tracks system currently processes over 98 million Medicaid claims annually, resulting in authorized Medicaid payments of approximately \$34 billion.

Discussion of NYSOH

GDIT developed, deployed and maintains NYSOH, the online insurance marketplace (referred to as an Exchange) for qualified New York individuals/families and small businesses to obtain health insurance under the ACA. NYSOH was the only ACA marketplace that went “live” on schedule in October 2013, and today nearly one in four New Yorkers get their health coverage through NYSOH. GDIT has consistently worked with our New York customer to make the enrollment process and user experience easier. For example, in May 2025 GDIT implemented a “mobile-friendly” capability that provides an enhanced user interface, allowing members to enroll (or re-enroll) using their mobile devices. NYSOH continues to be one of the most successful ACA Exchange implementations in the United States.

As noted above, the NYSOH system operated by GDIT makes limited eligibility determinations for those who qualify for health insurance under the Modified Adjusted Gross Income calculation. It is important to note, though, that GDIT itself does not “make” these eligibility determinations. Instead, the system’s eligibility decisions are made using rules that are defined and approved by the New York State Department of Health prior to implementation. In addition, GDIT plays no role in dispute resolution or appeals processes for individuals denied eligibility.

GDIT appreciates the opportunity to share the above information with you, and we are available to answer any follow up questions that you may have.



June 16, 2025

The Honorable Ron Wyden, Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Elizabeth Warren, Ranking Member
Banking, Housing and Urban Affairs
United States Senate
Washington, DC 20510

Re: June 9, 2025 letter regarding the Maximus role in Medicaid program administration

Dear Senator Wyden and Senator Warren,

Maximus welcomes opportunities to educate the Committee staff about our work with state Medicaid programs. Because your letter is so factually inaccurate and repeats many of the errors that have been levied against Maximus by special interest groups, it is important that we start by correcting the record. Maximus only does business with government agencies. Our independent and conflict-free role in helping government is transparent. Our record is exemplary, and our commitment to government leaders and the public is unwavering. We are an accountable organization responding to agencies with the most effective and efficient solutions, solving problems and improving services to designated populations.

Clarification of the Role Maximus Plays for Government Agencies

Maximus *does not* currently certify Medicaid eligibility; however, with our outstanding workforce, we achieve greater efficiency and accountability in the savings we provide to taxpayers while improving the quality of the citizen experience in other aspects of Medicaid support.

Maximus implements rules created in government statute and policy; *it does not create them*. Our services leverage process change, technological interventions, and trained staff to improve the transparency, efficiency, and effectiveness of program operations. We compete successfully for our contracts, and we are accountable – working under performance-based contracts when offered by governments so that we are paid for the quality of our work. We are bound to the terms and conditions of our contracts, which contain no incentives to disenroll Medicaid beneficiaries. We do not compete for Medicaid disenrollment contingency contracts.

An Explanation of Performance, Oversight, and Accountability

The programs we support are complex, yet Maximus does not shy away from accountability. We enforce rigorous internal quality assurance controls and submit to independent audits and regulatory reviews. When issues arise, we act immediately and transparently, working side by side with our government partners to resolve them. Our performance is closely monitored and

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continuously measured, leading to recommendations to improve outcomes, often exceeding the high standards set by our clients.

The Purpose of Advocacy and Lobbying

Maximus does not lobby to influence Medicaid eligibility rules. Our advocacy is strictly limited to sharing operational expertise and insights – helping government understand how to be more effective and efficient in operating government programs. The objective of our work is to provide the right services, to the right people, at the right time – being conflict free and achieving better outcomes in serving your constituents while maximizing the taxpayers' contribution to government programs. We pursue no agenda other than operational excellence – helping government better serve the people.

We take immediate corrective action in performing our work, addressing deficiencies using continuous process improvement techniques; we constantly identify root cause problems while safeguarding the dignity and rights of every beneficiary and recipient. In doing this work, we share insights into where oversight is maybe missing. For example, there are inherent conflicts of interest that can hurt beneficiaries regarding Medicaid work requirements where Medicaid Manage Care Organizations (MCOs) could be allowed to administer this function. This is the type of information we share with Committee members and staff to help you improve awareness.

Detailed Responses to Questions

1. Pay-for-Performance Clauses

Maximus does not have any state Medicaid contracts that tie payment or revenue to the disenrollment of individuals. Our compensation is based solely on performance-based standards such as program compliance, accuracy, timeliness, and service quality.

2. Documentation for Medicaid Eligibility

We do not set documentation requirements. Those are determined by federal and state policy makers. We do not assess the value of community engagement or work requirements – that is the sole purview of policymakers. If policymakers require additional documentation of eligibility, we execute those requirements, as directed by our government clients.

3. Penalties and Performance Standards

Our contracts include stringent performance standards, and we are held fully accountable for accuracy, responsiveness, and compliance. Where deficiencies are found, corrective measures – including financial penalties – are enforced. Our record speaks for itself: customer satisfaction scores are often above 90% with exemplary audit results.

4. Censure or Contract Failures

We are not aware of the context you are using the term “censure” but if we understand your question correctly, we have not been censured by CMS. We encourage oversight and respond to all feedback with immediate action.



The reason Maximus is now successfully operating in its fifth decade is because the federal government and each of the 50 state governments know we are a reliable partner who is accountable for delivering excellent results and helping government better serve the people.

Sincerely,



Bruce L. Caswell
Chief Executive Officer & President
Maximus





November 24, 2025

Senator Ron Wyden, Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Senator Bernard Sanders
United States Senate
Washington, DC 20510

Senator Elizabeth Warren
United States Senate
Washington, DC 20510

Re: October 31, 2025, letter with additional questions regarding the Maximus role in Medicaid program administration

Dear Senator Wyden, Senator Sanders, and Senator Warren,

Maximus appreciates the opportunity to respond to your inquiry regarding our role in the administration of state Medicaid programs. Our CEO has asked me to respond to your letter on his behalf in recognition of the discussions that have occurred previously between my office and your staff, most recently in September 2025, for which we are appreciative.

Because your letter raises important questions about systems, incentives, and contractor responsibilities, we want to begin by clarifying where Maximus sits within the Medicaid operations and managed care plan enrollment environment.

In the states where we support Medicaid operations and enrollment in managed care plans, including those addressed in your letter, Maximus operates call centers, assists beneficiaries in choosing Medicaid managed care plans (enrollment broker functions), and provides other Medicaid member-support services. We do not design state Medicaid policy, and we do not build, deploy or operate Medicaid Management Information Systems (MMIS) or Eligibility and Enrollment (E&E) systems. Those systems are developed and maintained either by the states themselves or by separate vendors under state direction. The only exception is that we have built a Medicaid provider enrollment module which enrolls providers serving Medicaid beneficiaries. This module is not related to Medicaid beneficiary enrollment and eligibility which is the scope of this inquiry.

This distinction is central to the concern raised in your letter: whether contractor incentives or system design could encourage improper disenrollment of eligible beneficiaries. Maximus' role and contract structures are not designed to do that, for four reasons:

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1. **We do not have authority to make final Medicaid eligibility determinations.** In the programs at issue, eligibility determinations are made by state agencies (and, in some states, county-administered agencies) using their own eligibility rules and E&E system. Our systems receive and use eligibility data transmitted by the state; we do not determine, create, override, or independently change the state's eligibility decisions. Put simply, Maximus does not decide who qualifies for Medicaid coverage in these programs; only the state does.
2. **Our compensation is not tied to reducing enrollment.** Our contracts do not provide bonuses or penalties based on lowering Medicaid enrollment or increasing disenrollment. We are typically paid based on per-call pricing, per-transaction fees, or fixed fees. Contract remedies are tied to service levels such as accuracy, timeliness, and call quality, so our financial interests are aligned with accurate execution of state policy, not with reducing the number of people enrolled.
3. **States require reconciliation between our systems and theirs.** In our enrollment broker contracts, states generally require periodic reconciliation between the state's eligibility file and our downstream enrollment platform. We support those processes and work with our state partners to investigate and correct discrepancies so that our systems reflect the same eligibility status as the state's beneficiary data storage and management system.
4. **We are responsible for remediating our operational errors.** When Maximus causes an operational error under our contracts, we are responsible for remediation and are subject to contractual remedies such as liquidated damages, payment withholds, or service level penalties. States do not pay us additional fees to correct errors that result from our performance.

Our mission in these programs is straightforward: to implement the eligibility determinations and policy requirements established by states and federal law, and to help eligible people access and keep their coverage with transparency, accuracy, and integrity. We carry out this work at the direction of our state customers and are accountable when we fail to execute that direction correctly.

With that context, our detailed responses to your specific questions follow below.

1. **Do any of Maximus's state Medicaid contracts include pay-for-performance clauses or other payment structures that tie payments or revenues to other factors?**
 - a. **If so, list all factors for which you receive bonus payments by contract.**
 - b. **If so, list all factors for which you receive payment reductions by contract.**
 - c. **Please provide a copy of any such contract provisions.**

We do not have any contracts that contain bonus provision for enrollment or disenrollment. Maximus' payment structure in state Medicaid contracts is based on transaction volume and service delivery — such as per-call pricing, per-transaction fees, or fixed fees — and on



meeting agreed standards for accuracy and timeliness. It is not tied to enrollment or disenrollment outcomes. Most contracts include service level agreements that hold us accountable for measures of accuracy, timeliness, call handling, and similar operational metrics. Where we do not meet those standards, states may assess liquidated damages, withhold payments, and require corrective action.

- 2. Does Maximus plan to compete for contracts to implement the new Medicaid eligibility requirements stemming from Trump and Congressional Republicans' new law?**
- a. If so, has Maximus begun the proposal process in any states? If yes, which states?**
 - b. Please provide a copy of any planning materials Maximus made in anticipation of competing for these new contracts.**

As discussed with your staff in September, several factors influence whether Maximus decides to bid on opportunities. These include our assessment of whether we have the capabilities to successfully perform, whether we can deliver the best value to the client, whether we can operationally meet the requirements, and, as a for-profit company, whether we can do so while earning a reasonable fee.

Accordingly, without addressing whether we have submitted proposals for any specific opportunities, we can share that Maximus has a long-standing history of competing for government procurement opportunities when they align with our capabilities, expertise, and professional standards. This approach remains consistent across administrations and policy changes.

If future contracts related to Medicaid eligibility requirements are a good fit for our services, we will evaluate and participate in those procurements in accordance with applicable laws and regulations.

- 3. Does Maximus have any contracts wherein it helps states process or secure Affordable Care Act (ACA) marketplace enrollment?**
- a. If so, which states?**

Maximus holds contracts in which we assist states or the federal government with Affordable Care Act (ACA) marketplace enrollment-related functions, such as operating consumer assistance centers, providing enrollment support, or processing certain transactions. Under those contracts, we do not design plan offerings or establish eligibility rules.

At the time of this letter, our ACA state-based marketplace-related work includes the following jurisdictions:

- Illinois
- Massachusetts
- Maryland
- Maine
- New Jersey



- New York
- Vermont
- District of Columbia

- 4. Are there any states where Maximus holds contracts related to both Medicaid and ACA enrollment and eligibility?**
- a. If so, which states?**
 - b. If so, is Maximus required to reconcile any conflicts of interest related to these coinciding contracts?**
 - c. How does Maximus navigate holding these two types of contracts concurrently? Please produce any written materials or guidance related to this.**

Maximus does not have organizational conflicts of interest in the Medicaid and ACA contracts that are the subject of this inquiry.

In most jurisdictions, Maximus' Medicaid and ACA-related work is structurally separated. In some states, our role is limited to Medicaid enrollment and member-support functions, while ACA eligibility is determined through the federally facilitated marketplace. In other states, we assist with ACA enrollment and member-support functions, but we do not perform Medicaid eligibility in those jurisdictions. In those models, the programs are administered through distinct systems and contracts.

In a smaller number of integrated environments, a state has chosen to use a single customer service center so that consumers can get help applying for coverage regardless of whether they ultimately qualify for Medicaid, the Children's Health Insurance Program (CHIP), a state specific program, or an ACA marketplace plan. In those states where it is done by a single vendor the goal is to provide a single point of entry for the full range of programs for which they may be eligible.

Across all these contracts, Maximus' role is limited to administrative and member-support services. Our contracts bar us from financial relationships with the managed care organizations and marketplace plans whose products we help beneficiaries compare, and our compensation does not vary based on the program or plan in which a beneficiary is enrolled.

- 5. In any state where Maximus has previously implemented federal welfare-to-work for programs, like TANF or SNAP, what percentage of beneficiaries were determined by Maximus to be eligible for a hardship exception from the so-called "work requirements"?**

Maximus does not make hardship determinations for federal or state work requirements. in Medicaid, SNAP, or TANF. Those determinations are made by state agencies and, in some states, by county-administered agencies under state policy.

In some programs, Maximus may assist with gathering information from beneficiaries, scheduling assessments, or processing documentation under the state's rules. In those cases,



our role is to collect and transmit information to the state or its designee; we do not decide whether a beneficiary qualifies for a hardship exception.

6. What pre-deployment testing and post-deployment monitoring does Maximus perform to ensure the accuracy and robustness of the MMIS and E&E systems being created for states? Please describe the testing that occurred, how the testing was carried out, and the types of issues, if any, that Maximus identified through these processes.

Maximus does not build, deploy or operate E&E or MMIS systems. These systems are developed, maintained, and operated either by the states themselves or by other vendors under state direction. They contain the eligibility rules, decision logic, and case records that determine whether an individual is enrolled in Medicaid.

Our role is to develop and operate downstream systems and services—primarily enrollment broker platforms, contact centers, and related tools—that rely on data sent from the state's E&E system. For example, in our enrollment broker work, we receive eligibility data from state systems (often through standard 834 transactions or comparable eligibility files) and use that information to help beneficiaries select or change managed care plans in accordance with state policy.

Our platforms do not overwrite or independently alter the state's eligibility records. To keep systems aligned, states generally require periodic reconciliation between the state's eligibility file and the enrollment data in our platform. In all cases, the state's eligibility system remains the system of record.

Maximus is responsible for testing our own systems to ensure they correctly interpret and apply the data we receive from the state. Before deploying changes to our systems or interfaces, we conduct testing consistent with state requirements and industry practice. After deployment, we monitor the performance of our systems and correct any defects that may be identified.

7. When Medicaid eligibility or renewal rules change, what is the process and average timeline by which Maximus updates its systems?

a. What role do states play in this process?

Each state has its own system as the Medicaid eligibility system of record; Maximus does not own any state's Medicaid eligibility system nor have we developed and deployed any Medicaid eligibility systems on behalf of states. If any Maximus systems need to be updated due to eligibility or renewal rules changes, we make those updates at the direction of the state.

8. What protocols are in place to address change request issues that are the result of Maximus?

a. In what instances do states bear the costs associated with Maximus-related errors?

b. Please describe how these protocols and protections vary across contracts.



States never bear the cost of correcting errors that result from Maximus' performance.

Maximus and its state customers use formal change-management processes to govern system and process changes. Those processes typically include documented initiation of a change request, impact analysis, approval by the state, development and testing, and controlled deployment.

Our contracts generally allow states to impose remedies such as liquidated damages, payment withholds, or service level credits when we fail to meet agreed performance requirements. States do not pay us additional fees to correct errors that result from our performance.

- 9. How many states have amended their original contract with Maximus to address change request issues beyond the original scope of the state's contract?**
- a. Please describe what contract amendments frequently entail.**
 - b. What are the minimum, maximum, and average costs associated with amendments to original contracts for change requests that Maximus has done since 2014?**

Several states have amended their original contracts with Maximus to address change requests beyond the original scope of the state's contract. These amendments typically involve adjustments to service delivery terms. These change requests are frequently driven by external factors beyond the control of either the states or Maximus, such as changes in federal rules and sub regulatory guidance, changes in program eligibility criteria, and emergency responses such as those necessitated by the COVID-19 pandemic. Such factors have required rapid adaptation to ensure continued compliance with federal guidelines and uninterrupted service delivery to beneficiaries.

The financial implications of these amendments vary and are influenced by the nature and extent of the requested changes. In some cases, cost adjustments have been necessary to reflect changes in responsibilities, service volumes, or technologies and systems. In all cases, contract amendments are negotiated following established state procurement rules and where required, in accordance with CMS oversight, review and approval.

- 10. To what extent does Maximus collaborate with other Maximus teams or other companies in other states to share code or other information technology resources related to MMIS and E&E systems?**
- a. Are Maximus MMIS and E&E systems proprietary?**
 - b. Do Maximus contracts contain any restrictive licenses that would prevent teams from coordinating across states?**
 - c. Do Maximus contracts contain any restrictive licenses that would lock in Maximus by making it prohibitively difficult for states to switch vendors?**
 - d. Should a state award another vendor a subsequent MMIS or E&E system, can the state build this from Maximus's MMIS and E&E system, or would the new vendor need to build the MMIS and E&E system from scratch?**

Maximus does not build, deploy or operate MMIS or E&E systems.



Our Medicaid-related applications and tools include proprietary components, but states own their program data and, in many cases, have rights to configuration artifacts, documentation, and interface specifications developed under their contracts. Our contracts do not restrict states from coordinating with one another, sharing their own implementation experience, or procuring services from other vendors.

Our internal teams share lessons learned, business processes, and configuration approaches internally across state projects where permitted by contract. This internal collaboration helps states benefit from prior experience without sharing state-specific data or confidential information across jurisdictions.

When a state selects a new vendor to perform services that Maximus previously provided, we support transition planning and knowledge transfer as directed by the state. Our goal in transitions is to ensure continuity of service for beneficiaries and a controlled handoff of knowledge and documentation, consistent with contract terms and state instructions.

- 11. To what extent does Maximus collaborate with CMS to share code or other information technology resources related to MMIS and E&E systems?**
- a. Do Maximus contracts contain any restrictive licenses that would prevent Maximus from doing so?**

As stated above, Maximus does not build, deploy or operate MMIS or E&E systems. Our contracts do not contain licensing terms that prevent us from providing CMS with the information it requires.

- 12. Under CMS regulations, Medicaid systems must use a “modular, flexible approach to systems development,” including “the separation of business rules from core programming.” Please describe how Maximus systems comply with this requirement and translate eligibility rules into executable computer code, including through the use of rules engines, where applicable.**
- a. Please describe how Maximus ensures that it continuously implements the latest technology and industry best practices throughout the duration of the contract lifecycle.**

As stated above, Maximus does not build, deploy or operate MMIS or E&E systems.

Maximus designs and operates its Medicaid-related services and tools so that they integrate with, rather than replace, a state’s E&E and MMIS system. Our components are deployed as discrete services that exchange data with the state’s E&E and MMIS systems through defined interfaces. This design allows states to modernize parts of their environment without disrupting core eligibility systems.

Over the life of a contract, we work with states to incorporate changes in federal and state guidance, CMS expectations, and industry best practices.

In all cases, changes are implemented under state direction and are subject to the same change-management and testing disciplines described above.



13. Please describe how Maximus staffs MMIS and E&E RFP teams and contracts, including the number of staff, their education level, their area(s) of expertise, their title, the aggregate billed number of hours per month, and the contract's monthly full-time equivalence.

As stated above, Maximus does not build, deploy or operate MMIS or E&E systems.

14. Please list all Maximus MMIS and E&E contracts dating back to 2014 and denote which contracts were and were not re-awarded.

a. Please provide any and all Contractor Performance Assessment Reporting System (CPARS) comments, ratings, and narratives.

The Contractor Performance Assessment Reporting System (CPARS) is a federal performance evaluation tool used for federal contracts. The MMIS and E&E referenced in your letter are administered by state Medicaid agencies and are not subject to CPARS reporting requirements.

State agencies monitor and evaluate contractor performance under their own oversight processes.

15. Please provide all Maximus MMIS and E&E contracts dating back to 2014, as well as the most recent APDs and RFPs associated with those contracts.

As stated above, Maximus does not build, deploy or operate MMIS or E&E systems.

Advance Planning Documents (APDs), and Requests for Proposals (RFPs) are developed, issued, and administered by individual state governments. The responsibility for providing information related to these documents resides with the respective state agencies.

Thank you again for the opportunity to respond to your letter and to clarify Maximus' role in state Medicaid programs. We take seriously our responsibility to implement federal and state policy as written, to support eligible beneficiaries in understanding and maintaining their coverage, and to provide our government customers with accurate, timely information about program operations.

Sincerely,



John T. Martinez
Chief Legal Officer
Maximus
www.maximus.com

