United States Senate

WASHINGTON, DC 20510–6200

November 12, 2026

Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Administrator Oz:

The Centers for Medicare & Medicaid Services (CMS) is running the most aggressive public enforcement campaign against state Medicaid programs in the agency's history, while accelerating the systematic dismantling of the federal infrastructure Congress funded to prevent Medicaid fraud in the first place. That is not program integrity. That is political theater layered over a decade of neglect, with states across the country, and in particular, an overwhelming number of Democratic-led states that have become the Trump administration's targets, left to answer for both.

Since you were confirmed as Administrator, you sent all 50 governors letters demanding provider revalidation on a ten-business-day clock.[1] You moved to withhold more than $2 billion annually in federal Medicaid funds from Minnesota without providing the State any details on its alleged noncompliance, and then issued successive deferral actions in February, April, and July 2026 totaling more than $500 million in additional federal Medicaid funds.[2] In successive

[1] Letter from Mehmet Oz, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Governors of the 50 States (Apr. 23, 2026), *reprinted in* Andrew Mark Miller, *Oz Puts All 50 Governors on Notice Over Billions Lost to Medicaid Fraud*, FOX NEWS (Apr. 23, 2026), https://www.foxnews.com/politics/read-dr-oz-puts-all-50-governors-notice-over-billions-lost-medicaid-fraud; *see also* Andy Schneider, *Governors and State Medicaid Directors Get a New Assignment from Dr. Oz: Quickly Recertify "High-Risk" Providers*, Geo. Univ. Ctr. for Child. & Fams. (Apr. 24, 2026), https://ccf.georgetown.edu/2026/04/24/governors-and-state-medicaid-directors-get-a-new-assignment-from-dr-oz-quickly-recertify-high-risk-providers/.

[2] Letter from Mehmet Oz, Adm'r, CMS, to Tim Walz, Governor of Minnesota (Jan. 6, 2026); Letter from Dorothy Ferguson, Director, CMS Division of Financial Operations West, to John Connolly, Medicaid Director, Minn. Dep't of Human Servs. (Feb. 25, 2026); Letter from Dorothy Ferguson, Director, CMS Division of Financial Operations West, to John Connolly, Medicaid Director, Minn. Dep't of Human Servs. (April 29, 2026); Letter from Dorothy Ferguson, Director, CMS Division of Financial Operations West, to John Connolly, Medicaid Director, Minn. Dep't

deferral actions in May, July, and October 2026, you also withheld more than $3.4 billion in federal Medicaid funds tied to California's In-Home Supportive Services program and personal care services, citing nothing more than California's growth rate relative to other states, with no specific evidence of wrongdoing.[3]

The U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) has decertified Hawaii and New York's Medicaid Fraud Control Units and placed all 53 Medicaid Fraud Control Units (MFCUs) under review. Though most MFCUs are housed within state Attorneys General offices, all serve as the primary mechanism for prosecuting Medicaid provider fraud; consequently, decertifying them in the name of fighting fraud is self-defeating. Moreover, while statutory oversight of MFCUs rests with HHS OIG, the CMS Center for Program Integrity (CPI), whose statutory role is to serve as the federal bridge to state MFCUs so that state Medicaid program integrity units work in partnership with and refer cases to their respective MFCUs, has provided no visible support to states navigating this review.[4] During New York's decertification, it appears that CPI provided no technical assistance or support to the program integrity unit, leaving state investigators without a functioning federal pathway. Instead, you have launched a Medicaid Fraud "War Room" that your Deputy Administrator publicly calls "what modern program integrity looks like."[5] Modern program integrity should start with meeting the mandates Congress already wrote into law.

---

of Human Servs. (July 21, 2026).

[3] Cal. Dep't of Health Care Servs., *State Condemns Federal Deferral of IHSS Funds, Warns of Immediate Harm to Hundreds of Thousands of Vulnerable Californians* (2026), https://www.dhcs.ca.gov/newsroom-office-of-communications/state-condemns-federal-deferral-of-ihss-funds-warns-of-immediate-harm-to-hundreds-of-thousands-of-vulnerable-californians/; Cailey Gleeson & Paige Minemyer, *CMS Defers $1.2B in Medicaid Funds from California, Puts New York on Notice After Raid*, FIERCE HEALTHCARE (Oct. 21, 2026), https://www.fiercehealthcare.com/regulatory/trump-admin-pausing-over-1b-medicaid-payments-california-minnesota; Ana Ceballos, *Feds Hold Back Additional $1.2 Billion in California Medicaid Reimbursements*, L.A. TIMES (Oct. 20, 2026), https://www.latimes.com/politics/story/2026-10-20/feds-hold-back-additional-1-2-billion-in-california-medicaid-reimbursements.

[4] Letter from T. March Bell, Inspector Gen., U.S. Dep't of Health & Hum. Servs., to Letitia James, Att'y Gen., State of New York (June 30, 2026), https://oig.hhs.gov/documents/medicaid-fraud-control-units/11727/NY_MFCU.pdf; Letter from T. March Bell, Inspector Gen., U.S. Dep't of Health & Hum. Servs., to Anne Lopez, Att'y Gen., State of Haw. (June 4, 2026), https://oig.hhs.gov/documents/medicaid-fraud-control-units/11679/Hawaii_Denial_of_Recertification_Letter.pdf; Letter from T. March Bell, Inspector Gen., U.S. Dep't of Health & Hum. Servs., to State Att'ys Gen. (May 13, 2026); *see also* Jessica Mathers & Elizabeth Hinton, Understanding the Role of Medicaid Fraud Control Units (MFCUs), Kaiser Fam. Found. (Sept. 28, 2026), https://www.kff.org/medicaid/understanding-the-role-of-medicaid-fraud-control-units-mfcus/; Jessica Mathers & Elizabeth Hinton, What to Know About Recent Federal Actions Involving State Medicaid Program Integrity, Kaiser Fam. Found. (June 9, 2026), https://www.kff.org/medicaid/what-to-know-about-recent-federal-actions-involving-state-medicaid-program-integrity/; 42 U.S.C. § 1396b(q); 42 C.F.R. 1007 (2024).

[5] Press Release, Ctrs. for Medicare & Medicaid Servs., *CMS Medicaid Fraud War Room Stops More Than $203 Million in Improper Payments During First 88 Days* (July 28, 2026), https://www.cms.gov/newsroom/press-releases/cms-medicaid-fraud-war-room-stops-more-203-million-improper-payments-during-first-88-days.

Medicaid program integrity has been under-resourced across administrations. That is precisely why Congress established the Medicaid Integrity Program (MIP) in the Deficit Reduction Act of 2005 and imposed a statutory floor of no less than $75 million and no fewer than 100 full-time employees (FTEs) dedicated annually to working collaboratively with states to fight Medicaid provider fraud and abuse. At the same time, Congress enacted mandatory federal technical assistance, on-site state reviews, and analytical support to states.[6] Those obligations are not discretionary, and CMS cannot treat dedicated funding as optional funding or repurpose it at will.[7]

The Trump administration and CMS under your leadership are not meeting these binding statutory obligations. Instead, you are hollowing out MIP under the guise of enforcement and compounding institutional failures:

- The Division of Fraud Research and Detection, the only CMS division dedicated exclusively to Medicaid analytics, which maintained direct data feeds from approximately sixteen states' Medicaid Management Information Systems (MMIS), was eliminated in the 2015 CPI reorganization.[8] The defining failure of the current era is that these vital tools were never rebuilt, allowing what was once a temporary reorganization to harden into a permanent blind spot.

- Comprehensive on-site State Program Integrity Reviews have been replaced with remote "Focused Reviews" issuing non-binding "Observations." CMS no longer tells states what to fix; it tells states what to consider.[9] Until this administration, even as the MIP infrastructure weakened, CMS and states maintained a working collaborative relationship on program integrity - sharing data, issuing joint fraud alerts with HHS OIG, and working through disallowances backed by evidence. That collaborative posture has been replaced by performative enforcement.

---

[6] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6034, 120 Stat. 4, 74–79 (2006) (codified at Social Security Act § 1936, 42 U.S.C. § 1396u-6); *see also* Medicaid Integrity Program; Eligible Entity and Contracting Requirements for the Medicaid Integrity Audit Program, 73 Fed. Reg. 55765-66 (Sept. 26, 2008).

[7] *See* Ctrs. for Medicare & Medicaid Servs., *Report to Congress: Medicare & Medicaid Integrity Programs for Fiscal Year 2024*, at 11 (Sept. 2025), https://www.cms.gov/files/document/fy2024-medicare-medicaid-report-congress.pdf; MACPAC, *Medicaid Program Integrity* (Apr. 2026), https://www.macpac.gov/wp-content/uploads/2026/07/Issue-Brief-Medicaid-Program-Integrity.pdf.

[8] Thomas Kessler, *CMS's Missed Opportunities in Supporting Medicaid Program Integrity*, LinkedIn (Jan. 6, 2026), https://www.linkedin.com/pulse/cmss-missed-opportunities-supporting-medicaid-program-thomas-kessler-1nwbe/.

[9] *Compare* Ctrs. for Medicare & Medicaid Servs., *Oregon Comprehensive Program Integrity Review: Final Report* (Dec. 2014), https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/ORfy13.pdf (mandating 90-day corrective action plan following on-site review), *with* Ctrs. for Medicare & Medicaid Servs., *Maine Focused Program Integrity Review: Final Report* (Jan. 2026), https://www.cms.gov/files/document/maine-fy2024-focused-pi-review-final-report.pdf (defining "Observations" as items that "do not represent areas of non-compliance with federal and/or state requirements" and instead "identify areas that may pose a vulnerability or could be improved").

- The Medicaid Integrity Institute's residential training at the Department of Justice's (DOJ) Ernest F. Hollings National Advocacy Center (NAC), CMS's flagship in-person training for state program integrity staff, has been eliminated in favor of an all-virtual calendar. State program integrity directors have asked, in every available forum, for the in-person peer-led instruction to return, and CMS has refused. Public reporting and CMS's own training calendars indicate the Institute has been reduced to a handful of virtual webinars per year and a few regional in-person listening sessions with State Medicaid Agencies and MFCUs between July and November 2026.[10]

- Publicly reported accounts indicate the federal workforce dedicated exclusively to Medicaid program integrity has fallen dramatically below the 100-FTE floor Congress set.[11]

- CMS state liaisons, fraud alerts issued jointly with HHS OIG, State Medicaid Director letters on program integrity, and the Annual Summary Report of Program Integrity Reviews have all been eliminated or discontinued.[12]

An enforcement campaign built on gutted infrastructure produces shoddy results. On April 10, 2026, news reports revealed that CMS acknowledged its fraud probe of New York Medicaid rested on a figure that was off by a factor of ten - a basic mathematical error in calculating annual unique beneficiaries that independent analysts traced to a fundamental misunderstanding of how Medicaid data is counted.[13] The administration publicly shared whatever figures served its political purposes, and the resulting mistake was then used to threaten a state. California has faced a separate but equally troubling pattern: CMS has imposed federal payment deferrals that have now accumulated to more than $3.4 billion, with California's Medicaid director publicly rejecting the validity of CMS's claims and stating that CMS has provided no evidence supporting the deferrals.[14] Minnesota has gone further and filed suit against CMS, HHS, you, and Secretary Kennedy over the attempted withholding of $243 million in Medicaid payments, alleging that CMS imposed the withholding, without informing the state, despite it asking repeatedly, how it was noncompliant or what corrective steps were required.[15]

---

[10] Ctrs. for Medicare & Medicaid Servs., *Medicaid Integrity Institute CY 2025 Training Calendar*, https://www.cms.gov/files/document/mii-cy-2025-training-calendar.pdf; Ctrs. for Medicare & Medicaid Servs., *Medicaid Integrity Institute CY 2026 Training Calendar*, https://www.cms.gov/files/document/mii-cy-2026-training-calendar.pdf; Kessler, *supra* note 7.

[11] Kessler, *supra* note 7.

[12] *Id.*

[13] Ali Swenson, *AP Exclusive: Trump Administration Admits a Glaring Error in Its New York Health Fraud Accusations*, ASSOCIATED PRESS (Apr. 10, 2026), https://apnews.com/article/new-york-medicaid-fraud-dr-oz-trump-342285a3c5d5b71f36ce3f3c77ec72c5; Michael Kinnucan, *The Basic Math Error in Dr. Oz's Fraud Letter*, Fiscal Policy Institute (March 30, 2026), https://fiscalpolicy.org/the-basic-math-error-in-dr-ozs-fraud-letter.

[14] Cal. Dep't of Health Care Servs., *supra* note 3.

CMS is putting on theatrics about going after states to "crush fraud" without any legitimate data to back up their claims, all the while starving the federal office Congress created to help states prevent those failures. A fake war room is not a substitute for a Medicaid integrity program that meets its statutory obligations. Contracting Medicaid analytics out to General Dynamics Information Technology (GDIT), the current Trusted Third Party for the Healthcare Fraud Prevention Partnership (HFPP), a multi-payer public-private partnership, is also not in compliance with a statute that requires Medicaid-dedicated federal capacity.[16]

On October 15, 2026, your Deputy Administrator announced at an industry conference that CMS is piloting artificial intelligence to flag suspicious Medicaid billing patterns "in near real-time before Medicaid payments are made," with the stated goal of scaling the pilots into a "national, standardized, continuously improving platform."[17] CMS does not, however, operate the claims systems that generate the underlying data. In fee-for-service Medicaid, state agencies adjudicate claims; in managed care, Medicaid Managed Care Organizations do. CMS receives Medicaid claims and encounter data on a lag, and the federal pre-payment analytical capacity that could plausibly support such a platform is precisely the capacity CMS dismantled. Congress is entitled to understand what data CMS actually has, how it is obtaining it, and under what legal authority, before any such platform is scaled nationally.

Therefore, to assess CPI's current compliance with Section 1936 of the Social Security Act (the Act) and the fiscal accounting of the MIP appropriation, I request the following documents and information by **November 27, 2026**:

1. For each fiscal year from FY 2015 through the present, please provide the number of filled federal FTE coded exclusively to the MIP appropriation, reconciled to the 100-FTE statutory floor under Section 1936 of the Act. To the extent the workforce has fallen

---

[15] Press Release, Office of Minn. Att'y Gen. Keith Ellison, *Minnesota Sues Trump Administration for Illegally Withholding $243 Million in Medicaid Payments* (Mar. 2, 2026), https://www.ag.state.mn.us/Office/Communications/2026/03/03_Medicaid-Funding.asp.

[16] *See* Delivery Order HHSM500201600012I-75FCMC19F0001, awarded to General Dynamics Information Technology (Sept. 28, 2019), valued at up to $105,358,111, https://www.highergov.com/contract/HHSM500201600012I-75FCMC19F0001/; Contract Summary: General Dynamics Information Technology, USAspending.gov, https://www.usaspending.gov/award/CONT_AWD_75FCMC19F0002_7530_HHSM500201600005I_7530 (last visited Sept. 29, 2026); Recipient Profile: General Dynamics Information Technology, USAspending.gov, https://www.usaspending.gov/recipient/455555be-773d-eab1-1e6b-7b94400b757e-C/latest (last visited Sept. 29, 2026); Ctrs. for Medicare & Medicaid Servs., *Healthcare Fraud Prevention Partnership: Current Partners*, https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership/about/current-partners (last visited Sept. 29, 2026); Ctrs. for Medicare & Medicaid Servs., *HFPP's Organizational Structure,* https://www.cms.gov/medicare/medicaid-coordination/healthcare-fraud-prevention-partnership/about/organizational-structure (last visited Sept. 29, 2026).

[17] Christian Robles, *CMS Hopes to Quadruple Provider Suspensions Over Next Six Months, Official Says*, Nextgov/FCW (Oct. 15, 2026), https://www.nextgov.com/artificial-intelligence/2026/10/cms-hopes-quadruple-provider-suspensions-over-next-six-months-official-says/416640/.

below the statutory floor in any fiscal year, please provide CMS's legal justification for its noncompliance.

2. Please provide SF-133 quarterly budget execution reports for the MIP Treasury Account Symbol for FY 2020 through FY 2025, including unobligated balances brought forward each fiscal year.

3. Please identify any MIP-appropriated funds obligated since FY 2015 for Medicare activities, shared CMS overhead, non-Medicaid purposes, or Medicaid beneficiary eligibility verification (as distinct from the statutorily specified provider fraud and abuse purpose), together with CMS's legal justification for those obligations under the Purpose Statute, the Anti-Deficiency Act, and the Miscellaneous Receipts Act, given that MIP is a mandatory appropriation with a specific statutory purpose.

4. Please provide the methodology for, and actual allocation of, Unified Program Integrity Contractor costs between the MIP appropriation and Medicare appropriations from FY 2020 through the present, with Medicaid-specific deliverables identified for each fiscal year.

5. Please provide, for each fiscal year from FY 2015 through the present, (a) MIP funds obligated to the Medicaid Integrity Institute residential training program housed at the DOJ NAC, including all deobligations and modifications of the CMS-DOJ interagency agreement, (b) actual institute expenditures by fiscal year, with a breakdown of in-person training expenditures, virtual training expenditures, and non-training expenditures (including per-class costs and number of classes offered) and (c) documentation of how funds no longer obligated for in-person training have been reallocated.

6. Please identify any current, planned, or forecasted contract action, modification, or statement of work moving Medicaid Integrity Institute functions, including training logistics, curriculum development, state travel administration, or data analytics, to a contractor, including but not limited to GDIT. For any such action, please provide (a) the proposed and executed contract value compared to historical institute operating costs under the DOJ interagency agreement; (b) the methodology for allocating contractor labor hours and overhead between MIP-funded Medicaid-exclusive activities and HFPP-funded multi-payer activities; (c) CMS’s legal analysis under the Purpose Statute, the Anti-Deficiency Act, and the Miscellaneous Receipts Act of using MIP’s Medicaid-restricted mandatory appropriation to fund any multi-payer or non-Medicaid-exclusive activity; and (d) the current status of the CY 2027 MII training calendar, including whether its publication is dependent on the execution of any HFPP-related contract action.

7. Please identify the appropriation account, funding source, staffing plan, contractor support, and Medicaid-specific deliverables of the Medicaid Fraud War Room. Please

state whether any Fraud War Room resources, including, but not limited to, personnel, contract, or overhead, are drawn from the MIP appropriation, and provide the legal basis for any such allocation. Please also provide the underlying data documentation for the $203 million and 50-provider figures announced on July 28, 2026, and a breakdown of amounts actually recovered versus payments flagged, together with the underlying data documentation for the updated $342 million and 124 notices-of-intent-to-exclude figures referenced in your Deputy Administrator's October 15, 2026 ADAPT conference presentation, and an explanation reconciling the two sets of public figures.

8. Please describe the artificial intelligence and machine learning pilots referenced by your Deputy Administrator at the ADAPT conference on October 15, 2026, including: (a) the data sources, data flows, and legal authorities under which CMS is obtaining Medicaid claims or encounter data on a pre-payment basis in fee-for-service and managed care Medicaid; (b) the states participating in each pilot and the terms of their participation, including the Indiana-Oracle pilot and the five additional state pilots referenced; (c) the contractor(s) supporting each pilot and the acquisition vehicle(s) under which they were engaged; (d) the appropriation account(s) funding each pilot, including whether any MIP-appropriated funds are being used; (e) the privacy, data security, and HIPAA frameworks governing CMS's collection and use of pre-payment Medicaid claims and encounter data; and (f) the relationship, if any, between the pilots' data architecture and the direct state MMIS data feeds maintained by the Division of Fraud Research and Detection prior to its elimination.

9. Please explain how the President's FY 2027 Budget submission treats the MIP appropriation, the Medicaid Integrity Institute, and the Section 1936 workforce, training, and technical assistance mandates, and state CMS's position on statutory compliance in the current and coming fiscal years.

10. Please provide all internal analyses, contractor deliverables, and data sources supporting (a) the 5 million people with personal care services figure cited in your April 2026 letter to New York Governor Kathy Hochul, (b) the alleged noncompliance related to the withholding action against Minnesota including the analytical and evidentiary basis, (c) all federal payment deferrals imposed against Minnesota, including the analytical and evidentiary basis for each deferral, (d) all federal payment deferrals imposed against California, including the analytical and evidentiary basis for each deferral, and (e) CPI's role, if any, in supporting the HHS OIG process leading to the decertification of Hawaii and New York’s respective MFCUs.

I also request a staff-level briefing within two weeks on CPI's current compliance with Section 1936 of the Act and the operational and fiscal relationship among the MIP, the Medicaid Fraud War Room, and the Healthcare Fraud Prevention Partnership.

Medicaid serves more than 73 million Americans. Program integrity in a program of that scale demands sustained investment, deep expertise, and genuine partnership with states. Congress created and funded the infrastructure to do this work, and the administration and CMS are required by law to carry out those mandates. CMS is not free to redirect the funding, redefine the mission, or replace true program integrity with a flashy, politicized rebrand.

Sincerely,

Ron Wyden
United States Senator
Ranking Member, Committee on Finance

Adam B. Schiff
United States Senator

Alex Padilla
United States Senator

Jeffrey A. Merkley
United States Senator

Kirsten Gillibrand
United States Senator

Edward J. Markey
United States Senator