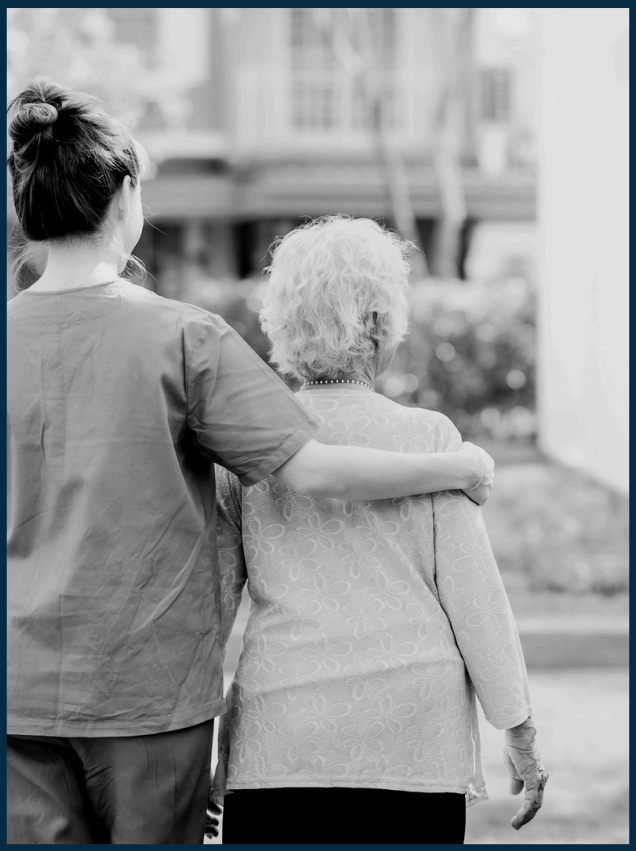
Medicaid Fraud and the Case for Responsible Reform

Reform is needed, not unchecked spending, to ensure the program remains viable and serves those in need.



Functional Government Initiative

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Medicaid Fraud and the Case for Responsible Reform

Medicaid is the largest public health insurance program in the United States, playing a vital role in ensuring healthcare access for vulnerable citizens. It provides medical and long-term care services to more than 80 million Americans, including low-income families, individuals with disabilities, seniors, and children. The program has grown substantially in cost and scope since its creation in 1965, and it now represents a significant portion of both federal and state budgets.

Unfortunately, like many programs of its size, Medicaid is beset by widespread fraud, waste, and abuse. The system's vulnerability to exploitation has been well-documented, with billions of taxpayer dollars lost each year to deceptive practices, improper payments, and lax oversight. Systemic failings eat away at the program's efficiencies, while substantially contributing to Medicaid's ballooning price tag. The result is a program that could work much better for the people who benefit from it and the people who pay for it.

Yet, despite these glaring inefficiencies, there is entrenched resistance to any effort—no matter how modest—to curb the program's runaway spending growth. Opponents of reform often frame such proposals as heartless austerity measures, but this framing ignores the extensive and ongoing misuse of funds. The reality is simple: allowing unchecked growth in a system riddled with fraud is fiscally irresponsible. Like pumping gas into a ruptured tank without repairing the leak – you may be able to drive on it for a while, but the big fix is inevitable and the gas lost in the meantime is a wasted resource.

Since 2008, federal Medicaid outlays have increased 207 percent, with 51 percent of that increase occurring since 2019. Medicaid spending as a share of federal outlays rose to 10 percent from 7 percent between 2007 and 2023. The provisions enacted in the One Big Beautiful Bill are designed to slow spending growth in Medicaid over the next 10 years by addressing waste, fraud, and abuse.

The Biden administration incentivized Medicaid to enroll healthy Americans and cost-shift funding responsibilities to the federal government, driving up costs for taxpayers and risking the program's sustainability for those who need it most. Even though they are supposed to be ineligible, illegal immigrants are enrolled in significant numbers. As spending has surged, so have improper payments and ineligible enrollments, along with gimmicks and loopholes.

These much-needed reforms to root out waste and fraud should put the program on a stronger fiscal footing. And spending on Medicaid is still projected to grow by billions of dollars over the next 10 years. Washington "math" calls this a cut.

Systemic Fraud and Mismanagement Highlight the Need for Reform

The following analysis of recent documented examples of Medicaid fraud across the United States demonstrates why responsible reform is not only reasonable but urgently necessary. Limping along on a bad leak for a few more years is foolish and self-defeating.

The One Big Beautiful Bill makes some enhancements to Medicaid as part of an effort to make the program more effective for Americans and place it on a sound fiscal footing:

- Requires able-bodied adults without dependents now have to work, volunteer or fulfill educational requirements 80 hours per month to maintain eligibility.

- Implements eligibility verification from states and Medicaid recipients twice a year in order to receive coverage, preventing payments for: beneficiaries who have died, who are enrolled in multiple states, or who otherwise do not qualify for the program.

- Prohibits states from waiving asset tests for long-term services, removing individuals from Medicaid rolls who have homes worth more than $1 million.

These commonsense changes, along with more effective management of the program by the Centers for Medicare and Medicaid Services, can ensure it is there for those who truly need the assistance, while stopping those who illegally exploit the generosity of the taxpayers.

A closer look at recent cases from across the country reveals increasingly common systematic exploitation of Medicaid—both by large institutions and individual providers. It is worth stressing that these are *recent examples*, so they are not meant to represent all ongoing maleficence or to even hint at the scope of the losses in Medicaid's 60 years of operation.

Examples of Fraud Around the Country

Arizona: $2.5 Billion Fraud Scheme Targeting Native Americans

Between 2019 and 2023, a sophisticated network of behavioral health providers and sober living homes fraudulently billed Arizona's American Indian Health Program for services that were never rendered. Some facilities allowed patients to continue using substances instead of providing treatment. More than $2.5 billion was lost to the scheme, which was described as one of the largest Medicaid fraud cases in U.S. history. Although more than 100 individuals have been indicted, Arizona has recovered just $125 million of the lost funds, or about 5 percent. [1] Fraud on such a scale illustrates how vulnerable specialized Medicaid programs are to exploitation.

Arizona: Guilty of Fraudulent Billing

In December 2024, CoEric Riley and Britney Gooch of Arizona pleaded guilty to healthcare fraud. They admitted to falsely billing for services that were not provided to their patients. As a result of the fraudulent billing submissions, Riley and Gooch obtained approximately $3.3 million in illegitimate proceeds from the Arizona Health Care Cost Containment System. [2]

California: Improper Reimbursements and Corporate Kickbacks

In 2024, California was ordered to repay over $52 million to the federal government for illegally claiming Medicaid reimbursement for services provided to immigrants with "unsatisfactory immigration status," a category not eligible under federal rules except for emergencies. [3] Separately, a 2025 settlement revealed that pharmaceutical company QOL Medical, along with its CEO, engaged in a kickback scheme involving free test kits to promote unnecessary prescriptions of its drug Sucraid. The company agreed to pay $47 million to resolve state and federal fraud allegations. [4]

In another major case, California settled a $10 million fraud claim with R&B Medical Group and other entities over kickbacks and self-referrals in Medi-Cal and Medicare billing. These instances show both systemic mismanagement and deliberate criminal intent among providers. [5]

Connecticut: A Wave of Fraud from Individuals and Providers

Connecticut saw multiple fraud schemes in 2025. A woman named Suhail Aponte pleaded guilty to orchestrating nearly $1.9 million in fraudulent claims for autism therapy services. Aponte, who was not licensed, created a shell company and submitted fake claims for services that she never delivered.[6] Another woman, Brittany Gresham, was extradited from Georgia after billing more than $44,000 in personal care services she never provided. These cases, while smaller in dollar amounts than institutional fraud and abuse, are indicative of a broader pattern: the ease with which individual actors can manipulate the system.

[1] https://www.propublica.org/article/arizona-medicaid-fraud-investigation-taxpayer-funds
[2] https://www.justice.gov/usao-az/pr/two-arizonans-plead-guilty-fraud-targeting-ahcccs
[3] https://www.latimes.com/california/story/2024-06-05/california-refund
[4] https://oag.ca.gov/news/press-releases/attorney-general-bonta-combats-medi-cal-fraud-announces-47-million-settlement
[5] https://oag.ca.gov/news/press-releases/attorney-general-bonta-combats-medi-cal-fraud-securing-10-million-settlement
[6]https://hartfordbusiness.com/article/medicaid-fraud-scheme-resulted-in-18m-in-losses-to-the-state/

Examples of Fraud Around the Country

Georgia: Multiple Medicaid Fraud Convictions
In May 2025, Teresa Owens was convicted for defrauding Medicaid of more than $300,000 through false claims for behavioral health services. She instructed her staff to fabricate patient records and used the stolen funds for personal gain. [7][8] The fraudulent activity included claims of more than 100 one-hour visits per day—an obvious impossibility.

Maryland: Behavioral Health Fraud
In March 2025, Tasha Saunders of Maryland was convicted of defrauding the Medicaid program of $3.6 million by billing for psychiatric rehabilitation services that were never provided. Saunders went so far as to forge records and steal identities of both patients and providers to carry out the scheme over five years.[9]

Massachusetts: Overcharging by a Major Retailer
In 2025, the Massachusetts Attorney General filed a lawsuit against CVS Health for charging Medicaid more for prescription drugs than the price offered to cash-paying customers. CVS allegedly colluded with a discount card company to offer better prices to private individuals, while denying those same prices to MassHealth, Massachusetts' Medicaid program.[10] This case illustrates how even major corporations manipulate pricing practices at the expense of public health budgets.

New York: Medicaid Fraud Spanning Multiple Sectors
In 2024, Fidelis Care paid a $7.6 million settlement after it referred Medicaid patients to Cornerstone Herkimer LLC, which then billed Medicaid for services. Cornerstone Herkimer was run by a person who had lost his clinical license and been convicted of a misdemeanor, and he was barred from participating in Medicaid.[11]

Also in New York, two Brooklyn-based home care agencies were found to have defrauded more than 25,000 workers and submitted false claims to Medicaid. The total settlement reached more than $17 million, with $9.75 million going back to the program.[12] In yet another case, Community Options Inc. agreed to pay more than $5 million for billing Medicaid for services that failed to meet standards, as well as for avoiding the return of improper payments.[13]

From 2017-2020, there was also a birth tourism scheme operating in New York that facilitated pregnant Turkish women fraudulently entering the United States using tourist and business visas to give birth so that their children would obtain birthright citizenship and medical benefits. This resulted in Medicaid programs distributing over $1 million in benefits to these Turkish nationals.[14]

[7]https://www.fox61.com/article/news/national/georgia-woman-arrested-extradited-to-connecticut-for-alleged-medicaid-fraud/520-2b5be382-e41e-427b-a5fb-aee70e068d19
[8]https://law.georgia.gov/press-releases/2025-05-12/carr-brookhaven-woman-convicted-305k-medicaid-fraud-scheme
[9]https://www.marylandattorneygeneral.gov/press/2025/030425a.pdf
[10]https://www.wpri.com/new-england/massachusetts/campbell-accuses-cvs-of-unfair-prescription-drug-pricing-medicaid-fraud/
[11] https://ag.ny.gov/press-release/2024/attorney-general-james-and-us-attorney-peace-secure-over-17-million-home-health
[12] https://ag.ny.gov/press-release/2024/attorney-general-james-secures-more-76-million-health-insurer-using-banned
[13] https://www.justice.gov/usao-sdny/pr/acting-us-attorney-announces-5-million-false-claims-act-settlement-providers-programs
[14] https://www.justice.gov/usao-edny/pr/turkish-national-pleads-guilty-conspiracy-commit-health-care-and-wire-fraud-birth

Examples of Fraud Around the Country

North Carolina: Home Visit Fraud
In May 2025, Steven Osbey of North Carolina agreed to a consent judgment against him requiring repayment to the government for charging Medicaid for physician home visits that never occurred. His clinic, co-owned with Aljihad Shabazz, conspired to carry out an extensive health care fraud scheme wherein they submitted or caused to be submitted claims to NC Medicaid for in-home physician visits with patients that simply never occurred—in all, billing more than 30,000 hours of these purported physician visits and sometimes billing as if the physician provided over 100 in-home visits in a single day, purportedly lasting an hour each (an obvious physical impossibility).”[15]

Ohio: Medicaid Fraud by 13 Separate Providers
In June 2025, twelve home-health aides and one behavioral-health specialist allegedly billed Medicaid for a combined $189,332 in services they did not provide, resulting in felony charges of Medicaid fraud and theft. [16]

Pennsylvania: Almost $1.1 Million Billed for Services that Were Not Performed
In June 2025, Hemal Patel of Pennsylvania was alleged to have received kickbacks to refer home care patients to home care agencies. Patel and others devised a scheme to fraudulently bill Medicaid for home care services that were never provided, resulting in a loss to Medicaid of approximately $1,069,384.38. Patel forged doctor signatures on forms required to certify individuals as eligible for home care services, and unlawfully used individuals’ personally identifiable information without their knowledge to enroll them for home care services they were not entitled to while those individuals were living out of the country.[17]

Virginia: Fraudulent Timesheets
In August 2024, four defendants pleaded guilty to scheming to defraud Virginia Medicaid by submitting fraudulent timesheets for work never performed, resulting in the loss of nearly $1 million.

The defendants identified and selected Medicaid recipients to sign up for Medicaid reimbursed personal care or respite care services. They executed agreements that designated numerous different individuals as personal care attendants (PCAs) for those recipients. The conspirators used the personal identifying information of the Medicaid recipients and purported PCAs to create accounts for the submission of timesheets for purported personal care and respite care services.[18]

For more than eight years, the conspirators submitted fraudulent timesheets to Medicaid showing thousands of hours of personal care and respite care services. They approved these timesheets attesting that services were provided, when the conspirators knew that none of the PCAs provided any personal or respite care services to the Medicaid recipients.

In total, the defendants knowingly caused Medicaid to pay at least $936,950.70 in fraudulent reimbursements for personal care and respite care services that never occurred.

[15] https://www.justice.gov/usao-wdnc/pr/charlotte-clinic-owner-agrees-settle-allegations-medicaid-fraud
[16] https://www.ohioattorneygeneral.gov/Media/News-Releases/June-2025/13-Medicaid-Providers-Facing-Fraud-Charges
[17]https://www.justice.gov/usao-edpa/pr/bensalem-woman-charged-home-care-fraud-kickback-scheme-caused-loss-medicaid-nearly-11
[18] https://www.justice.gov/usao-edva/pr/four-defendants-plead-guilty-defrauding-virginia-medicaid

Common Themes and Systemic Failures

Across these cases, a few consistent themes emerge:

- **Minimal Oversight**: In many instances, Medicaid providers operated for years with little scrutiny, allowing fraudulent billing to continue unchecked.
- **Exploited Populations**: Vulnerable groups—including Native Americans, immigrants, children with autism, and low-wage home care workers—were frequently the targets of schemes.
- **Lax Enforcement**: Even when fraud was discovered, the recovery rate is usually dismal. Arizona, for example, recovered only 5 percent of the $2.5 billion in fraudulent payments in the case above.
- **Institutional Complicity**: Fraud wasn't limited to small bad actors. Corporations like CVS Health and healthcare conglomerates knowingly engaged in abusive practices, suggesting deeper institutional rot.

The Case for Reform: Don't Believe Washington Math

Despite this overwhelming evidence of abuse, and despite false charges from status quo defenders, the proposals finalized in the OBBB continue to fund the program at increased levels. Curbing the growth of Medicaid, while tightening its vulnerabilities, is not a denial of care to vulnerable populations. Reforming Medicaid spending is not about eliminating care either – it is about protecting the system from exploitation and ensuring that funds are directed to those who truly need them.

Spending after enactment of the One Big Beautiful Bill is projected to reduce federal Medicaid outlays to states from $715 billion to $793 billion over the next 10 years. But according to the Congressional Budget Office and other analysts, that reduction would only slow spending growth, not reverse it. Medicaid funding will continue to grow, but at a slower rate than the current one. The slowed increases would grow federal Medicaid spending by $1.3 trillion by 2034, as opposed to $2 trillion on its current trajectory.

There are several more commonsense measures that would slow growth and end waste, without harming legal citizens who are eligible to be beneficiaries.

Enhanced Fraud Detection and Enforcement Tools

The OBBB increases protection against waste, fraud, and abuse by preventing Medicaid payments for beneficiaries who are enrolled in multiple states, deceased, or to those who do not qualify for the program. Lax enforcement had led to taxpayers paying $543 billion to these unqualified recipients over this past decade. This number is likely significantly higher due to the government only measuring improper payments in two out of the last ten years. Based on the two years of meaningful measurements, it is estimated that there is nearly $1.1 trillion in improper Medicaid payments over the decade from 2015 through 2024 – or double the amount of improper payments reported by Centers for Medicare and Medicaid Services (CMS).[19]

As the bill is implemented, Congress should consider building on these efforts.

Mandatory Provider Background Checks and Ongoing Audits

In only two out of the past 10 years did audits by the CMS assess the accuracy and completeness of state eligibility reviews. In those two years that did include meaningful, complete audits of state Medicaid programs, improper payment rates exceeded 25 percent. Applying a 25 percent improper payment rate across the $4.3 trillion of federal Medicaid spending between 2015 and 2024 yields roughly $1.1 trillion in federal Medicaid improper payments over the past decade.

Currently, states do not have a strong incentive to reduce their improper payments because the federal government picks up most of the tab. Many states even scheme with providers to use Medicaid to pay for non-health-related budget items.

[19] https://epicforamerica.org/education-workforce-retirement/medicaids-true-improper-payments-double-those-reported/

The Case for Reform: Don't Believe Washington Math

In many states, pervasive financing gimmicks mean that states do not pay any of the cost of the expansion population. In these cases, the state share of the expansion population is paid with provider and insurer contributions, which are then used to obtain nine times as much money as the contribution, which fuels higher Medicaid payments to those providers using federal dollars.

Stricter Eligibility Verification

The OBBB establishes work requirements for able-bodied adults who are choosing not to work and do not have young dependent children or elderly parents in their care. For those able-bodied adults without dependents, they can choose to work, participate in a work training program, enroll in school or volunteer for 20 hours per week to receive taxpayer-subsidized Medicaid coverage.

States and recipients will have to verify eligibility twice a year to receive Medicaid benefits. The OBBB prevents payment for Medicaid beneficiaries who have died, are enrolled in multiple states or do not qualify for the program. It also prohibits states from waiving asset tests for long-term services, removing individuals from Medicaid rolls who have homes worth over $1 million.

The frequency of eligibility verifications for able-bodied adults will be increased under the OBBB.

Reassessment of Reimbursement Formulas and Incentive Structures

One of the most concerning aspects of the Medicaid policy for several years has been that illegal immigrants were eligible to receive Medicaid benefits. Not only is this a misallocation of Americans' taxpayer dollars, but also it directly incentivizes illegal immigration. The Biden administration incentivized Medicaid to enroll healthy Americans and illegal immigrants, driving up costs for taxpayers and risking sustainability for those who need the program most.

The OBBB ends longstanding Medicaid financing gimmicks that increase federal spending by freezing and reducing provider taxes. It also disincentivizes abortion by prohibiting Medicaid payments for abortion services.

Additionally, the OBBB ensures that Medicaid payments are fiscally responsible and align with other federal government programs. This prevents one-size-fits-all, burdensome staffing requirements that increase costs on nursing homes and other long-term care providers.

With such widespread abuse, a refusal to even consider these types of reforms reflects either ideological blindness or political cowardice.

Conclusion: Compassion Requires Fiscal Responsibility

The evidence of fraud presented here, while anecdotal, makes one thing abundantly clear: Medicaid is structurally vulnerable to fraud on a vast scale. Leaving a program rampant with fraud and off the fiscal rails is not compassion. It is setting it up for failure with disillusionment from the public and by diverting resources from laudable goals to financial mismanagement.

Taxpayers are footing the bill, while vulnerable Americans suffer at the hands of charlatans and cheats. While the program remains a cornerstone of healthcare for many Americans, it is unacceptable to maintain the illusion that more spending automatically equals more compassion. Responsible stewardship of Medicaid requires scrutiny, reform, and a willingness to confront uncomfortable facts.

Sustained reform and accountability will help preserve Medicaid for future generations and ensure those who truly need it are not crowded out by fraudsters and corporate opportunists. Federal and state governments owe it to the public whose taxes fund these programs – and importantly to the beneficiaries who rely on Medicaid in good faith – to build a system that is compassionate, competent, and as free as possible from the abuse that harms us all.