DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

February 6, 2026

The Honorable Janet Mills
Governor of Maine
1 State House Station
Augusta, ME 04333

Sara Gagné-Holmes
Commissioner
Maine Department of Health and Human Services
109 Capitol Street
11 State House Station
Augusta, ME 04333-0011

Dear Governor Mills and Commissioner Gagné-Holmes:

Pursuant to sections 1902(a)(4), 1902 (a)(77), 1903(i)(2), and 1903(q) of the Social Security Act and implementing regulations at 42 CFR Parts 431, 455 and 456, which establish the Centers for Medicare & Medicaid Services' (CMS) oversight responsibilities for program integrity in state Medicaid programs, I am formally requesting detailed information regarding program integrity, eligibility verification, and provider oversight within Maine's MaineCare program to ensure public confidence and protect beneficiaries in your state's Medicaid program.

CMS values the federal–state partnership that underpins Medicaid. As partners, CMS and state Medicaid agencies share mutual obligations and accountability to maintain the integrity of the program, including reviewing claims payments and developing programmatic safeguards necessary to protect proper and appropriate use of federal and state taxpayer dollars.

Recent findings from the U.S. Department of Health and Human Services Office of Inspector General (OIG) and public reporting raise serious concerns about MaineCare's oversight of rehabilitative and community support (RCS) services for children diagnosed with autism and interpreting services. These findings, combined with national trends and prior OIG and CMS reviews, underscore the need for immediate corrective action and enhanced transparency.

Recent public reporting and actions in Maine

In January 2026, OIG issued its final report, *Maine Made at Least $45.6 Million in Improper Fee-for-Service Medicaid Payments for Rehabilitative and Community Support Services Provided to Children Diagnosed With Autism* (Report No. A-01-24-00006), that found serious improper payments, documentation failures, and oversight gaps resulting in improper payments that reduced resources available for legitimate beneficiary services while misusing taxpayer funds intended for proper Medicaid purposes. The OIG report found that 100% of the 100 sampled enrollee-months contained improper or potentially improper claims with an estimated $45.6 million in improper payments (including $28.7 million in Federal share). The OIG report also found numerous instances of missing, incomplete, or contradictory documentation in violation of federal and state requirements. The OIG report also found that MaineCare has never conducted a statewide post-payment review of RCS services and failed to provide clear guidance to providers since the program's inception in 2010.

Also in January 2026, federal criminal charges were brought against Lewiston-based Bright Future Healthier You, the largest MaineCare biller of interpreting services over the past decade, alleging a tax-fraud scheme that leveraged publicly funded interpreter payments.[1] This fact pattern shares alarming similarity to patterns elsewhere in the U.S. where CMS and law enforcement have observed rapid program cost growth, minimal documentation standards, and coordinated schemes across providers. Underlying risk patterns or fraudulent conduct, including low provider entry barriers, community-based services,[2] apparent paperwork manipulation, and provider clustering in small geographic areas, warrant heightened vigilance in similar programs and benefit categories in Maine. CMS seeks Maine's assessment of, and proactive measures to address, any analogous risks.

CMS's Review of MaineCare Claims for Federal Financial Participation (FFP)

CMS has analyzed recent MaineCare claims for FFP submitted by the state to better understand the scale of potential fraud, waste, and abuse (FWA) in Maine's Medicaid program.

Behavioral health services present significant concerns, with more than $21 million flagged by CMS' Fraud Prevention System based on unusual billing patterns. These services were concentrated in psychosocial rehabilitation, wraparound services, day treatment, and community support. A single provider accounted for over $13.6 million of these expenditures, signaling an unusually high volume within a narrow segment of the market.

Similarly, professional physician services exhibit elevated utilization patterns, with $4.3 million tied to high-frequency office visits, preventive care, and evaluation and management (E/M) codes, suggesting potential overuse or upcoding among a concentrated group of providers. CMS is aware that shortages in primary care physicians may partly impact rates these services are provided.

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[1] https://themainemonitor.org/criminal-case-immigrant-health-provider-mainecare

[2] https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services

Across inpatient and facility-based services, spending trends raise concerns about systemic vulnerabilities. Room and board codes, particularly for psychiatric and detoxification services, have surged year-over-year, signaling risks tied to length of stay and discharge timing. Analysis of CMS data shows one MaineCare provider rapidly increased detoxification service claims payments by 82% between January and August 2025. CMS recognizes these increases may partly reflect state policy priorities for behavioral health and substance use disorder services. Pharmacy codes continue to grow, raising concerns about drug add-ons and wastage controls. Similarly, habilitation and residential waiver program expenditures exhibit persistent upward trajectories, indicating risks of rate inflation and inadequate utilization oversight.

Notably, community-based and residential programs are expanding rapidly. CMS' analysis of MaineCare claims data shows that, for example, Residential Habilitation (T2016) payments increased by 30 percent between 2023 and 2025. Separately, but during that same timeframe, claims data shows that the number of recipients of Personal Care Services stayed the same, while Medicaid payments increased by 62 percent (from $112M to $182M).[3] These patterns could indicate systemic risks in rate inflation, coding intensity, and utilization controls, potentially warranting targeted audits and enhanced oversight across MaineCare.

CMS requests that the state of Maine provide written responses and supporting documentation addressing the following areas:

Fraud, Waste, Abuse, and Improper Payments — Program-Level Oversight

- Does DHHS determine targets for state fraud recoveries, and if so, what targets does DHHS have for recoveries?
- Does DHHS refer cases to the state's Medicaid Fraud Control Unit (MFCU), and if so, how many cases were referred to the MFCU by the state, by year, for the past 5 years? What were the resolutions of those cases?
- What are the primary areas where FWA has been identified and recovered?
- What internal controls does MaineCare have, in addition to those required by CMS, to identify and recover potential FWA?
- Does DHHS validate encounter data to ensure it accurately reflects services delivered and to support program integrity monitoring?
- How many payment suspensions did DHHS implement due to credible allegations of fraud over the last 5 years, pursuant to 42 CFR 455.23?
- Does DHHS oversee its claims processing, including but not limited to the use of automated edits, prepayment reviews, and prior authorization, and if so, how is claims processing overseen?
- Please provide all internal DHHS policies and procedures related to fraud detection, prevention, and reporting specific to state staff.
- Please provide all guidance, policies, or training materials related to fraud, waste, and abuse that have been shared with MaineCare providers.

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[3] The data is annualized for 2025 because T-MSIS data has a 3-4-month lag. For the recipient count, CMS used a linear trend based on the last two years. For the total paid amount, CMS averaged the available months in 2025 and extrapolated to the full year.

- Please provide all reports from Quality Improvement Organizations (QIOs), External Quality Review Organizations (EQROs), or other independent review bodies from the past 5 years that identify or describe overpayments, instances of upcoding, or fraud.
- Please provide all records or logs documenting cases of FWA referred to the state from providers, managed care organizations, or other stakeholders over the past 5 years, including how these cases were investigated and resolved.

Provider Screening, Enrollment, and Revalidation

- Please provide a list of all currently enrolled MaineCare providers, regardless of investigation status.
- What criteria does DHHS use to determine the risk level (limited, moderate, high) that applies to MaineCare providers pursuant to 42 CFR 455.450?
- Does DHHS conduct off-cycle revalidations pursuant to 42 CFR 455.414, and if so, in what circumstances?
- In what circumstances does DHHS terminate a MaineCare provider's enrollment?
- How many providers have been terminated, including through off-cycle revalidation?
- Does DHHS identify and monitor related entities, common ownership, or shared management across multiple enrolled providers, and if so, how?
- What tools are used to detect improper provider screening, enrollment, and revalidation, across locations?

Program Integrity Infrastructure and Accountability

- Are program integrity responsibilities divided among DHHS, other state agencies, contractors, or providers, and if so, how?
- What metrics does DHHS use to assess the effectiveness of its program integrity initiatives over time?
- Are trends in error rates, recoveries, and enforcement outcomes evaluated and reported to CMS and the public, and if so, how?
- How, including by what metrics, does DHHS measure potential FWA risks, and use that information to prioritize prevention, detection, and remediation activity and staffing?

Targeted Oversight Questions to Address High-Risk Billing Patterns and Systemic Vulnerabilities in MaineCare

- Does DHHS undertake any fraud investigation or oversight specifically related to the below list of five high-risk services, and if so, what activities has the state undertaken?
  - Rehabilitative and Community Support (RCS) services for children with autism
  - Interpreting services
  - Psychosocial rehabilitation services
  - Personal care services
  - Residential habilitation services
- How frequently does the state conduct post-payment reviews or audits for the high-risk service categories identified in this letter?
- What are DHHS's total annual overpayment recoveries for the past 5 years, and what proportion relates to the high-risk service categories identified in this letter?

- What processes are in place to monitor high-volume behavioral health providers, particularly those accounting for disproportionate shares of psychosocial rehabilitation and wraparound services?
- How does MaineCare identify and investigate outlier providers with unusually high claim volumes or concentrations of payments in narrow service categories?
- What controls exist to detect upcoding or overuse in professional physician services, especially for high-frequency office visits and E/M codes?
- How does the state validate length of stay and discharge timing for psychiatric and detoxification services to prevent inappropriate billing for room and board codes?
- What data analytics tools or dashboards are currently deployed to flag coding intensity and utilization anomalies across behavioral health, pharmacy, and residential services?
- Are predictive models or algorithms used to detect patterns of fraud, waste, and abuse in community-based and residential programs?
- What corrective actions are applied when documentation deficiencies or improper billing are identified?
- How does the state coordinate with CMS and law enforcement to address systemic vulnerabilities and pursue recovery of improper payments?

CMS respectfully requests that the state submit its response, along with any relevant supporting documentation, within 30 days of receipt of this letter. If additional time is required, please notify CMS promptly with a proposed timeline.

We look forward to your timely response.

Sincerely,

Dr. Mehmet Oz

Cc:
Kimberly Brandt
Acting Director, Center for Program Integrity, Centers for Medicare & Medicaid Services

Dan Brillman
Director, Center for Medicaid & CHIP Services, Centers for Medicare & Medicaid Services