

To the office of U.S. Representative Michael A. Rulli

Re: HR 10636 (119th Congress), Medicaid Fraud Prevention Act • Latest action (2026-09-28): Referred to the House Committee on Energy and Commerce.

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Medicaid Integrity Partnership with State Flexibility and Five-Year Sunset

The measure, as described from the official record: Reduce fraud and payment errors in state Medicaid programs while keeping coverage working for eligible people. The bill would pursue that goal through regular state risk reviews and reports to federal overseers.

THE PROPOSAL

Congress has power to set clear conditions on federal Medicaid funds under Article I, Section 8, Clause 1, and the Tenth Amendment reserves day-to-day administration of Medicaid to the states. This draft therefore conditions funds on a limited annual review and report, without giving federal officers control over state staffing, contracting, or eligibility decisions. The strongest objection is that even light reporting can become coercive paperwork; this draft answers it with a fixed standard form, a cure period, a cap on any fund hold, and a five-year end date unless Congress votes to extend.

Each state Medicaid program would complete one fraud risk review each year. The review would cover fee-for-service claims, managed care entities, and eligibility and enrollment systems. States would use existing program integrity data where practicable, including findings from Medicaid fraud control units. The Centers for Medicare and Medicaid Services would publish plain written guidelines on high-risk areas and accepted review methods.

Each state would then adopt a focused correction plan tied to what its review found. The plan would list the top risks, the specific fix for each risk, the office responsible, and the date for completion. States would report results to CMS once per year in a standard format. CMS would compile the state reports into one public annual summary for Congress. The summary would show national trends and state progress without directing state staffing or contracting choices.

Strong safeguards would protect patients, providers, and state authority. VFA proposes these notice and review protections as new safeguards in this draft. No person who is eligible would lose coverage based only on a risk score or a system flag. Any payment hold, enrollment denial, or provider exclusion proposed under this program would require written notice and an opportunity for prompt review. Federal funds could not be used for broad data matching beyond the stated fraud-prevention purpose.

Costs and federal power would be capped. VFA proposes a federal support cap of \$40 million per year, subject to appropriations. VFA proposes that if a state report is incomplete, CMS would first offer help and a cure period. VFA proposes that only after notice and a hearing opportunity could

CMS hold a capped share of federal administrative funds until the state files a complete report. VFA proposes the authority would end after five years unless Congress reviews results and votes to extend it.

OPERATIVE PROVISIONS (VFA PROPOSAL)

Effective Date	VFA proposes: first fiscal year beginning at least 180 days after enactment, per future statute; the supplied excerpt states no effective date
Enforcement Mechanism	VFA proposes: CMS reviews state reports for completeness; incomplete reports trigger technical assistance and a cure period, then a capped temporary hold on a share of federal administrative matching funds after notice and a hearing opportunity; this cure-period fund-hold is a VFA addition, not stated in the excerpt
Funding Amount	VFA proposes: capped at \$40 million per year in federal administrative support, subject to appropriations; the excerpt states no amount and this cap is a VFA addition
Funding Source	Federal Medicaid administrative matching funds, subject to annual appropriations; no new tax or mandatory fee stated in excerpt
Oversight Body	Centers for Medicare & Medicaid Services, with annual summary to Congress and state audit rights retained
Sunset Years	5 years

CONSTITUTIONAL BASIS

- Article I, Section 8, Clause 1
- Tenth Amendment
- Fifth Amendment Due Process

Concerns with the measure as written:

- If open-ended reporting or corrective mandates displace state administration of Medicaid, that may raise Tenth Amendment and conditional-spending concerns.
 - If fraud findings lead to payment holds or enrollment changes without notice and review, that may raise Fifth Amendment Due Process concerns.
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WHY BOTH SIDES CAN BACK IT (VFA'S ASSESSMENT)

VFA assesses this draft honors Republican priorities for fiscal restraint, program integrity, and state-led correction over open-ended federal mandates. VFA assesses it honors Democratic priorities for protecting Medicaid access for eligible people and using oversight to preserve funding for care rather than cutting benefits.

Strongest objection, and the answer: The strongest objection is that even light reporting can become coercive paperwork; this draft answers it with a fixed standard form, a cure period, a cap on any fund hold, and a five-year end date unless Congress votes to extend.

CHECK BEFORE RELYING ON THIS

Basis: This draft is based only on the supplied official summary excerpt for H.R. 10636 stating annual state fraud risk assessments, corrective action plans, reports to CMS, CMS guidelines and annual report to Congress, and referral to House Energy and Commerce on 2026-09-28.

The full bill text, current Medicaid law, eligibility and enrollment rules, appeal rights, managed care contract terms, data system limits, fiscal effects, and likely votes were not supplied and remain unverified; readers should verify the official bill text at the [congress.gov](https://www.congress.gov) page before relying on scope, cost, or rights described here.

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