Congress of the United States

Washington, DC 20515

October 29, 2026

Michelle Baass
Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Director Baass:

We have serious concern regarding the California Department of Health Care Services' (DHCS) oversight of the Medi-Cal program and the Department's ability to protect patients and safeguard taxpayer dollars from fraud. Medi-Cal provides coverage to nearly 14.5 million Californians, with total Medicaid spending in the state reaching approximately $196.7 billion, over 60% of which is paid for by the federal government.[1] Given the program's size and importance to millions of vulnerable Californians who depend on it, DHCS has a responsibility to ensure rigorous oversight to maintain the integrity of the program.

On October 15, 2026, the California State Auditor issued a report identifying alarming deficiencies in DHCS's efforts to investigate high-risk providers, detect potentially fraudulent billing, and recover improper payments.[2] We would also note the State Auditor first deemed DHCS as a "high risk" agency in 2007, underscoring longstanding concerns regarding the Department's oversight and administration of Medi-Cal.[3]

These findings are particularly concerning following the Centers for Medicare & Medicaid (CMS) October 20, 2026 announcement that the Agency would defer an additional $1.2 billion in federal Medicaid payments to California due to concerns over the state's ability to provide sufficient documentation to justify certain Medi-Cal expenditures.[4] Together, the California State Audit findings and CMS actions underscore mounting scrutiny of DHCS's management of the Medi-Cal program at both the state and federal levels.

The Audit Report found that during fiscal year 2024-2025, DHCS self-identified approximately 28,000 Medi-Cal providers whose risk scores placed them among the top ten percent for potentially improper billing. These risk scores reflect factors such as unusually high claim volumes, numbers of patients served, and telehealth claims; as well as claims submitted for deceased beneficiaries or by previously sanctioned providers. These indicators raise alarming red flags for potential fraud and demand further investigation. Despite the fact that DHCS identified these providers as high risk, DHCS had not initiated referrals or investigations for more than 26,000 of these providers. Collectively, these providers accounted for at least $12 billion in

[1] https://lao.ca.gov/Publications/Report/5146

[2] https://www.auditor.ca.gov/reports/2025-605/

[3] https://information.auditor.ca.gov/reports/summary/2006-601

[4] https://www.latimes.com/politics/story/2026-10-20/feds-hold-back-additional-1-2-billion-in-california-medicaidreimbursements

Medi-Cal services during fiscal year 2024–2025. Compounding these concerns, the report also found that DHCS identified more than $2 billion in provider overpayments from FY 2020 through FY 2025, approximately $300 million of which remain unrecovered.

The report also highlights instances in which DHCS failed to adequately investigate reports of potentially improper payments. In 2023, DHCS closed an investigative referral from a Medi-Cal managed care plan despite the plan finding that a provider had received inappropriate payments and failed to cooperate with its investigation. The provider then billed more than $5.5 million in Medi-Cal services during fiscal year 2024–2025 before DHCS referred the case to the California Department of Justice in April 2026. This case raises further questions over why DHCS failed to pursue credible concerns over improper payments.

In light of these findings, we request that DHCS provide responses to the following questions:

- Of the approximately 28,000 providers identified as high risk, why were only 2,000 investigated?
- What steps does DHCS take to ensure that providers flagged for potentially improper billing are appropriately screened, validated, and, when warranted under applicable law, referred for suspension, exclusion, or other enforcement action?
- Why did DHCS close the 2023 investigative referral despite the managed care plan identifying inappropriate payments and a lack of cooperation from the provider? What review or approval process governed that decision, which officials were responsible for it, and what corrective action has DHCS taken to prevent similar failures?
- What is DHCS doing to recover the $300 million in unrecovered provider overpayments the DHCS report cites, and how will the Agency avoid making these overpayments in the future?
- What steps is DHCS taking to address the documentation and expenditure concerns identified in CMS's recent Medicaid payment deferrals, and how will DHCS ensure that future federal reimbursement requests are adequately supported?
- What additional steps is DHCS actively taking to strengthen its fraud and detection tools following the State Audit report?

The Medi-Cal program is intended to serve the state's most vulnerable population. DHCS has a responsibility to ensure that Medi-Cal beneficiaries are protected and that taxpayer dollars are spent appropriately. Failure to address these oversight deficiencies risks further undermining public confidence in the program and jeopardizing the resources available to those who rely on it. We urge DHCS to take immediate corrective action to strengthen program integrity, improve accountability, and restore confidence in its administration of Medi-Cal. We look forward to your prompt response.

Sincerely,

Jay Obernolte
Member of Congress

Ken Calvert
Member of Congress



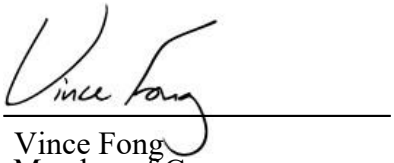
Tom McClintock
Member of Congress



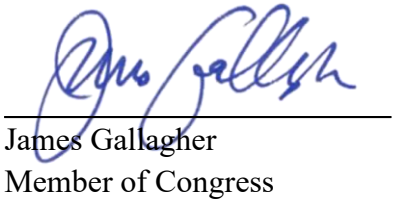
David G. Valadao
Member of Congress



Young Kim
Member of Congress



Vince Fong
Member of Congress



James Gallagher
Member of Congress