Opening Statement for Chairman John Joyce, MD
Subcommittee on Oversight and Investigations
"State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies."
June 25, 2026

(As Prepared for Delivery)

Good morning, and welcome to today's hearing titled, "State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies."

Today's hearing will examine Medicaid program integrity in four states: Minnesota, California, New York, and Ohio. For the first time in years, State Medicaid Directors are testifying before Congress to share what they are doing to address rampant fraud in government health care programs.

Let me be clear: fraud is not isolated to these states. As we have discussed in two previous hearings before this Subcommittee, Medicaid fraud is a real problem. It happens in every single state, red and blue, and has been harming patients and draining taxpayer resources for decades.

In Minnesota, a recent 90 million dollar Medicaid fraud takedown brought charges in autism therapy services, housing support, home health care, and personal care services. This was just the latest set of charges in ongoing fraud investigations occurring there.

In California, a man recently pleaded guilty to 270 million dollars in fraudulent prescription drug claims to Medicaid. Earlier this year, charges were filed against 21 suspects for defrauding Medicaid hospice benefits of 267 million dollars.

In New York, 226 million dollars in social adult day care fraud has been charged in 2026 so far. Millions of dollars have been implicated in non-emergency medical transportation fraud schemes in recent years.

In Ohio, a 42 million dollar Medicaid fraud takedown implicated nine defendants in connection with therapeutic behavioral health services for children and young adults. Recently, there were also charges made in connection with hundreds of thousands of dollars in in-home services fraud.

These fraud schemes harm patients. When services are billed but not rendered to vulnerable Medicaid recipients—who are dependent on this support—the consequences can be severe, and sometimes fatal.

Elderly and disabled patients in need of in-home care do not receive the help they need to live their lives with dignity. Children who benefit from essential therapies do not receive them. Those who rely on transportation assistance to attend medical appointments miss the preventative care and treatments that they need to stay healthy.

This morning's hearing is the culmination of a months-long investigation led by this Subcommittee into Medicaid fraud with the goal of strengthening program integrity. After two hearings, letters to 11 states requesting documents and information, and reviewing over 90,000 pages of documents and information produced to the Committee, it is clear that some states are not doing enough to safeguard the Medicaid program, and gaps remain in program integrity requirements that are opening the door to fraud.

Thankfully, fraud is finally getting the attention it deserves. I commend this Administration for surging resources to the War on Fraud by forming the Task

Force to Eliminate Fraud. Additionally, CMS and the Office of Inspector General are leveraging their authorities to hold states accountable when they are not meeting the mark. We are seeing accountability for the first time in a long time. But more remains to be done.

We can no longer tolerate criminals taking advantage of the Medicaid system. Fraud is not and should not be the cost of doing business. It is preventable and we all have a duty to help rein it in.

It is no longer sufficient to do the bare minimum. States must rise to the occasion and tackle fraud head-on. Our Medicaid program and the patients that rely on it to be healthy depend on it.

I want to thank our witnesses for being here today. We look forward to hearing from you and learning more about the steps your state is taking to address Medicaid fraud.

With that, I now recognize our Ranking Member of the Subcommittee, Ms. Clarke, for her opening statement.