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STATE MEDICAID PROGRAM INTEGRITY:

EXAMINING FRAUD RISKS AND OVERSIGHT DEFICIENCIES

THURSDAY, JUNE 25, 2026

House of Representatives,

Subcommittee on Oversight and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:21 a.m. in Room 2123, Rayburn House Office Building, Hon. John Joyce [chairman of the subcommittee] presiding.

Present: Representatives Joyce, Balderson, Palmer, Weber, Allen, Harshbarger, Rulli, Guthrie (ex officio); Clarke, DeGette, Tonko, Trahan, Fletcher, Mullin, and Pallone (ex officio).

Also present: Representatives Bentz, Bilirakis, Miller-Meeks, and Landsman.

Staff Present: Ansley Boylan, Director of Operations; Jessica Donlon, General Counsel; Reagan Dye, Professional Staff Member; Sydney Greene, Director of Finance and

Logistics; Jay Gulshen, Chief Counsel; Brittany Havens, Chief Counsel; Megan Jackson, Staff Director; Olivia Jensen, Staff Assistant; Jonathan Kupperman, Professional Staff Member; Brayden Lacefield, Special Assistant; Joel Miller, Deputy Staff Director; Ryan Murphy, Director of Member Services; Lillian Noland, Clerk; Brice Ogle, Special Assistant; Claire Richey, Clerk; Seth Ricketts, Clerk; Chris Sarley, Senior Director of Policy and Stakeholder Director; Dray Thorne, Director of Information Technology; Timothy Trimble, Staff Assistant; Matt VanHyfte, Communications Director; Katie West, Press Secretary; Jordan Antwi, Minority Intern; Ruth Campos, Minority Intern; Austin Flack, Minority Professional Staff Memer; Waverly Gordon, Minority Deputy Staff Director and General Counsel; Tiffany Guarascio, Minority Staff Director; Ciara Horne, Minority Fellow; Alyssa Kimura, Minority Intern; Brendan Lopez, Minority Press Assistant; Will McAuliffe, Minority Chief Counsel, OI; Constance O'Connor, Minority Senior Counsel; Christina Parisi, Minority Professional Staff Member; Kyle Parker, Minority Law Clerk; Harry Samuels, Minority Counsel; Andrew Souvall, Minority Director of Communications, Outreach, and Member Services; Samantha Tate, Minority Intern; Hannah Treger, Minority Staff Assistant; and Caroline Wood, Minority Research Analyst.

*Mr. Joyce. The Subcommittee on Oversight and Investigations will now come to order.

The chair now recognizes himself for five minutes for an opening statement.

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 four 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 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 in fraudulent prescription drug claims to Medicaid. Earlier this year, charges were filed against 21 suspects for

defrauding Medicaid hospice benefits of $267 million.

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

In Ohio, a $42 million Medicaid fraud takedown implicated 9 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 service fraud.

These fraud schemes harm patients. When services are billed but not rendered to vulnerable Medicaid recipients who are dependent each and every day on this support, the consequences can be severe. And unfortunately, sometimes those consequences can be fatal. Elderly and disabled patients in need of in-home care do not receive the help that they need to live the lives that they have with dignity. Children who have benefitted from essential therapies often don't 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 a culmination of months-long investigation led by this subcommittee into Medicaid fraud with the goal of strengthening the 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 this 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 far too wide to fraud.

Thankfully, fraud is finally getting the attention that it deserves. I commend this Administration for surging resources to the war on fraud by forming a task force to eliminate fraud. Additionally, CMS and the Office of the 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 far too long.

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 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 that to be healthy each and every day of their lives, they depend on it.

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

[The prepared statement of Mr. Joyce follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. With that I now recognize our ranking member of the subcommittee, Ms. Clarke, for her opening statement.

*Ms. Clarke. Thank you very much, Mr. Chairman, and I'm glad to have another opportunity in this subcommittee to discuss the partisan actions that the Trump Administration has taken against state Medicaid programs under the guise of fighting fraud.

Democrats have been raising concerns about CMS's threats of funding cuts to blue states, which are destabilizing programs and risk further cuts to health care in states led by Democratic governors, leaders who President Trump sees as political enemies. The Administration's partisan motivations are clear. In January, amidst terror and chaos in Minnesota caused by the Trump Administration, CMS announced it would withhold up to $2 billion from 14 of Minnesota's health care services. Days later, on the heels of the killing of an innocent American citizen by ICE agents, President Trump threatened Minnesota with a quote, “day of reckoning and retribution,” unquote.

When CMS Deputy Administrator Brandt testified before this subcommittee in March, I asked her when a hearing would be scheduled on CMS's decision to withhold more than 500 million in quarterly Medicaid funding from Minnesota. She said that CMS had been stayed from scheduling a hearing,

which proved to be entirely false. When we asked for correction or clarification of her false testimony, Deputy Administrator Brandt did not provide one. We cannot conduct oversight if CMS is going to lie about its actions.

CMS has also deferred 350 million in Medicaid funding from Minnesota for two consecutive quarters in sweeping cuts to entire service categories, but has not provided Minnesota with a meaningful or consistent guidance on how to address CMS's concerns.

In California CMS has put 1.3 billion in Medicaid funding in jeopardy through a deferral for home health care service payments. CMS Administrator Oz proudly announced that this was the largest deferral ever by the agency. He fails to acknowledge the impact that these over-broad, indiscriminate actions will have, and he has refused to accept California's explanations for the growth in those services which are due to longstanding efforts by the Federal Government and states to keep patients out of institutions and in their homes and in communities. The need for home health care does not disappear when funding is suspended. The -- and California patients are terrified of losing care at home and being forced into institutions.

CMS has also threatened my state, New York. When it began investigating New York's program it touted clumsy and entirely inaccurate math which ultimately overstated the

number of New Yorkers receiving home health care services by nearly 11 times. Even though CMS admitted its error, the Trump Administration has not let up on its threat to rob New Yorkers of Medicaid for their health care.

We have also heard that the way CMS treats state officials in some blue states has completely changed. CMS seems to be looking for reasons to cut funding to certain states rather than ways to preserve it. Administrator Oz and Vice President Vance have held numerous press conferences to hastily -- to announce hastily-determined funding cuts that harm patient access to health care. They have clearly prioritized headlines over health care and partisanship over people. The Administration has repeatedly treated blue states as enemies rather than partners.

HHS Inspector General March Bell has also joined this campaign against blue states by decertifying Hawaii's Medicaid fraud control unit, cutting $3 million from -- for the entity that is responsible for finding and prosecuting Medicaid fraud and patient abuse or neglect. This is particularly ironic, as just the other day the Department of Justice touted numerous arrests and charges for health care fraud.

And buried in the DoJ press release is a shout out to the Medicaid Fraud Control Unit of Hawaii as one of the many agencies responsible for prosecuting the cases in the

crackdown. One day they are being denied recertification, the next day they are part of a major operation that the Administration wants all the credit for. Which is it? The answer is that this Administration will do anything to cover up for the massive Republican cuts to health care.

Enrollment in Medicaid and the Affordable Care Act are dropping precipitously, more than five million people just over the past year. CMS and states should work together to address fraud, just as they always have, getting actual fraud out of the programs and hold actual fraudsters accountable. But wagging a politically-motivated assault against -- wait, excuse me, waging a politically-motivated assault against the sick, the disabled, the blue states, and taking health care away from millions of Americans is not fighting fraud; that is just using fraud as a convenient excuse to carry out the President's harmful agenda with the most vulnerable individuals in our country paying the price.

[The prepared statement of Ms. Clarke follows:]

**********COMMITTEE INSERT**********

*Ms. Clarke. With that, Mr. Chairman, I yield back.

*Mr. Joyce. Thank you. The chair now recognizes the chairman of the full committee, Mr. Guthrie, for five minutes for an opening statement.

*The Chair. Thank you, Mr. Chairman. I thank you for holding this important hearing. I want to thank all of our witnesses for being here. I know some came in challenging situations, and we really appreciate you being here today.

This hearing is about accountability and what all of us can do moving forward to strengthen the Medicaid program integrity. We have a duty to do everything possible to protect the Medicaid program from fraud and preserve it for those who need it most.

Each state administers its Medicaid program and is responsible for making sure that fraud prevention and enforcement mechanisms are effective. Unfortunately, this is not always the case.

Fraud is not a victimless crime. Not only does it squander taxpayer dollars, but it harms vulnerable patients. Fraudsters are blatantly lining their pockets with taxpayer dollars, often at the expense of the elderly, the disabled, and young patients that are receiving substandard or no medical care. Americans are tired of seeing their hard-earned tax money end up in the hands of criminals.

So, we can't deny this is happening. It is amazing that

it just seems like this is happening. We have a California man, Paul Randall, who pleaded guilty to $270 million in Medicaid fraud. So instead of going to help the most vulnerable and the disabled, where did the money go? He bought luxury cars, rare sports memorabilia including Mickey Mantle rookie baseball cards, and game-worn sneakers by Kobe Bryant. These are facts. This isn't something that is just -- that came from this Administration. These are facts in law.

Similarly, in Ohio, law enforcement recently seized 14 luxury vehicles owned by defendants in a $30 million Medicaid or -- Medicaid behavioral health case fraud.

Just this week, the Department of Justice announced in 2026 another health care fraud takedown, which charged 455 defendants with over $6.5 billion in health care fraud. This takedown was a collaborative effort between Federal, state, and international partners -- included fraud schemes and Medicare and Medicaid. This is another example of how big this problem is. Through more rigorous oversight and enforcement, we can stop these brazen criminal schemes and make the Medicaid program stronger and ensure its stability for the future.

So, my friend from New York commented on and brought up that the Administration just ceased payments and said, "Just because you have fraud, you are ceasing payments on all these

other programs." Well, let me tell you what happened with that. We had over 400, 400 home health providers -- so we do want them out of the nursing homes and in their homes -- 400, over 400, home health care providers providing services in LA County. They knew there was rampant fraud, and they couldn't figure out which ones were legit, which weren't. So, let's just suspend payments. So, if you perform the service, your payment was suspended. If you were cheating, your payment was suspended. Those who -- 12 companies out of over 400 called and said, "Where is the money for the -- what we served," 12 legitimate companies out of over 400 in LA County.

So it is not the Administration that was just represented here saying that we are just going to hold -- we are going to hold blue states -- we are going to punish blue states because they are blue states, it is this Administration making the decision that we have rampant fraud, it is ripping off the taxpayers, it is cheating the most vulnerable -- some who are in the audience today, the elderly, the disabled, and those who need Medicare the -- Medicare and Medicaid the most. And so, they are using the tools available.

And I will tell you the 12 people who -- 12 companies who legitimately performed those services did get paid, and the other 400 who were cheating never got their money because

they didn't do the services. And so, I will defend that. I think your taxpayer dollars, the most vulnerable need to be defended, as well. I will defend that. And we look forward today to kind of frame this debate to understand what has happened, how we are going to deal with it, and how we make sure that the American people who are generous with their tax dollars -- as we had some debates on Medicaid, talked to a lot of people about Medicaid, the American people want this program to work, they want the most vulnerable to be taken care of, but they also want to know that people care about their money, as well.

And so that is what this hearing is about. That is what we are going to fight for on our side of the aisle. If you are cheating the system, we are going to come after you and we are going to make sure, if you are the -- in the most vulnerable, you are going to be taken care of. And that is our task.

[The prepared statement of The Chair follows:]

**********COMMITTEE INSERT**********

*The Chair. And I will yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes the ranking member of the full committee, Mr. Pallone, for five minutes for an opening statement.

*Mr. Pallone. Thank you, Mr. Chairman.

Nearly a year ago Republicans passed their big, ugly bill that included the largest health care cuts in American history. Republicans cut health care by $1 trillion, which is expected to rip health care away from 15 million Americans. According to a recent study, five million Americans have already lost their health insurance as a result of these cuts and, unfortunately, this is just the beginning.

During the markup of the big, ugly bill committee Republicans repeatedly insisted that the cuts wouldn't hurt patients and would only affect waste, fraud, and abuse in the program. But that has proven to be completely false, and they knew that. You cannot cut health care by $1 trillion and not impact millions of people's health care.

Earlier this month the Trump Administration released a rule showing just how burdensome and cruel the new requirements to receive care through Medicaid would be. That rule includes a provision that those receiving ongoing treatment for cancer could lose their Medicaid coverage if they don't jump through all the hoops and red tape that

Republicans put in their way. Even cancer patients are under attack by Republican cuts to their health care.

The Republicans' big, ugly bill was never going to strengthen Medicaid, as they claimed. It was just another step in the Republican campaign to dismantle it. And now, as Republicans try to figure out a way to pay for President's -- Trump's reckless war of choice with Iran through another partisan reconciliation bill, they are reportedly considering even more cuts to Medicaid.

More than 70 million Americans who are disabled or chronically ill, elderly, or children rely on Medicaid for their health care. The Trump Administration and Republicans in Congress continue to find ways to endanger or take away that care. They have decided that if they simply say they are eliminating fraud in Medicaid, then they can get away with eliminating Medicaid. Well, they are wrong. We are not standing for that. The attacks on health care don't stop with the big, ugly bill. The Department of Justice just ripped up decades worth of guidance and precedent that helped keep those with disabilities out of institutions, and the Centers for Medicare and Medicaid Services has selectively abandoned its practice of working in partnership with states to administer the Medicaid program.

It's becoming increasingly clear that under Dr. Oz CMS does not intend to work with states in good faith,

particularly states that do not vote or did not vote for President Trump. In California, for example, CMS has deferred $1.3.4 [sic] billion in quarterly payments to the state, mostly for home and community-based services, solely based on how quickly the program has grown. If the goal was finding fraud, CMS would identify specific concerning charges and work with the state to resolve them. It would not threaten to defer payments to all in-home supportive services for an entire quarter, and then have the vice president hold a celebratory press conference.

CMS continues to hold hostage funding to Minnesota, repeatedly making demands of that state with short deadlines only to move the goal posts when the state meets them. And CMS sent a letter to New York making outlandish allegations about that state's Medicaid program accompanied by bombastic social media posts from Dr. Oz claiming -- and I quote – "nearly three-fourths of the state's 6.8 million Medicaid enrollees receive personal care services." But Dr. Oz and CMS had to walk back those claims after it was pointed out that they had committed obvious errors in math that grossly inflated the number of enrollees receiving those services.

Now, I would say if Republicans are really interested in looking into waste, fraud, and abuse, they should look no further than the actions of the Trump Administration and the President. I mean, talk about rip-off. The American

taxpayers are ripped off every day by Trump's policies and personal, you know, effort to try to make a profit for him and his family. Why don't you go after them? Why don't you go after the Administration?

But it is outrageous to watch the Trump Administration going after state Medicaid programs while it is engaged in a reckless war of choice that is costing the American people $132 billion, tanking the economy, and fueling inflation that the President says he loves. He loves inflation.

Republicans also had no problem supporting a $1.8 billion slush fund to reward Trump's friends and insurrectionists who assaulted police officers on January 6. You think that is not a waste of money? A huge waste of money.

The combination of the Republicans' big, ugly bill and the politically-motivated cuts by CMS put states in an impossible situation, and patients are already paying the price. Playing politics with Americans' health care is cruel and dangerous. Unfortunately, that is what we are repeatedly seeing from Republicans here in Washington.

[The prepared statement of Mr. Pallone follows:]

**********COMMITTEE INSERT**********

*Mr. Pallone. And with that, Mr. Chairman, I yield back the balance of my time.

*Mr. Joyce. The gentleman yields. That concludes members' opening statements. The chair would like to remind members that, pursuant to the committee rules, all members' written opening statements will be made part of the record.

We want to again thank our witnesses for being here today, taking time to testify before the subcommittee. You will have the opportunity to give an opening statement, followed by a round of questions from members.

Today's witnesses are Mr. John Connolly, temporary commissioner and state Medicaid director, Minnesota Department of Human Services; Mr. Tyler Sadwith, state Medicaid director for the California Department of Health Care Services; Mr. Amir Bassiri, state Medicaid director of New York State Department of Health; and Mr. Scott Partika, director of Ohio Department of Medicaid. We appreciate all of you being here today, and I look forward to hearing from each of you.

You are aware that the committee is holding an oversight hearing and, when doing so, has the practice of taking the testimony under oath. Do you have an objection to testifying under oath?

Seeing no objection, we will proceed. The chair advises that you are entitled to be advised by counsel pursuant to

House rules. Do you desire to be advised by counsel during your testimony today?

Seeing none, please rise. Please raise your right hand.

[Witnesses sworn.]

*Mr. Joyce. Seeing the witnesses answered all in the affirmative, you are now sworn in and under oath, subject to the penalties set forth in title 18, section 1001 of the United States Code.

With that I will now recognize -- please be seated. With that I will now recognize Mr. John Connolly for five minutes to give your opening statement.

STATEMENT OF JOHN CONNOLLY, TEMPORARY COMMISSIONER AND STATE MEDICAID DIRECTOR, MINNESOTA DEPARTMENT OF HUMAN SERVICES; TYLER SADWITH, STATE MEDICAID DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES; AMIR BASSIRI, STATE MEDICAID DIRECTOR, NEW YORK STATE DEPARTMENT OF HEALTH; AND SCOTT PARTIKA, DIRECTOR, OHIO DEPARTMENT OF MEDICAID

STATEMENT OF JOHN CONNOLLY

*Dr. Connolly. Thank you, Chairman Joyce, Ranking Member Clarke, and members of the subcommittee. Thank you for the opportunity to be here today, first of all, and for your continued focus on the important issue of Medicaid integrity.

The programs we administer at Minnesota's Department of Human Services are essential to the health, stability, and economic security of communities across Minnesota. They help children, families, seniors, and people with disabilities access health care and other essential services every day. These programs are lifelines relied upon by over a million Minnesotans and communities large and small.

As is the case with government-funded programs throughout the country and, in fact, across all health care payers, including private insurance, bad actors have tried to take advantage of our well-intended services. But let me be

clear. The Minnesota Department of Human Services and Minnesota Government have a zero tolerance policy for any fraud within our government programs. We take attempts to undermine the integrity of these programs very seriously. We are taking aggressive measures to secure our Medicaid programs, and here are just a few recent examples.

Minnesota DHS has conducted over 4,000 investigations and identified more than 50 million in recoveries since 2020, resulting in over 1,150 cases referred to law enforcement, state and Federal.

Last year we hired a new inspector general with a decade-long record of prosecuting Medicaid fraud, and we have also increased his staff to enhance oversight and accountability.

We have expanded our pre-payment review protocols to grow our capability to block payments to fraudulent providers on the front end, rather than paying them out and trying to recover those funds later.

We have aggressively moved to stop payments to providers upon credible evidence of fraud.

We designated 14 Medicaid benefits as high risk, determining that these benefits warranted heightened levels of scrutiny and controls under Medicaid's regulatory framework. Ultimately, we took decisive action to terminate one of those benefits and to impose licensing for service

providers in another.

We recently completed a 5-month comprehensive review of almost 5,600 high-risk Medicaid providers to ensure they meet rigorous eligibility and compliance standards. In appropriate cases we issued disenrollment notices and stopped payments.

We've been doing this work since long before the recent headlines, and we will continue doing it every day. There is no finish line when it comes to protecting the integrity of our programs.

Importantly, however, our work is always done with beneficiaries and the broader public in mind. We strive to enhance program integrity while also providing access to care and continuity of service. So, for example, when we disenroll providers we work closely with counties and, in some cases, reach out directly to affected Minnesotans to help beneficiaries connect with alternative providers and resources.

In pursuing these dual objectives of program integrity and responsible delivery of services, we welcome opportunities for dialog with Congress, the Centers for Medicare and Medicaid Services, and our fellow states. We all have valuable lessons to learn from each other. We all know that our decisions, as well as those of our Federal and state partners, have real-world impacts.

Medicaid in Minnesota serves approximately 1.16 million people -- again, children, families, seniors, people with disabilities, those with serious mental health needs, and others who depend on care to remain safe and stable in their homes and communities. Moreover, Medicaid is a foundation for our entire health care delivery system, including hospitals and nursing facilities. And major funding losses threaten to destabilize care for all Minnesotans.

Recent Federal deferrals of Medicaid payments to Minnesota have put our residents at severe risk. This is not an accounting dispute on a spreadsheet; these decisions affect Minnesotans with significant needs, people for whom a missed appointment, a gap in treatment, or an interrupted support service can quickly become a crisis. This is not an either/or decision. We can protect program integrity while still operating these programs effectively. We can root out fraud, waste, and abuse while still caring for those in need. And we can protect taxpayer dollars while simultaneously directing them to their intended beneficiaries. It is our job that we share with our Federal partners.

I believe strongly in public service and am proud of the work Minnesota DHS has done to strengthen program integrity, combat fraud, and ensure that we continue to secure the Federal funding that is crucial to our programs and to Minnesotans. I welcome and encourage continued dialog with

you all as we continue these efforts.

Thank you again for the opportunity to share the work we're doing in Minnesota to protect Medicaid program integrity. I look forward to your questions.

[The prepared statement of Dr. Connolly follows:]

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*Mr. Joyce. Thank you. The chair now recognizes Mr. Sadwith for five minutes for an opening statement.

STATEMENT OF TYLER SADWITH

*Mr. Sadwith. Chairman Joyce, Ranking Member Clarke, and members of the subcommittee, thank you for the opportunity to testify. My name is Tyler Sadwith, and I am the Medicaid director for California, a position in the California Department of Health Care Services.

I want to be clear from the start. We take program integrity seriously and work hard every day to protect California's Medicaid program from fraud so taxpayer dollars can go to health care services for eligible patients who need them.

I would like to touch on three areas: first I want to highlight California's program and the people we serve; second I'd like to demonstrate our unwavering commitment to combating fraud, waste, and abuse; finally, I want to emphasize our valuable partnership with the Federal Government and make very clear our ongoing commitment to collaborating with our Federal partners at CMS, the Centers for Medicare and Medicaid Services.

Medi-Cal is California's Medicaid program. It provides health care services to approximately 14 million vulnerable

Americans including pregnant women, seniors, children, and people with disabilities. California is the country's most populous state. It is the fourth-largest economy in the world. This means we support more health care services for more vulnerable individuals than any other state Medicaid program in the country. This is a responsibility we take seriously, and it is a vital part of our mission to protect this program.

California is wholly committed to combating fraud, safeguarding taxpayer dollars, and holding bad actors accountable. To meet these commitments the department prioritizes program integrity at all stages, from provider screening and eligibility determinations to claims processing to back-end analysis and investigations. Approximately 20 percent of staff are dedicated exclusively to program integrity. We have strong policies and protocols that are designed to prevent, identify, and block fraud, waste, and abuse. Our comprehensive oversight strategy includes robust provider vetting that exceeds Federal standards, provider suspensions including approximately 5,000 over the past 5 years, and secured fraud recovery totaling more than $1 billion over the past 5 years.

California is one of only two Medicaid -- two states with a Medicaid agency that employs armed sworn peace officers with the legal authority to execute search and

seizure warrants. Our teams of auditors, investigators, clinicians, and data scientists conduct top-to-bottom reviews of providers. Our strong partnerships with district attorneys, Medicaid fraud control units, and Federal law enforcement and investigators are critical to our success. But we must remain vigilant because we know bad actors seek to exploit Medicaid, Medicare, and private health insurance. That is why we continue to strengthen our program in higher-risk areas such as hospice care. We are implementing new safeguards to ensure appropriate use of services such as applied behavioral analysis and transportation.

We're proud of our program, but I want to emphasize the importance our partnership with CMS plays in ensuring Medi-Cal operates with accountability, transparency, and in compliance with Federal requirements. We value that partnership and our shared commitment to protecting taxpayer dollars and maintaining public confidence in Medicaid. A productive relationship with CMS is a key ingredient for continued success.

And CMS recognizes California as a national program integrity leader. Across bipartisan administrations CMS's Medicaid Integrity Institute and the National Association for Medicaid Program Integrity have highlighted our advanced data analytics and investigative strategies. California's program integrity leader recently served on the executive board of

the Health Care Fraud Prevention Partnership, a CMS-convened body working across public and private sector to fight fraud. We will be most successful in keeping bad actors out of the program if we continue working closely with CMS and other Federal partners. I know this from my own experience at CMS, where I served seven years across bipartisan lines.

The vast majority of Medi-Cal providers follow the rules. Rooting out unscrupulous providers is critical to safeguarding taxpayer dollars and ensuring Medi-Cal can fulfill its mission to serve the children, pregnant women, and other vulnerable Californians who rely on it. I assure you California is committed to this important work and unwavering in our efforts to combat fraud.

Thank you, and I look forward to your questions.

[The prepared statement of Mr. Sadwith follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. Thank you. The chair will now recognize Mr. Bassiri for five minutes to give an opening statement.

STATEMENT OF AMIR BASSIRI

*Mr. Bassiri. Chairman Guthrie, Ranking Member Pallone, Subcommittee Chairman Joyce, Ranking Member Clarke, and members of the subcommittee, thank you for the opportunity to testify today regarding New York's Medicaid program and our efforts to combat fraud, waste, and abuse. My name is Amir Bassiri. I'm deputy commissioner and the Medicaid director at the Office of Health Insurance Programs at the Department -- the New York State Department of Health.

I've devoted my career in public service to helping ensure that government programs are effective, accountable, and worthy of the trust that the taxpayers put in -- place in them. I entered this role with a clear responsibility to do what is in the best interest of New York's Medicaid program, including the safeguarding of taxpayer resources with strong oversight and program integrity so that services are maintained for those who need them the most.

New York's Medicaid program is one of the largest in the country, serving more than 6.4 million residents, including over 2 million children, approximately 100,000 pregnant women, and 1.5 million aged, blind, and disabled residents.

Given the magnitude and overall scope of our program, we work every day with state and Federal partners, law enforcement, and oversight entities to prevent, detect, and address fraud, waste, and abuse. We also engage regularly with the Center for Medicare and Medicaid Services on program integrity matters, and we sincerely value that partnership as a critical component of our ability to strengthen program integrity efforts.

The state recognizes the importance of technology and has made a considerable number of investments in modernizing key technology to both support the consumer and provider experience, as well as improving data interoperability and accountability across the delivery system. New York's approach to program integrity relies on multiple state agencies working in close coordination. This provides complementary points of accountability and redundancy and responsibilities to ensure no single point of failure. The structure creates several layers of accountability, including provider monitoring and screening to audits, investigations, and coordinated enforcement actions.

This approach has produced measurable results. The state continuously enhances its efforts to prevent and detect fraud, waste, and abuse. And in 2024 the Office of the Medicaid Inspector General completed more than 2,500 audits and investigations, referred over 450 matters for criminal

prosecution, and generated approximately $4 billion in recoveries. These outcomes reflect years of sustained work across agencies to identify improper activity, recover funds, and hold bad actors accountable.

We are proud of these results, but we also recognize that a program of this size and complexity requires constant vigilance and continuous improvement. Under Governor Hochul's leadership New York has pioneered a myriad of reforms in high-risk areas to safeguard taxpayer resources. This is most evidenced by the state's right-sizing of the Consumer Directed Personal Assistance Program, a program that allows Medicaid members to hire their own caregivers, by transitioning from a system of over 600 fiscal intermediaries to 1 single statewide fiscal intermediary, thereby reducing administrative costs in the program while establishing a stronger and more consistent overnight mechanism with full accountability.

In addition, a result of enhanced screening and oversight of the non-emergency medical transportation program was done through the creation of a statewide transportation broker. Nearly 800 providers were terminated or rejected from the network as a result of this transition to the broker, mitigating opportunities for improper billing while preserving access to this critical service.

I am proud of the work we've done to protect both the

integrity of the Medicaid program and the millions of New Yorkers that depend on it. Protecting the integrity of Medicaid requires collaboration, transparency, and a shared commitment to fiscal stewardship of taxpayer dollars. We deeply value our partnership with Federal agencies on this effort, and I appreciate the opportunity to testify today and am prepared to answer the subcommittee's questions.

[The prepared statement of Mr. Bassiri follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. Thank you. The chair now recognizes Mr. Partika for five minutes for an opening statement.

STATEMENT OF SCOTT PARTIKA

*Mr. Partika. Mr. Chairman --

[Audio malfunction.]

*Mr. Partika. Apologies -- and members of the Subcommittee on Oversight and Investigation, my name is Scott Partika. I'm honored to serve as the director of Ohio Medicaid and represent all of Ohio Medicaid team who wake up each and every day with a passion to serve those in need, support our providers, especially our direct caregivers, and execute the program at the highest level of program integrity each and every day.

Since joining the department in November of 2025 I found myself laser focused on program integrity to secure this vital program. Addressing fraud, waste, and abuse within Ohio Medicaid program has always been a focus of the DeWine Administration, and our work has especially sharpened and expanded in response to recent program trends noticed in Ohio, and our work is far from over.

Ohio has implemented a series of system reforms over the last five years to add operational efficiencies through administrative consolidation, new advanced IT infrastructure,

and the results of that are growing transparency and additional tools for accountability that are just now beginning to bear fruit.

Key program concerns of previous years include payment accuracy, member eligibility, and concurrent enrollment in other states, as well as broader program spending in certain areas. Ohio has taken steps each concern head on [sic], including reducing the PERM finding to two percent, adding new supports for county caseworkers to increase accuracy and efficiency of applications, and increasing data transparency along the way that has helped guide policy-making for the administration and Ohio legislature. Other ongoing initiatives include rule and policy updates, enhanced provider screenings, new UM practices, and targeted provider audits. These and other activities have helped us address concerns highlighted by state partners and partners at CMS.

When looking at Federal initiatives to combat program integrity concerns, it's important to recognize the Working Families Tax Cut legislation, which dramatically increased the level of program oversight and elevated program integrity priorities in state Medicaid programs, including addressing concurrent enrollment across states, ensuring deceased individuals are no longer on the rolls, increased emphasis of audits and subsequent corrective action, increased frequency of eligibility determination, mandating community engagement

requirements to help facilitate people moving up and off the program. These efforts are helpful, and we believe our Federal partners can and should continue to improve protection and oversight of state programs.

Now to Ohio. Troubling data in home health space was uncovered in Ohio late last year. We began investigating the information in conjunction with Ohio auditor Keith Faber and former Attorney General Dave Yost shortly thereafter. The result culminated in new actions and initiatives to address areas of weakness to combat the fraudsters' attempt at exploiting these critical programs. In recent weeks governor DeWine announced several new initiatives aimed at curbing that trend: a six-month moratorium on new home health providers; increased frequency of provider revalidation; new rules to conduct provider payment suspensions during periods of investigations; and updating Ohio's electronic visit verification rules.

Additionally, the Ohio legislature passed senate bill 315, which includes a myriad of reforms to the integrity of the Ohio Medicaid program, including increased penalties for fraud violations, expanded oversight of provider ownership structures, enhanced provider enrollment requirements, and expanded use of electronic visit verification.

Work to strengthen other high-risk programs is also underway. It is a full press forward to address fraud,

waste, and abuse through a thorough policy review across the agency. Through these efforts we have identified certain areas such as Ohio's Nursing Facility Ventilator program for improvements. Private room compliance monitoring, oversight of certain behavioral health services, home health, and skin substitute coverage are just a few where we are making policy updates.

Moving forward, one area we believe the Federal Government and states could partner is through improved data sharing and tracking of provider ownership and affiliation across state lines and programs. As we continue our program integrity work it is critical that we are able to systematically root out bad actors and not leave the door open for any exploitation of this program. If somebody is taking advantage of our program in northwest Ohio, I certainly want to ensure our partners across the state lines in Michigan are aware of that as well.

The department is committed to ensuring Ohioans receive health care in accordance with the law and rooting out fraud, waste, and abuse to protect this vital and critical program for the people who need it. Chairman Joyce, Vice Chair Balderson, Ranking Member Clarke, and members of the committee, thank you for having me today and I look forward to your questions and continued work moving forward. Thank you.

[The prepared statement of Mr. Partika follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. I thank you all for your testimony. We will now move to questioning, and I will begin and recognize myself for five minutes.

Director Sadwith, California has a large Medicaid program spending more than $4.7 billion in 2025 on home and community-based services alone. Fraud in these services, as you would recognize, is a serious matter. In some cases across the country patients have died when fraudsters bill Medicaid for services that were needed but never provided. Your office has stated in correspondence with this committee and CMS that California goes beyond Federal requirements for providing screening and enrollment. If that is the case, why has your Medicaid agency classified all Medicaid-only providers as limited risk, a classification that comes with less stringent oversight standards?

Do all of California's Medicaid providers being considered as limited risk really reflect what you are seeing in these programs?

*Mr. Sadwith. Thank you, Chairman, for the question, and thank you again for the opportunity to be here today.

Home and community-based services are a vital program in California. We know, for example, that they're cost effective, reflecting a prudent use of taxpayer dollars. One year of receiving in-home supportive services saves Federal and state taxpayer dollars approximately $100,000 compared to

a stay in a nursing facility, and we are absolutely committed to ensuring the integrity of these vital services.

*Mr. Joyce. But by classifying all Medicaid-only programs as limited risk, are you saying that all of these programs really show that -- limited risk as far as fraud goes?

*Mr. Sadwith. Thank you for the question. So the risk classification, categorical risk level classification, is one of many tools that we use to assess program risk.

*Mr. Joyce. Is this adequate? When you paint with one brush all of those as limited risk, which requires less oversight, are you missing fraud?

*Mr. Sadwith. We employ a number of safeguards to prevent bad actors from entering the program for in-home supportive services, specifically. We do conduct fingerprint and criminal background checks, which is one of the features of a high-risk categorical level designation. So even though --

*Mr. Joyce. But is that -- that is high risk, but we are talking about limited risk which you ascribed to all Medicaid-only providers. Does that catch all the fraudsters, or should this be more of an individualized approach, and not painting just with one brush?

Is there an opportunity to really read -- to weed out the fraud at its beginning stages?

*Mr. Sadwith. Absolutely, I share your focus on --

*Mr. Joyce. Have you previously designated any Medicaid-only provider types that were classified as moderate or high risk?

*Mr. Sadwith. To my knowledge, we have not classified any Medicaid-only provider types. We have gone above and beyond, historically, the federally-designated risk --

*Mr. Joyce. In California, are you reassessing any provider risk designations in the state?

*Mr. Sadwith. Thank you. We are actively assessing opportunities to strengthen program integrity in key areas. This includes but is not limited to the categorical risk level designation.

We do have other tools that we use to go after higher-risk areas. We have developed provider risk profilers for services, you know, such as hospice care, such as dental care, and other areas that are on our radar that we use, you know, in conjunction with, you know, comprehensive --

*Mr. Joyce. Okay, so you brought you brought into this conversation now home health and hospices. Am I correct that California licenses home health and hospices before they can operate in the state?

*Mr. Sadwith. Thank you for the question. This is a really important issue that I'm happy to talk about. It's really important --

*Mr. Joyce. Please do.

*Mr. Sadwith. Yeah, the partnership between the State of California and the Federal Government is paramount to making sure bad actors stay out of the program when it comes to hospice care and home health.

Just as context, Medicare, the Federal program, is the primary payer for hospice care in California. The state department -- California Department of Public Health, my sister state agency, does perform licensure for hospice providers, and the state has acted swiftly to root out bad actors --

*Mr. Joyce. So, before they can operate in California -- this is just a simple yes-no -- do you allow this hospice organization to operate with or without a California license?

Is that required before they can operate in California? Yes or no.

*Mr. Sadwith. The California Department of Public Health has imposed a licensure moratorium that was enacted in 2021, and just this week implemented new regulations strengthening the standards for licensure for providers to be able to obtain --

*Mr. Joyce. So, prior to just this week, your words, you could operate a hospice in California without a license. Is that what you just said to me?

*Mr. Sadwith. Pardon me. I respectfully disagree with

the framing. I'm actually not an expert on that specific --

*Mr. Joyce. Okay, so let's move on.

Director Bassiri, personal care and home health aides are the largest and fastest-growing job category in New York, and according to CMS, accounted for more than $44 billion in total payments between 2023 and 2025. I understand, based on information that New York provided to the committee just yesterday, even though it was requested in March, that the New York State Department of Health is in the process of designating waivered personal care services as a high-risk program. Given that CDPAP, which is a self-directed personal care service waiver program, is provided in home -- private homes with minimal oversight, what safeguards currently exist to verify the services are billed actually and delivered?

*Mr. Bassiri. Thank you for the question, Chairman.

*Mr. Joyce. I am going to ask you -- my time has expired -- I am going to ask you to respond to that in writing.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. And with that I will yield to the ranking member for her five minutes of questioning.

*Ms. Clarke. Thank you very much, Mr. Chairman.

Under the partisan leadership of Donald Trump and Dr. Oz, CMS's use of its authority to withhold and defer Medicaid funding for Minnesota and California is extreme and unprecedented. And the CMS threat against New York based on basic math errors are an embarrassment.

Under the leadership of Administrator Oz, CMS no longer supports all states in administering their Medicaid programs. Instead, it seems to be looking for ways to undermine these programs. CMS is demanding that states solve problems in their Medicaid programs without defining what the problems are or, in the case of New York, CMS has based its scrutiny of Medicaid spending on an embarrassing misinterpretation of its own data.

Mr. Bassiri, Dr. Oz sent you a letter on March 3 that stated that nearly three out of every four Medicaid beneficiaries receive personal care services from 2023 through part of 2025. Dr. Oz posted that letter on social media, along with a video threatening New York's Medicaid funding. Mr. Bassiri, was the statement that Dr. Oz made about the number of Medicaid beneficiaries receiving personal care services accurate?

*Mr. Bassiri. Thank you for the question, Ranking

Member Clarke. That information that was reported was inaccurate. We did confirm and state that -- and the administration confirmed -- there are 450,000 New Yorkers that receive some form of personal care services, including consumer directed and licensed home care. It is not the four million that was referenced. It's a little under five percent.

*Ms. Clarke. Mr. Bassiri, do you know about how far off Dr. Oz was from the actual number? I think you just stated it a minute ago.

*Mr. Bassiri. Thank you for the follow-up. The discrepancy was between 4 million and 450,000. So --

*Ms. Clarke. Yikes. This is not a minor rounding error. This is a fundamental misunderstanding of Medicaid programs and basic math. And it is not -- it is shameful to be that far off and think that it is New York that has the problem.

Setting aside the egregious misrepresentation of the facts, Mr. Bassiri, were you aware that one of the footnotes in the same letter shows that CMS apparently used ChatGPT to find an article on CMS's own data?

*Mr. Bassiri. Thank you for the question. I had not been aware of that.

*Ms. Clarke. Yes, I think this is relevant because it demonstrates that CMS is not taking the time to assess its

data to identify specific program integrity concerns. And it is clear that President Trump and Dr. Oz decided to go after New York and then try to manufacture the basis for doing it.

Mr. Sadwith, in response to CMS's determination in May to defer $1.34 billion from your program, you said CMS has used what was once a routine payment reconciliation process with states to undermine exactly what Federal HCBS policy has long sought to achieve, helping more people remain safely at home rather than enter institutions for long-term care. Can you explain how the May referral announced by CMS defers -- excuse me, differs -- from your -- from prior deferrals?

*Mr. Sadwith. Thank you, Ranking Member. I'd be happy to.

You know, first of all, we value transparency and we do value the review process with CMS. Some of the deferrals in that deferral are actually a result of California proactively reaching out to CMS and disclosing concerns and issues we had identified in seeking partnership with CMS to ensure Federal appropriate claiming.

However, the $1.1 billion deferral for our in-home supportive services is unprecedented. We began addressing CMS questions before the deferral was ever issued. They reviewed intensively, and we value that partnership. We explained the growth, we explained that intentional policy choices reflecting longstanding Federal policy and Federal

authorities to expand home and community-based services and keep vulnerable Americans at home, saving taxpayer dollars, was part of our strategy, part of our policy. We explained what drove the growth, and CMS decided to defer the payments, and they have not provided any instances of fraud, waste, or abuse as part of their review.

*Ms. Clarke. Does an extended delay in releasing Federal funds threaten accessibility of services for patients?

*Mr. Sadwith. We are continuing to monitor the impact on access to patients as a result of this deferral, and working steadfastly to continue responding to every question CMS asks us.

*Ms. Clarke. Very well. Mr. Chairman, I yield back.

Thank you, gentlemen.

*Mr. Joyce. The gentlelady yields. The chair now recognizes the chairman of the full committee, Mr. Guthrie, for five minutes of questioning.

*The Chair. Thank you.

So, first for Director Bassiri, New York has failed to provide certain information in response to our -- to the committee's letter. For example, you have not provided simple information such as all the state's designated risk levels for Medicaid-only providers -- types. I would also note that you only provided the basic information that was

requested about the frequency of on-site visits in yearly improper payment and recovery efforts the day before. Why have you been unable to provide that information to the committee?

*Mr. Bassiri. Thank you for the question, Chairman. We have been as responsive as we can. We're handling many inquiries from both the committee, the Center for Medicare and Medicaid Services, and HHS OIG, but I'm happy to take that back, and we will --

*The Chair. We brought this up to you on March the 3rd. It's now June 25th. If your agency doesn't have this information readily accessible, that is a problem in itself. But the committee and the American people deserve to have transparency of how New York and all states are operating in their program. And will you commit to providing that information to this committee that we have requested?

*Mr. Bassiri. Thank you for the follow-up. We agree that transparency is paramount. I can't commit to that here, but I'm happy to take that back and get back to you as soon as possible.

*The Chair. You can't commit to providing this information I just laid out?

*Mr. Bassiri. I think we've been -- I'm happy to take that back and get back to you.

*The Chair. Well, thank you. So, Director Sadwith,

kind of the same. The committee requested documents and information from your agency on March 3, including all audits related to fraud, waste, and abuse in the state's Medicaid programs, including audits completed by third-party contract auditors from January 1, 2021 to present. I think that is about the time you said the licensing was ceased.

I think I said -- I might have said in home; I think it was hospice care when I was referring earlier. Based on the information that has been provided to the committee, we know that California has conducted such audits, but the committee did not receive a single audit document from California until 7:00 p.m. last night. Do you believe that providing more than 1,300 pages of documents on the eve of a hearing is fair to this committee?

*Mr. Sadwith. Thank you, Chairman, and I acknowledge the frustration. We have been working with committee staff to produce information and address the questions, including the list of 26,000 audits and investigations that we have conducted over the past 5 years. Last night we provided some audits related to transportation and mental health that the committee had indicated were --

*The Chair. There were also others that we have requested. Do you commit to providing that -- what we have requested to this committee in a timely manner?

*Mr. Sadwith. Thank you, Chairman. There are ongoing

law enforcement investigations that would be impacted by those specific audits that were requested. We're happy to provide the appropriate information at the appropriate time.

*The Chair. Well, I would say it just seems unfair to us to prepare for a hearing that you send everything at 7:00 p.m. last night. It almost seems like that was intentional. It appears that way.

So, temporary Commissioner Connolly, the Early Intensive Development Behavioral Intervention Program, which provides autism therapy services in Minnesota, is currently experiencing unprecedented levels of fraud exemplified by a recent fraud takedown in Minnesota charged by DoJ totaling 46.6 million, one of the largest in history. In this scheme, it is alleged that the defendants paid kickbacks to parents to bring their children to the autism centers where children were diagnosed with autism, regardless of the medical necessity.

What are you doing to restore the Early Intensive Development and Behavioral Intervention Program to provide these services to those who it is intended for?

*Dr. Connolly. Thank you, Chairman Guthrie, for the question.

So, we are engaged in a number of efforts related to the autism services benefit in Minnesota. And certainly, significant fraud happened and I am not here to minimize

that.

However, as the fraud became apparent to us based on the information we were able to collect through investigations and through data analytics, we took a number of actions. I think one of the first was in October of 2024. Our staff did an on-site audit of all autism service providers in the program across the state. Later, it was designated as a high-risk service. So that comes with enhanced fingerprint background checks, unannounced site visits, and more frequent revalidation. Those providers are also included in the revalidation of the 5,600 providers that I described in my opening comments.

We also implemented, pursuant to the direction of the legislature, a new licensing framework for autism service providers. That is being implemented now. It is being phased in. We have a provisional licensure framework that providers -- the vast majority of providers have applied for. And then full licensure will come into place in 2027.

*The Chair. Well, thank you. My time is running out. I just want to say you said significant fraud has -- was being committed, and you are not denying that or downplaying that. I think that is the word you said, which -- I appreciate that. I think, hopefully, all of you would admit to that.

And my wish is that, in a bipartisan way, all of us on

here, instead of, well, the administration did this and fraud and whatever, there is significant fraud in the programs that not just the four of you are representing. I think if you look across, I don't know every -- I am not going to say every state because I don't know that, but I think it is absolutely significant. And it just seems like this is one thing we could all agree that we should fight the fraud of significant levels. You said -- "significant" is the word that you used.

And I want to ask you -- my time is now up, but I think this is just something that is frustrating that we are not -- this isn't a bipartisan effort to root out fraud.

I yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes the ranking member of the committee, Mr. Pallone, for five minutes of questioning.

*Mr. Pallone. Thank you, Mr. Chairman.

The Republicans' big, ugly bill cut health care by $1 trillion, and then the Trump Administration launched a campaign to cut health care to blue states even more. On February 26, just two days before Trump began his reckless war of choice with Iran, Vice President Vance announced a deferral of $250 million in Medicaid funding to Minnesota. So I want to ask Dr. Connolly -- actually, I am going to go to each of the three state representatives. So, you know, if

you could just respond in a minute or so.

So Dr. Connolly, you have described the deferral as a quote, "catastrophic funding loss" for Minnesota and the children, families, and seniors that rely on the program. So what does an unprecedented deferral of this size mean for Minnesota children and families?

And has CMS given you any indication of whether these deferred payments will be released, or when?

*Dr. Connolly. So the size of both the deferrals, which are roughly $350 million, on top of the $2 billion, roughly, annual withholding associated with CMS's compliance action, that is a significant amount of money when the entire program is roughly $20 billion in entire Federal and state spend. So that is a very large sum of money that threatens the state's ability to finance the services and benefits that are part of the program.

In addition, we have a structural budget deficit in Minnesota. We've had that for a couple of years now. And so we are already struggling to maintain the services, the payment levels for providers across the state, the eligibility levels that we have in the program. So this adds another layer of pressure and risk to those realities.

With respect to CMS and us working with them, we have done everything since December 5 and the notification that they were requiring a corrective action plan of us that they

have asked. We've revised it once, provided that timely on time, and have implemented every step and milestone in that corrective action plan since we submitted it.

*Mr. Pallone. Any indication of whether these payments will be released, or when? I am just trying to move on.

*Dr. Connolly. None yet, Representative Pallone, thank you.

*Mr. Pallone. I appreciate it. I am just trying to get all of you in.

In California CMS has targeted home and community-based services, or HCBs [sic]. Cuts to HCBs mean Medicaid recipients will end up in institutions rather than get care in their homes or receive no care at all possibly. So Mr. Sadwith, if HCB -- if HCBs are cut and patients are forced into institutions, what are the consequences for patients, their families, and taxpayers? In about a minute, if you don't mind.

*Mr. Sadwith. Thank you for the question, Representative. So I'd like to take a minute just to talk about what these services are and who is receiving them to put a human face on them.

So in-home supportive services are provided to some of California's most vulnerable residents including children with disabilities, adults with disabilities, and seniors who cannot live safely at home. All in-home supportive services

recipients meet institutional level of care, which means that they qualify to be admitted and to live in facilities and in institutions. IHSS services assist people with living safely at home. These services include, you know, things like helping with bathing, with grooming, with hygiene, with meal preparation, and paramedical supports such as changing colostomy bags, injections, medication administration, and driving recipients to doctors appointments. So without these services, children would be living in facilities and adults and seniors would also be living in facilities.

And these are also cost-effective services. It's a good use of taxpayer dollars to invest in these services. Every year that we provide in-home supportive services and keep someone out of a nursing facility, we save state and Federal taxpayers approximately $100,000.

*Mr. Pallone. I appreciate it, and I -- you know, institutionalization is not only terrible, but costs so much more money.

So Mr. Bassiri, you have said the effects of paperwork requirements could be quote “catastrophic” for New York. What impact will these requirements have on patients and providers in New York's Medicaid program? And you have only got about 45 seconds to answer.

*Mr. Bassiri. Thank you for the question, Ranking Member Pallone.

I believe you're referring to the implementation of community engagement requirements, which we are set to do on January 1 of this year. I think the biggest challenge is communicating effectively and accurately with our members about the changes that are forthcoming and the varied nature of those changes at different time periods. We are incurring about a 20 percent increase in administrative costs to accommodate some of the implementation requirements to mitigate from consumers, but we are taking proactive steps to make sure we're making sure people are aware of the changes. We don't want any disruptions in continuity of care, and that's where our focus has been.

*Mr. Pallone. Thank you.

Thank you, Mr. -- Thank you, Mr. Chairman. I yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes the vice chairman of the subcommittee, Mr. Balderson, for his five minutes of questioning.

*Mr. Balderson. Thank you, Mr. Chairman, and I thank all of you for being here today. This is a very challenging subject to talk about, and I reiterate what the chairman said during his statement. So relax, breathe a little bit, all of you, and just -- let's do the best we can here and work together.

Mr. Partika, November 2025. Seven months into this.

This has been quite an interesting challenge for you, and I appreciate the work that you have done in the great State of Ohio, and the state that I am blessed and fortunate to represent.

This committee implemented robust Medicaid program integrity reform in last year's Working Families Tax Cut legislation. You mentioned some of that. Can you share how the Ohio Department of Medicaid has benefitted from these reforms so far?

*Mr. Partika. Thank you, Congressman. Yes, the -- as I referred to in my testimony around the benefits from that, one of the frequent audit findings we had was inaccuracies around member eligibility. The Working Families Tax Cut legislation increased the frequency of those redeterminations of individuals which will increase the accuracy of our rules as well as work requirements and additional supports around identifying individuals enrolled in multiple states, which, as we look across the board, is producing a significant savings to the ongoing state budget as we move forward.

*Mr. Balderson. Okay, thank you. Ohio recently announced steps to build a national model of Federal and state cooperation on fraud enforcement. What does this Federal-state partnership look like? Could you explain a little bit?

*Mr. Partika. Yes, Congressman. Yes, the effort, I

think, is a great reflection of the longstanding work that Ohio has had between the department, from the administrative perspective, and our law enforcement partners at the attorney general's and at the Federal level. A longstanding history of convictions, over 2,000 individuals since 2011 have been convicted.

Upon recent trends that we have found in this area, we have started to move from this caught-and-stopped policy to say, how can we go upstream and start to close doors before fraudsters enter our program?

In the wake of recent trends we have seen, we were collaborating very closely with our partners at CMS, from new data sharing agreements to having robust conversations around how to handle a provider suspension to stop the bleed where appropriate, but also be cognizant and aware of individuals who need to continue to receive care. That all has culminated into the recent efforts.

Most recently, the Federal Government has been rolling out a new dashboard that compares states and compares risk of certain services. That is serving for a good guiding tool as we look and say, what are the anomalies in Ohio? Is that consistent with what we're seeing across state lines, which is a new way of looking at things. It's evolving, and we plan to continue to respond as we move forward.

*Mr. Balderson. All right. Thank you, well done. Mr.

Partika, a recent article explained how Ohio's Medicaid paid more than five million to a company whose president had a daycare shut down because of signs of fraud, and her husband has a felony conviction for billing for non-existent elder services. How is Ohio reforming its provider enrollment and revalidation process to detect known criminals that may be operating in concert with Medicaid providers?

*Mr. Partika. Congressman, as I mentioned, recent legislation increased the frequency of those revalidations as one particular tool. I know in instances where we find individuals have committed a past violation that was not captured upon enrollment is one of the areas -- I think, from a data-sharing perspective across state lines, would be incredibly helpful to know from across multiple programs -- not just Medicaid, but also Medicare.

In Ohio we are proactively starting to share this information with our partners at other state agencies not to determine if there is a potential for fraud, waste, and abuse in other programs, as we see individuals involved in not just Medicaid services, but perhaps daycare services and the like.

*Mr. Balderson. Okay. We are down to about 50 seconds, Mr. Partika. What considerations are being made in Ohio, if any, to reassess Medicaid-only provider categorically risk types [sic] after fraud allegations and charges that have recently been made?

*Mr. Partika. Congressman, one of the -- our revalidation plan that we have submitted to CMS in particular, looking at the categories of risk but also looking at how can we do a data dive to not just determine what type of provider they are, but what is the behavior of that provider, what are the billing patterns. Are they massive outliers from others? And moving them into a high-risk category based on behavior.

Moving into a high-risk category, of course, does not mean you are fraudulent on its face; it means you require additional investigation and oversight on a more frequent basis.

*Mr. Balderson. All right. Thank you very much.

Mr. Chairman, I yield back. Thank you all for being here.

*Mr. Joyce. The gentleman yields. The chair now recognizes Ms. DeGette for her five minutes of questioning.

*Ms. DeGette. Thank you so much, Mr. Chairman, and I want to thank the witnesses for being here.

All of you are taking time out of your busy schedules, and we appreciate it because you don't have an easy job. I would imagine that a large part of what you do is try to integrate your programs with CMS and the other executive branch agencies, and I would imagine it would help if it was that collaborative. So I have a long list of questions. I

would appreciate yes-or-no answers, and you do not need to thank me for the questions.

Mr. Partika, I want to start with you. Has CMS been collaborative with Ohio in pursuing anti-fraud initiatives?

*Mr. Partika. Yes, ma'am.

*Ms. DeGette. Earlier this month DoJ announced a collaborative Federal-state partnership with Ohio to combat fraud. Is that correct?

*Mr. Partika. Yes.

*Ms. DeGette. And during this Administration, has CMS sent Ohio a formal inquiry regarding the state's anti-fraud policies?

[No response.]

*Ms. DeGette. Has CMS sent Ohio a formal inquiry regarding the state's anti-fraud policies?

*Mr. Partika. Ma'am, I will have to confirm. We've had various inquiries from CMS.

*Ms. DeGette. Oh, you don't know. Okay.

Dr. Connolly, on December 5, 2025 CMS sent Minnesota a letter demanding a corrective action plan. Is that correct?

You need to turn your mike on.

*Dr. Connolly. Yes.

*Ms. DeGette. You submitted a corrective action plan to CMS by the deadline they provided, and then your office met with CMS on January 6 to discuss that plan. Is that correct?

*Dr. Connolly. I'd have to confirm the date of the meeting, but yes.

*Ms. DeGette. Yes, you met with them. Later that same day, on January 6, Administrator Oz announced CMS would withhold up to $2 billion from Minnesota. Did the agency give you any indication it was about to make a significant funding threat just hours later?

*Dr. Connolly. Not in advance of the meeting in January.

*Ms. DeGette. Thank you. And also, Dr. Connolly, is it true that after receiving additional questions from CMS Minnesota submitted a revised corrective action plan January 20 and met with CMS on February 3, February 10, February 17, and February 24?

*Dr. Connolly. Yes, I believe that's true.

*Ms. DeGette. And on February 25, after four weeks of refusing to provide Minnesota feedback on its plan, Administrator Oz announced he was deferring $259 million in Medicare funding.

During your four meetings, Dr. Connolly, with CMS in February alone, did the agency ever provide notice that it was planning to defer nearly a quarter billion dollars in funding?

*Dr. Connolly. I personally was not given that information.

*Ms. DeGette. You don't think so, right?

*Dr. Connolly. I personally was not aware of that coming, no.

*Ms. DeGette. Okay. Mr. Sadwith, California had a $1.3 billion deferral from CMS. Did CMS provide you with any notice of the incoming deferral or any concrete things you could do to prevent it?

*Mr. Sadwith. CMS asked questions and we responded to them.

*Ms. DeGette. But they didn't tell you what to do, right?

*Mr. Sadwith. Correct.

*Ms. DeGette. Has CMS told you anything about what your state needs to do to get that critical funding released?

*Mr. Sadwith. CMS continues to pose questions to us, and we continue --

*Ms. DeGette. So they haven't told you what you need to do to get it released, yes or no?

*Mr. Sadwith. No.

*Ms. DeGette. And is this a departure from how CMS and California have collaborated in the past?

*Mr. Sadwith. Yes.

*Ms. DeGette. Thank you. And so CMS, in my view, is going out of its way to blindside blue states while pampering red ones. In fact, CMS has sent letters investigating

Medicaid programs in New York, California, Maine, Minnesota, and Florida. Florida's letter is a fig leaf to pretend the agency's investigations were not partisan, coming minutes before CMS leadership was to -- set to appear before this subcommittee. Soon after sending the letter to Florida, however, Dr. Oz took to social media to praise the DeSantis Administration. Only blue states have had their Medicaid funding deferred or threatened, and CMS has shown no evidence that these states are worse actors.

Frankly, unfortunately, this is a staged performance to target blue states, not a genuine fraud investigation. It is exemplary of how this whole Administration works and how hollow the Administration's focus on fraud really is. Donald Trump has pardoned or commuted the sentences of several convicted fraudsters who seem to be his supporters. Lawrence Duran stole $205 million from Medicare and was sentenced to 50 years in prison. Sentence commuted. Paul Walczak stole money from the employees of his nursing home. President Trump pardoned him in April of 2025 after his mother attended a $1 million-a-person fundraiser at Mar a Lago. We can figure this out.

I am reminded of an old phrase that sums up everything this administration is all about: amicus omnia inimicis legis. To my friends everything; to my enemies, the law.

I yield back.

*Mr. Joyce. The gentlelady yields. The chair now recognizes Mr. Palmer for his five minutes of questioning.

*Mr. Palmer. My first three questions are a yes-or-no answer. You do not have to thank me for the question.

Given that providers engaged in fraud, waste, and abuse that -- may involve being enrolled in both Medicare and Medicaid, does your state share information between the two programs to prevent enrollment of bad actors?

Mr. Connolly?

*Dr. Connolly. I'm sorry. Could you --

*Mr. Palmer. Yes or no.

*Dr. Connolly. Are we sharing information with the Medicare program?

*Mr. Palmer. To ensure that you don't have fraudulent dual enrollment, Medicare and Medicaid.

*Dr. Connolly. We are sharing information weekly with the Centers for --

*Mr. Palmer. It is a yes or no.

*Dr. Connolly. -- Medicare and Medicaid Services.

*Mr. Palmer. It is a yes.

Mr. Sadwith?

*Mr. Sadwith. Yes, we share information with CMS.

*Mr. Palmer. Mr. Bassiri?

*Mr. Bassiri. Yes, we --

*Mr. Palmer. Mr. Partika?

*Mr. Partika. Yes, sir.

*Mr. Palmer. Okay. Does your state share information with the Treasury's Do Not Pay system or other Federal databases?

Mr. Connolly?

*Dr. Connolly. I'm sorry, could you repeat the question?

*Mr. Palmer. I know I have a Southern accent. I'll try to speak a little clearly.

Does your state share this information with the Treasury's Do Not Pay system?

*Dr. Connolly. I'd have to confirm whether or not we've done that.

*Mr. Palmer. Okay. Mr. Sadwith?

*Mr. Sadwith. Our state collaborates with CMS to share tax information --

*Mr. Palmer. It sounds like you don't even know what I am talking about.

Mr. Bassiri?

*Mr. Bassiri. I am happy to take that back and --

*Mr. Palmer. Okay, find out.

Mr. Partika?

*Mr. Partika. I'm sorry, sir. I'll have to provide follow-up on that question.

*Mr. Palmer. Okay. Does your state work to share this

information across state lines to ensure that you don't have people enrolled in your states that are enrolled in other states?

Mr. Connolly?

*Dr. Connolly. Yes, that is part of a regular exercise.

*Mr. Palmer. Thank you.

Mr. Sadwith?

*Mr. Sadwith. We share information on eligibility that is --

*Mr. Palmer. It sounds like you don't know.

Mr. Bassiri?

*Mr. Bassiri. We do, to the --

*Mr. Palmer. Thank you.

Mr. Partika?

[No response.]

*Mr. Palmer. Just --

*Mr. Partika. I apologize, sir, I'd have to confirm that we --

*Mr. Palmer. Okay, thank you.

*Mr. Partika. -- share with CMS --

*Mr. Palmer. Mr. Connolly, CMS asked that you revalidate all providers in the 14 high-risk Medicaid programs. That is nearly 5,600 providers. After the initial revalidation, your office reported it disenrolled more than 3,400 providers. That's 60 percent of those enrolled.

However, last week it appears your agency restored the billing privileges for over 2,100 of -- that submitted the appeals. What is going on with this revalidation process, and how are you making sure that providers who were restored pending appeal are filing legitimate claims in the meantime?

*Dr. Connolly. To preserve continuity of service for the beneficiaries --

*Mr. Palmer. But what are you doing to make sure that they are not filing illegitimate claims?

*Dr. Connolly. All of those services are subject to enhanced prepayment review and all of the high-risk designation requirements that are associated with it.

*Mr. Palmer. Of the 3,400 providers who were initially disenrolled, when were those providers last revalidated? Was it within the last five years?

*Dr. Connolly. Yes, all providers have to revalidate within the -- within five years.

*Mr. Palmer. It has also been reported that many of the providers that were disenrolled have been flagged by your agency before. Is that true?

*Dr. Connolly. I'm sorry, could you repeat the question?

*Mr. Palmer. It has also been reported that many of the providers that were disenrolled had been flagged by your agency before. In other words, there was some suspicion. Is

that true? Had they been flagged before?

*Dr. Connolly. I'd have to confirm the details of that for you.

*Mr. Palmer. All right. When -- did your agency ascertain whether the providers that were disenrolled when re-enrolled pending appeal were providers that had been previously flagged for fraud?

*Dr. Connolly. Providers that are flagged for fraud have a payment withhold applied, and are sent -- those cases are sent to law enforcement.

*Mr. Palmer. So you are saying that none of the ones that have had their billing privileges restored were flagged for fraud in the past.

*Dr. Connolly. If we are aware, our inspector general is aware of a credible allegation of fraud, there would be a payment withhold and they would be referred to law enforcement for investigation and prosecution.

*Mr. Palmer. Can you confirm that your agency is conducting this revalidation in a thorough manner, and that no providers being revalidated are fraudulent or have been flagged as potentially fraudulent?

*Dr. Connolly. Our team is being very exacting, making sure that providers meet all the compliance requirements.

*Mr. Palmer. The thing I want to make certain here is that none of us on this side of the aisle are -- want to deny

services to anybody who legitimately needs it. What this is really about is that there have been billions of dollars stolen from state and Federal programs that should have gone to help people who legitimately need them. That is the shame of this. That is the tragedy of this, is that there are people who need these services that don't -- that are having to have limited compensation, limited access because so much money has been stolen. That is what this is about, and that is why we are going to get to the bottom of it and correct it so that the people who should be getting the funding for these services get what they are supposed to get.

And I yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes Mr. Tonko for his five minutes of questioning.

*Mr. Tonko. Thank you, Mr. Chair.

We have heard all of you express how your states value the Federal-state collaboration to manage your Medicaid programs. And we have heard the same from other witnesses on this topic in prior hearings. It is clear that the Medicaid program cannot work without a productive partnership between the Federal Government and the states. But CMS has abruptly shifted from providing support to states toward creating obstacles for them, or at least for certain states that did not support the President in the last election.

So Mr. Bassiri, New York has received scrutiny and

threats directly from Dr. Oz about its Medicaid funding. It turns out that CMS had an analysis that led to these threats and questions -- and questions, and it was completely faulty. However, Mr. Bassiri, how important is it to state anti-fraud efforts to have CMS operate as a good faith partner rather than a bad faith antagonist?

*Mr. Bassiri. Thank you for the question, Congressman.

Partnership is paramount to addressing and combating fraud, waste, and abuse. I think our work with CMS does -- is ongoing and is focused on high-risk areas. However, I think it's important to note that the working relationship is necessary to systematically root out any fraud, waste, and abuse and ensure that that fraud doesn't persist elsewhere.

We do have complex programs. And as others have mentioned on the panel, it's not just one area. Things can be in multiple areas. So that Federal partnership is key and critical to our ability to successfully address program integrity.

*Mr. Tonko. Thank you.

And Dr. Connolly, your department has been in talks with CMS for over six months regarding the CMS withholding of your state's corrective action plan and subsequent deferrals of funding. In April you said about these talks, and I quote, "The goal posts keep moving rather than work with us to fight fraud while protecting programs. CMS is taking actions that

punish Minnesotans who need these services." Since that statement, CMS has taken yet another deferral against your state's Medicaid program.

So can you explain what your interactions have been like with CMS regarding your program integrity efforts, and whether CMS has been consistent and clear in what it needs you to provide in order to release the deferred funds?

*Dr. Connolly. So we've been engaged very regularly with CMS since December 5, the initial letter from Administrator Oz requesting -- really, directing us to develop a corrective action plan that was submitted after the first draft was submitted on the 31st of December 2025. At the end of January 2026 we met for a multiple months weekly with CMS to make sure that we were fulfilling their requirements, providing deliverables, meeting milestones on time. And our team has worked days, nights, weekends, holidays to do that.

In addition, beyond the first corrective action plan direction, the second required revision of the corrective action plan and the compliance action in January, there was, as you noted, the deferral issued and the focused review initiated in February. So there have been multiple different additional actions after the first in December. And we continue to work with them continuously and at their request to meet all of the milestones, provide all of the

deliverables, meet the marks so that we can be released from those compliance actions and deferrals.

*Mr. Tonko. But the consistency and clarity here are important, obviously, in order for the partnership to work on behalf of the consumer and the taxpayer.

In your testimony you note that your state's anti-fraud policies have been mischaracterized by Federal officials, and that those public statements erode trust in the Federal-state partnership and carry risks to care. So Dr. Connolly, have you tried to correct the mischaracterizations with CMS?

And if so, what has been the reception from CMS officials?

*Dr. Connolly. Thank you for the question, Representative Tonko.

We continuously try to correct mischaracterizations, both through public statements but also through written statements in addition to our program integrity dashboard and website on our department's website.

*Mr. Tonko. And how do you respond to remarks that Secretary Kennedy, Administrator Oz, and Vice President Vance have made that Minnesotans -- that Minnesota has not been cooperating with the Federal Government to fight Medicaid fraud?

*Dr. Connolly. I would say that we reached out proactively to CMS when we decided to designate programs or

benefits high risk in the first half of 2025.

We also then engaged them to partner on terminating -- taking the painful step of terminating the Housing Stabilization Services benefit. That was at our initiative as a state. They worked with us on that. It was executed by the end of October.

We also designated the full 14 services as high risk at our initiative. And again, that's something that CMS provides the framework for. We've continuously worked with them, and that was well in advance of the December 5 letter from Administrator Oz.

*Mr. Tonko. Okay. Mr. Chair, I have other questions that I will get to the committee, subcommittee.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Tonko. But with that I thank you and yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes Mr. Allen for his five minutes of questioning.

*Mr. Allen. Thank you, Chairman, and thank you for being here today and informing us on what in the world has had -- this took place.

The first question I have -- and I think all of you have admitted that you have significant waste, fraud, and abuse in these programs in your states. Is that correct? Would anyone dispute that?

I think the question here is should taxpayers continue to pay and be put on the line for this waste, fraud, and abuse, or should the taxpayers say, okay, you fix it and then we will be glad to fund those who, by law, are allowed to use these programs. That is the question. And that is the difference of opinion here, in my mind.

For all the witnesses, ongoing criminal investigations in many states have identified shared ownership or affiliations where individuals are enrolled in perpetrating fraud in numerous Medicaid services. What exactly is your state doing to more closely examine currently enrolled Medicaid providers to identify shared ownership or affiliations with excluded providers that have previously perpetrated fraud? That is your responsibility. Tell me what you are doing there.

And I will start with Mr. Connolly.

*Dr. Connolly. Thank you, Representative Allen.

So the first thing I would point out is that fraud is unacceptable. We agree with that. And we have fought very hard to root out fraud in our programs.

With respect to different steps taken to find connections among bad actors or criminals in our program whom we hope are prosecuted and go to prison because of fraud they're committing, we have initiated, of course, the revalidation effort among the high-risk providers that we designated. So 14 services, as I said, were designated high risk. They were all subject to that revalidation, that off-cycle revalidation that I mentioned, the 5,600. And part of that work is to identify through the fingerprint background check, through the site visit, and the review of credentials and documentation who those providers are led by, what ownership is, and do analysis with the appropriate databases, and work with law enforcement to understand what connections there may be among bad actors and criminals.

*Mr. Allen. Yes.

*Dr. Connolly. So we are taking that action, I think principally --

*Mr. Allen. Okay.

*Dr. Connolly. But also, we do work with Federal and state --

*Mr. Allen. Yes, I have got --

*Dr. Connolly. -- law enforcement.

*Mr. Allen. I have got three more I need to get to, so if we can make our answers short -- and I am going to have a follow-up question, as well.

Are there any elected political officials in your state that are doing everything they can do to keep you from uncovering this fraud, waste, and abuse? And of course, now I will go to the next witness.

*Mr. Sadwith. Thank you. So to address your first question, fighting fraud is a top priority for our department. And we know fraud is not unique to Medicaid or even Medicare. It is also in private health insurance, and that's why we have to work together to protect taxpayer dollars.

Making sure that we crack down on bad actors who have -- you know, use business structuring to conceal their illicit activity is a top priority for California. We collect comprehensive disclosure ownership and control interest information from every provider applying. We check those against Federal and state exclusionary database lists. We also check those lists for subcontractors of those providers and other business entities that they have a significant business relationship with.

*Mr. Allen. Is it --

*Mr. Sadwith. I --

*Mr. Allen. Okay, Mr. Bassiri.

*Mr. Bassiri. Thank you for the question, Congressman.

And last year, under Governor Hochul's leadership, we really prioritized the development and implementation of a provider services portal which is a new provider enrollment system, and putting that in place. It is slowly rolling out now. And as part of the revalidation plan being requested by CMS, we are sort of expediting that implementation plan.

We are adding new Medicaid-only providers to high-risk designations and pursuing moratoriums where applicable. We completely agree that the front door to the program is very important safeguard.

*Mr. Allen. Right, okay, good. Mr. --

*Mr. Partika. Yes, Congressman. In Ohio, we've identified shared ownership --

*Mr. Allen. Okay.

*Mr. Partika. -- indictment of fraud we will take action. Recent improvements have helped that.

*Mr. Allen. Okay.

*Mr. Partika. As folks continue to conceal their ownership and control of entities, that is a challenge that I think states --

*Mr. Allen. Yes, okay.

*Mr. Partika. -- and the Federal Government will be

tasked --

*Mr. Allen. And yes or no, this all happened in the last year, when this was brought to the public eye? It has been a year. And my question is, did the Biden Administration notify you of any of these issues when they were in charge of CMS? Did you get any requests from them for identification of waste, fraud, and abuse?

*Mr. Sadwith. These processes have been in place for -- in California. They're not new. And yes, we did collaborate with the Center for Program Integrity at CMS.

*Mr. Allen. But it was not publicly known at that time, I don't believe. Is that correct?

[No response.]

*Mr. Allen. Okay. Well, I am out of time and I yield back, Mr. Chairman.

*Mr. Joyce. The gentleman yields. The chair now recognizes Mrs. Trahan for her five minutes of questioning.

*Mrs. Trahan. Thank you, Mr. Chairman, and thank you all for being here today.

Republicans have made state Medicaid programs nearly impossible to administer. Their so-called efforts to root out waste, fraud, and abuse have only created more bureaucracy, more costs, and more money diverted from patient care. Meanwhile, hospitals across the country continue to close, providers worry about making payroll, and Americans

with disabilities wonder whether they will be able to get the care that they need.

This year CMS was -- has attacked providers of home and community-based services, sending shockwaves for caregivers and patients across the country. In the district I represent, UMass Memorial has worked with MassHealth to help patients with acute care needs receive inpatient-level care at home, improving outcomes and freeing up sparse hospital beds. State Medicaid agencies should be supporting these programs, but instead they are being forced to spend their time and money complying with new Federal mandates that will result in fewer people receiving health care.

Mr. Bassiri, last year New York State Comptroller DiNapoli stated that the total cost of the Republicans' big, ugly bill to New York State would be $13 billion annually, including the administrative costs of implementation. The Medical Society of New York projected that the bill will increase administrative costs to the state by at least 20 percent. Is it fair to say that the administrative burdens of implementing H.R. 1 uses time and resources that could otherwise be used to deliver health care and fight fraud?

*Mr. Bassiri. Thank you for the question, Congresswoman.

First and foremost, when we, as -- overseeing the Medicaid program, we do take compliance and implementation of

Federal legislation very seriously. And as part of the passage of H.R. 1 we are committed to doing that in an efficient and time effective way.

You are correct that the administrative cost associated with that implementation is significant. This is the largest administrative cost the state has incurred since the implementation of the ACA. But I don't necessarily -- can't really speak to whether we would be using our time differently or elsewhere. I think we are very, very committed to --

*Mrs. Trahan. Well, what resources has your state had to deploy to ensure that Medicaid beneficiaries aren't thrown off their care because of H.R. 1?

*Mr. Bassiri. We have had to incur a range of costs, both from a media, marketing, outreach -- just informing people of the changes. We've been implementing new eligibility and enrollment systems so that the process for consumers and providers or their caregivers is simple and transparent.

*Mrs. Trahan. Yes.

*Mr. Bassiri. And then we've been augmenting our county staff --

*Mrs. Trahan. I appreciate all that. But, like, resources are not infinite, which is why I asked the question.

I think Democrats warned that the red tape requirements in the big, ugly bill will divert millions of dollars from health care to administrative overhead.

Mr. Chair, I would like to submit a document for the record.

*Mr. Joyce. So ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mrs. Trahan. Thank you. Last year the GAO published a report investigating Georgia's Medicaid red tape requirements program. They found that since Georgia first received Federal approval to implement its Medicaid red tape requirements, nearly 70 percent of all spending in that program has gone to administrative costs rather than to health care and 88 percent of those administrative costs were paid by Federal taxpayers.

Dr. Connolly, last August Minnesota's Department of Health -- of Human Services shared that new requirements from the big, ugly bill could potentially increase state, local, and tribal administrative spending by $165 million annually. What do patients lose when Federal Medicaid dollars are diverted from health care to setting up new administrative requirements?

*Dr. Connolly. So I think there -- thank you for the question, Representative Trahan. I think there are two main considerations here and worries.

Number one is, of course, the people who would lose coverage because of the new requirements. That is, of course, the principal concern that we have and that we've talked about in Minnesota.

And the second, of course, is that we, as I stated earlier, have a structural budget deficit that we have to solve for. And so when additional requirements are placed on

the state to administer that piece of the program or that piece of the Federal legislation, that does, of course, require resources from the state which we are already struggling to find.

*Mrs. Trahan. At a time when CMS is adding insult to injury, deferring $350 million in Medicaid payments to Minnesota, look, Republican policies are increasing Medicaid administrative costs to states, leaving fewer resources for care, reducing access for patients, and kicking people off their coverage. And CMS is piling on by threatening funding and issuing endless requests to states that did not support the President.

Sadly, it's patients and families across the country who will have to bear the consequence. It doesn't have to be this way, Mr. Chair. We can target waste, fraud, and abuse in our health care system. We all want to do that. But we have to do it in a way that doesn't threaten the care that the Americans desperately need.

Thank you. I yield back.

*Mr. Joyce. The gentlelady yields. The chair now recognizes the gentlewoman from Tennessee, Dr. Harshbarger, for her five minutes of questioning.

*Mrs. Harshbarger. Thank you, Mr. Chairman, and thank you to the witnesses for being here today. I am going to start with Mr. Connolly and go down the line. And if you

could be brief, it would be awesome.

When your agency receives reports of suspected fraud or comes across suspicious behavior, what does your preliminary investigation process entail?

I will start with you, sir.

*Dr. Connolly. There's an intake process. If it meets -- the evidence meets a certain threshold, then it's considered a case. The case is reviewed. If there's credible evidence of fraud, then it is reviewed to both the attorney general's office, the Medicaid Fraud Control Unit, as well as, in many cases, the U.S. Attorney's Office.

*Mrs. Harshbarger. Okay. Yes, sir.

*Mr. Sadwith. Thank you, Representative.

We receive referrals and complaints from a variety of sources, including plans, providers, members, and internal referrals from data analytics. When we receive a complaint, we review it across a number of different criteria including comprehensiveness of information, credibility, impact, et cetera. We then place these complaints in a risk queue based on prioritization.

*Mrs. Harshbarger. Yes.

*Mr. Sadwith. And then, as warranted, investigations are open through a multidisciplinary investigation process with financial auditors, sworn peace officers, investigators, data scientists, and clinicians to develop a comprehensive,

credible allegation of fraud that is referred to the California Department of Justice.

*Mrs. Harshbarger. Okay, all right. Next.

*Mr. Bassiri. Thank you for the question. Similar to what you've heard, we have an intake process. What we do in New York is my office, who is primarily responsible for attempting to prevent, we'll do an investigation. We then work with our Office of Medicaid Inspector General who can make that credible allegation of fraud. And then, depending on the outcome of that, we will take payment sanction routes, or we will be referring it to --

*Mrs. Harshbarger. Yes.

*Mr. Bassiri. -- Federal law enforcement.

*Mrs. Harshbarger. Okay. Yes, sir. Thanks.

*Mr. Partika. Congressman, similar to others, we have an intake process. Those are reviewed by a multidisciplinary team that includes people from our department as well as our attorney general MFCU unit. Those are reviewed and then referred to appropriate law enforcement as needed --

*Mrs. Harshbarger. Okay.

*Mr. Partika. -- for additional investigation.

*Mrs. Harshbarger. Yes, sir. So they are all about the same. At what point is the case referred to the Medicaid Fraud Control Unit?

*Dr. Connolly. So in Minnesota -- thank you for the

question -- we refer to the Medicaid Fraud Control Unit when the case reaches the threshold of a credible allegation of fraud.

*Mrs. Harshbarger. Okay. It is the same for you?

*Mr. Sadwith. Yes, Representative.

*Mrs. Harshbarger. Okay. The same thing?

*Mr. Bassiri. Same.

*Mr. Partika. Same here.

*Mrs. Harshbarger. And I will ask all of you the same -- this question: On average, how long does it take your state to move from identifying a credible fraud allegation to payment suspensions?

And if there is a delay, what is the primary cause of that delay, and any timeline?

*Dr. Connolly. Thank you, Representative Harshbarger. So in Minnesota that occurs as promptly as possible, sometimes within days or weeks depending on how quickly we can implement that. But we do that now very, very immediately.

*Mrs. Harshbarger. Okay. Sir?

*Mr. Sadwith. So it is dependent on the circumstances. California is one of the few states with the ability to stop payments even before the level of a credible allegation of fraud is reached --

*Mrs. Harshbarger. Okay, great.

*Mr. Sadwith. -- at which point payment suspensions are typically put into place.

At some points in time, however, the Medicaid Fraud Control Unit will request good cause exemptions so that they can continue to build their criminal or civil prosecution case without interfering.

*Mrs. Harshbarger. Yes, very good.

*Mr. Sadwith. So that could be a factor.

*Mrs. Harshbarger. Yes, sir.

*Mr. Bassiri. Thank you for the question.

It is dependent on both the type of allegation fraud, but also, to the extent it goes beyond Medicaid or just the public programs, it does vary and it can be relatively quick, depending on how credible that allegation is.

*Mrs. Harshbarger. Weeks? You know --

*Mr. Bassiri. Maybe a couple of months.

*Mrs. Harshbarger. Months?

*Mr. Bassiri. But it can take a long time, as well. It's very variable, depending on the issue.

*Mrs. Harshbarger. Okay.

*Mr. Partika. Congresswoman, similar to theirs, ours varies depending on the allegation and depending on our deconfliction with our law enforcement partners to ensure we are not conflicting with their investigation.

*Mrs. Harshbarger. Okay. When a provider is allowed to

continue receiving payments under a good cause -- as you mentioned -- determination during an investigation, what is the average duration of continued payment before a final suspension or corrective action is implemented?

And anybody can answer that. I will start with you, Mr. Connolly.

*Dr. Connolly. So if I understand the question, you're asking what is the duration of time between those two things happening.

*Mrs. Harshbarger. Yes. If you suspend -- I mean, if you are receiving payments under a good cause determination.

*Dr. Connolly. I think I'd have to take that back and get details for you.

*Mrs. Harshbarger. Okay.

*Mr. Sadwith. It varies, but we have been engaging our Medicaid fraud control unit to reduce the number of good cause exemptions that they request.

*Mrs. Harshbarger. Okay.

*Mr. Bassiri. It varies.

*Mrs. Harshbarger. Yes.

*Mr. Bassiri. And it's very important for us to prioritize continuity of care or ensure that access can be provided if an instance like that is reached.

*Mrs. Harshbarger. Okay.

*Mr. Partika. Ours varies. However, we have made

recent efforts to improve --

*Mrs. Harshbarger. Okay.

*Mr. Partika. -- that timeline.

*Mrs. Harshbarger. Well, that is all I got to, Mr. Chairman, so my time is up and I will yield back.

*Mr. Joyce. The gentlelady yields. The chair now recognizes Mrs. Fletcher for her five minutes of questioning.

*Mrs. Fletcher. Thank you, Chairman Joyce, and thank you to our witnesses for your time here today.

Fraud is a genuine problem in Federal programs, including in Medicaid. That is why Congress and many past administrations have worked to pass laws and develop procedures to investigate, document, and remedy it. And Federal law has well-developed procedures for how agencies must address fraud, and that includes requirements that agencies identify a credible basis for suspecting fraud before pausing funds, provide notice and an opportunity to be heard, impose penalties that are proportionate to their findings. They are tools that many administrations have used of both parties for many, many years. In fact, under President George W. Bush there was a Medicare fraud strike force that charged thousands of defendants and recovered tens of billions of dollars doing it the right way. And that is the key here.

This issue is not new, but this is the third

subcommittee hearing that we have had in this Congress on Medicaid fraud in state programs, and we have not had hearings on so many other areas in the government where fraud is not only possible, but appears to be happening right in front of our eyes.

So one of them, I think, appears to be the Trump Administration's claim of waste, fraud, and abuse indiscriminately to cut funds from states and from programs that it doesn't like or it doesn't understand -- we don't need to look a lot further than DOGE's cuts to the screwworm research programs to see that when they don't understand what the government is doing, they would cut it -- or cutting funds and using these claims because it appears to them that it benefits their perceived political opponents. That is what is going on here, and this Congress has been a willing partner in that effort: repeating waste, fraud, and abuse ad nauseam to justify cutting health care funding and food assistance; taking care away from people who are sick; and taking food away from people who are hungry.

And, you know, the purported concerns about waste, fraud, and abuse that we keep hearing are really belied by the facts of the last year and a half. President Trump has pardoned, according to The New York Times, at least 70 allies, donors, and other people who have been convicted of fraud, including convicted of defrauding the United States

Government through Medicaid fraud. The President is pardoning them, people who defrauded the United States and took away the very services that we have been hearing about throughout this hearing from the people who are gathered in this room who deserve to receive them. The President is pardoning those people. And we also see not only has that increased since the first term, there have been nearly three dozen pardons and commutations of people who have been accused of fraud.

And, of course, this Administration has dismantled the agencies and the organizations that are designed and that have been created to investigate fraud and to root it out. For example, the 20 inspectors general that President Trump fired or demoted that identified more than $50 billion in waste and abuse in the 2024 fiscal year. These things don't add up with the stated purpose of rooting out waste, fraud, and abuse.

Don't be fooled about what is going on in this Administration and what is going on in this Congress. We know that hundreds of billions of dollars in funding for people across this country flows from the Federal Government to the states through programs like Medicaid and SNAP. And we know that, by invoking fraud as a grounds for freezing states' funds, this Administration is extracting its retribution against its perceived enemies. Do not be fooled

by it, and don't be used by it, and don't look away from the other waste, fraud, and abuse that is happening before our eyes.

Thank you, and I yield back.

*Mr. Joyce. The gentlelady yields. The chair now recognizes the gentleman from Ohio, Mr. Rulli, for his five minutes of questioning.

*Mr. Rulli. Well, I appreciate that, Chairman, and I think there is a lot of fraud in these states at local levels. And my attention goes to Mr. Partika from Ohio.

I also want to thank Keith Faber from Ohio for actively investigating discrepancies that we found implemented in the Medicaid expansion program of the State of Ohio.

HCBS services allow seniors in the State of Ohio with disabilities to receive care at home rather than an institution. This is, at the core, a beautiful thing where we could have a family member stay at home and take care of their loved ones, which is everyone's ideal situation. The problem that we find out is sometimes you have 3 or 4 family members that are all staying at home, and the family is bringing in 150 or $200,000 of money to that family by them all staying at home and doing nothing. The program wasn't built for that, and that is not what it was supposed to be about.

However, fraud diverts resources away from patients who

truly need that care. And in Ohio, when I was a state senator, Ohio was fourth in the country for Medicaid expansion. We have a $93 billion budget in the State of Ohio, which is every bipartisan -- which is every -- by two years, that -- it runs on $93 billion, and we are using almost half of that for Medicaid expansion. In Ohio we correct our wrongs.

I saw Governor Walz, whose state is the number-one worst fraud in the entire country, gallivanting all over the country, trying to attack Republicans when he was at home -- he should have been at home correcting this fraud.

So my question to you, Director, is I know that your administration has already been working. Can you go through some of the fraud that you already discovered?

And more importantly than that, can you go through the fraud that you think you might find?

*Mr. Partika. Congressman, thank you for the question, and we share -- Medicaid -- your sentiment towards the meaningful intent of many of these programs, which is why we fight anyone defrauding them, insulting -- and needing address so that we could provide that long-term stability.

As we've talked about in the home health safety space, we've identified abnormal trends in different parts of our state, abnormal billing patterns that we are now working to address. We, as -- have identified -- and it's been in the

news, the $42 million finding on the behavioral health services provided in our community that we have been working on making policy changes including prior authorizations, reviewing our enrollment process, and identifying high-risk providers in each of those areas.

The critical challenge as we do this work moving forward is making sure we are doing it in a way that is responsible and does not punish the hard-working providers that are doing it the right way each and every day so we can fulfill that commitment to provide those services to those that are truly intended and needing that care.

*Mr. Rulli. What was exciting for me, Director, is when I realized that we had the attorney general and we had the auditor working with your office. Because you know what? In life sometimes we are not perfect. And the wonderful story about America is -- like, and you look at our history. We correct our wrongs like we do in Ohio. So we are not all full of ourselves that says that we are perfect in the State of Ohio. We know that we are flawed. But I like the idea that the three branches over there -- you got the attorney general's office, you got the Ohio auditor, and then you have you that are all working together to make it better. When you are fourth in the country for Medicaid expansion, we want to make sure that our people have their services.

Now, in the next year or two, how do you think this

partnership that you have with the attorney general's office and the auditor's office is going to look like?

Do you think we are going to really be able to get down into the nitty gritty and even get a lot more fraud in the next six months, the next two years?

How do you think this is all going to play out with that union of your three different branches helping each other?

*Mr. Partika. Congressman, as you stated, that partnership over the years spanning multiple administrations has been incredibly valuable. Many of the findings the auditor has had have directly correlated improvements to the Medicaid program. I expect that to continue.

The work with our attorney general and our new attorney general, Andy Wilson, I expect to be incredibly powerful. As the teams work together, the newfound partnership of not just looking at each individual case and where we're identifying trends to identify new investigations but bringing that back to our team and saying, here are potential risks from a policy standpoint and the administration of that program, I'm incredibly hopeful that we continue to make improvements moving forward, much thanks to that expertise that those multiple teams bring.

*Mr. Rulli. I really appreciate it, and it gets exciting thinking that when we discover something like that and just seeing how horrific it is, when we can look at the

future and preserve these wonderful institutions like when you have a Medicaid or Medicare or even Social Security, if we are able to find this fraud we will preserve these so they can last for generations for our grandkids and great grandkids. I appreciate all the work you do for the fine State of Ohio.

And with that I yield my time, Chairman.

*Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from California, Mr. Mullin, for his five minutes of questioning.

*Mr. Mullin. Thank you, Mr. Chair, and thank you to the witnesses for your testimony today.

The Medicaid program embodies a deep and longstanding partnership between the Federal Government and the states. Every individual has a right to health care, so thank you for working to ensure the most vulnerable in our communities can also benefit from that right.

This is the third Medicaid fraud hearing the Republican majority has held this year, despite their presenting zero -- I repeat, zero -- evidence of widespread fraud. At the same time, they have let the Trump Administration fire inspectors general and others actually doing the work to address the narrow cases where fraud does exist. President Trump has been using the guise of investigating fraud as a smokescreen to punish the states he does not politically agree with.

This Administration is putting the health coverage of millions at risk in states like California, all to score political points. While the majority is politicizing this vital health care program, hard-working public servants like Director Sadwith aren't focused on cheap headlines. He is working to ensure Californians have health care coverage and that public dollars are being spent responsibly as intended.

So Director Sadwith, you mentioned in your testimony that Medi-Cal goes above Federal standards to screen providers before they gain access to the program. Can you please explain how California is exceeding Federal requirements to prevent bad actors from ever gaining access to Medi-Cal?

*Mr. Sadwith. Thank you, Congressman. I'd be happy to.

So when providers initially screen, we collect and review information that CMS doesn't require. These include state-specific standards around established place of business. So for every single provider site that enrolls, we look at leases, business licenses, general liability insurance, and so forth.

We also require our managed care plans to conduct monthly screening against state and Federal exclusionary lists and databases just to, you know, further ensure there are no bad actors in our program.

We also exceed requirements regarding how frequently we

revalidate providers. And revalidating is, in effect, rescreening against all databases and checking to make sure that they're legitimate. Any time a provider in California adds a new location, changes their address, or changes ownership, that triggers a full revalidation which often happens more frequently than every five years, as federally required.

*Mr. Mullin. So thank you for that explanation. Your testimony today is vital for us to parse between false claims about Medicaid and what is actually happening on the ground in my home state of California.

The Administration has been laser focused on the IHSS program in Medi-Cal which allows elderly and disabled individuals with long-term care needs to remain in the comfort of their homes. Based almost solely on growth in the program, the Trump Administration recently deferred over $1 billion for that IHSS program. So Director Sadwith, what are the reasons for the IHSS program's growth and cost increases that you have explained to CMS?

And what are the impacts of this billion-dollar deferral on Medi-Cal, and how are you working to ensure that beneficiaries still have access to those services?

*Mr. Sadwith. Thank you, Congressman.

The intentional investment in our in-home supportive services program reflects a longstanding partnership with the

Federal Government, including Congress and CMS who have consistently, over the past quarter century, promoted and expanded the use of home and community-based services. That is because these are the services that are best for individuals who depend on them. It's also better for taxpayers. We know these are cost effective.

CMS asked about our growth. We explained that, you know, several years ago the California state auditor, an independent fiscal watchdog, reviewed our IHSS program. And while they found no program integrity concerns, the audit did have one recommendation. They recommended we increase reimbursement rates so we can expand the IHSS workforce to meet the needs of California's aging and growing population. So we did that. We increased payment, we increased caseloads so more people can get these services. And as a result, the program grew.

This is a concerning deferral, and we are working steadfastly with CMS to respond to all of their questions, provide all the information they need so they can release the deferral and recipients can get the care they need.

*Mr. Mullin. So let me just conclude that Medicaid is a lifeline for millions of Americans. Rather than using California as a political punching bag, we need to be focusing on our efforts to strengthen this important Federal-state partnership.

And with that, Mr. Chair, I yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from Texas, Mr. Weber, for his five minutes of questioning.

*Mr. Weber. Thank you, Mr. Chairman. I am late because of Science, Space, and Technology. We had a markup that I had to participate in. I walked in on a bunch of claims from our colleagues across the aisle there. Mr. Chairman, it is not that they are ignorant, it is just that so much of what they know ain't so.

So let me go to you, Mr. Connolly. Thank you for your testimony. The level of fraud that has been unearthed in Minnesota's Medicaid program is alarming. In what ways is the Department of Human Services revising the state's previous Medicaid provider enrollment process for new providers in the 14 high-risk programs to improve provider screening going forward?

*Dr. Connolly. Thank you, Representative Weber, and we agree the fraud that has occurred is unacceptable, and that's why we worked hard on provider enrollment and compliance.

Directly to your question, we have designated 14 services as high risk, 13 remaining. And part of that involves provider and -- provider enrollment and compliance action that is escalated. So there's an unannounced site visit that could occur -- that does occur, rather -- in

addition to a fingerprint background check, and more frequent revalidation. And all of those providers have been revalidated within the past five months, as well, in partnership -- and completing that corrective action plan at the direction of CMS.

*Mr. Weber. So these are targets. These 14 services were targets for the fraudsters. Is that low-hanging fruit? Why do you think that is?

*Dr. Connolly. Could you repeat the question one more time?

*Mr. Weber. So these 14 services were targets for the fraudsters. Is that because of low-hanging fruit, we are not a paying enough attention? What do you think? Why do you think that is?

*Dr. Connolly. Thank you for the question, Representative Weber. So I think it's for a variety of reasons. And we've demonstrated in our actions what we think those reasons were.

So it starts with the design and the policy around the program. So are there different requirements that need to be escalated? New billing parameters, for example. We implemented enhanced prepayment review to vet claims before they go out to providers so we don't pay and then have to recover if there's fraud.

We also do post-payment activity, often in the form of

investigations. We have data analytics that also inform referrals to our inspector general for investigation. And then, of course, if those cases rise to the level of a credible allegation of fraud, we then refer promptly to Federal and state law enforcement for further investigation and prosecution if they deem that necessary.

*Mr. Weber. Do you keep a list of all the fraudsters and their procedures so that you can recognize that going forward?

*Dr. Connolly. Yes. As a part of our investigations we have a list of all of the providers that have risen to the level of a credible allegation of fraud, and certainly we're paying attention to any announcement of charges with respect to law enforcement. So we do look at the behaviors and the different things that we've found in terms of how they've billed and behaved, and we do keep that intelligence.

*Mr. Weber. So if there is any cracks in our walls, you are able to go back and fix those cracks.

*Dr. Connolly. Yes, exactly. So if there is a pattern or a concerning issue that we identify that does inform perhaps administrative changes in policy, we might also engage legislators to make changes to those programs which we've done in the last two sessions as a good example.

*Mr. Weber. All right. Thank you for that.

Mr. -- is it Sadwith? Is that how -- is it --

*Mr. Sadwith. Yes, sir. Sadwith.

*Mr. Weber. Okay. Have you had that name long?

*Mr. Sadwith. Excuse me, sir?

*Mr. Weber. I am just messing with you.

[Laughter.]

*Mr. Weber. Your written testimony highlights that Medi-Cal has "strong policies that are designed to prevent, identify, and block'' the fraud, waste, and abuse we were just talking about. Below this your testimony cites that California's Medicaid Fraud Control Unit, MFCU, received 700 credible fraud allegations over the last 5 years. While fraudulent hospice billing in Los Angeles County alone is estimated at 3.5 billion -- with a B -- dollars, that accounts for 18 percent of all nation -- national hospice billing. Would you say California's MFCU was effective in preventing that abuse?

*Mr. Sadwith. Thank you for the question, and this is an incredibly important issue and it underscores the need for collaboration, continued collaboration between states and the Federal Government.

In California the primary payer for hospice care is Medicare. In Medicaid, which the Medicaid Fraud Control Unit sort of prosecutes, we've referred over 300 credible allegations of fraud to the MFCU over the past 5 years for the purposes of investigating and cracking down on hospice

fraud in the Medi-Cal program, the state program that I oversee. But that's why it's important to work in partnership with the Federal Government and CMS, which is responsible for oversight of Medicare.

*Mr. Weber. Yes, but you said 300 and I cited 700. That is not even a 50 percent success rate, is it?

*Mr. Sadwith. So we view the 300 referrals as a strong commitment to California's rooting out bad actors in our Medicaid program. And we -- just like Medicare and CMS, we have experienced issues in hospice and have taken comprehensive steps to protect the program, protect the Medicaid program, through new requirements and new safeguards, and institute licensure moratoriums, institute new regulations. We've criminally charged over 100 individuals in the past few years. We've stood up a statewide hospice task force. We've revoked over 300 licenses, and we have over 300 licenses that are ongoing --

*Mr. Weber. Well, I am going to have to yield back, but I insist that is a little short of the target.

I yield back, Mr. Chairman.

*Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from Ohio, Mr. Landsman, for his five minutes of questioning.

*Mr. Landsman. Thank you, Mr. Chair, and thank you all for being here. A couple questions.

One is it seems, based on the testimony that you all have provided, one of the biggest ways in which you are getting fraud, tackling fraud, is the investments that you are making, right?

So whether it is technological investments, staffing -- I mean, the more, you know, cops on the beat, so to speak, the more fraud you are going to get. And I am hoping that each one of you could just list out the investments that you all have made in going after fraud.

I will start with Minnesota.

*Dr. Connolly. Thank you, Representative Landsman.

So I'll start with Governor Walz's executive order 2510 in September of 2025 directing the state to take a number of actions to strengthen its anti-fraud efforts. And, of course, the Department of Human Services, as the Medicaid agency, was front and center in that.

And as I described earlier -- and I appreciate the opportunity to say more -- many different policy changes were made as a result of that. We implemented, of course, the high risk designations which heightens provider compliance.

*Mr. Landsman. Just list the top three or four investments. What new things are in place?

*Dr. Connolly. You bet. So I'll start with enhanced prepayment review. That is a new process that's entirely new. We have, you know, external vendors helping us with

that and staff working on that. We had 450 new staff given to us as a result of the legislation passed this year to enhance program integrity, in addition to new data analytics capacities. I'll stop there.

*Mr. Landsman. That is significant. I mean, that is a lot of new staff.

California. Sorry.

*Mr. Sadwith. Thank you, Congressman.

So just as a baseline, approximately 20 percent of our staff are dedicated exclusively to program integrity. We've made several new investments to strengthen the integrity of the program based on lessons learned. One example is strengthening our eligibility determination processes based on our experience with the stolen identities of individuals being used to enroll. So we have multiple new residency safeguard checks, as well as new technology to detect bad actors trying to mask their identity -- so remote spoofing detection, virtual private networks, et cetera.

Another example is a new investment in sophisticated data analytics in our pharmacy benefit, in particular --

*Mr. Landsman. Yes.

*Mr. Sadwith. -- partnering with our vendor using Google Cloud Platform and machine learning to not just have static rules-based pre-payment, but this is training based on our data to actively learn, adapt, and evolve in real time

based on the patterns in the data.

*Mr. Landsman. Smart.

New York?

*Mr. Bassiri. Thank you for the question. Similar to what you've heard, we've made investments in people and program integrity staff over the years at the Office of Medicaid Inspector General.

We've also staffed up, as I mentioned before, on implementation of H.R. 1, and a lot of that includes program integrity-related or managed care oversight-related staff, technology on eligibility and enrollment system, new provider enrollment system, and data analytics to do more risk-based stratification, identify providers before the fraud occurs, and try and proactively address that.

*Mr. Landsman. Ohio.

*Mr. Partika. Congressman, thank you. The -- to your point, the investments in those data infrastructure have been incredibly helpful not just for fighting fraud, but for also identifying areas of waste and abuse.

The move to a single pharmacy benefit manager in Ohio, as well as building out a single fiscal intermediary has been incredibly helpful not just from observing fraudulent trends, but when making policy decisions to be able to dive deep into the data. We've frequently been told by policy-makers and legislators just how incredibly helpful that has been as we

have navigated difficult decisions to tackle waste and where dollars maybe are spent not as intended. To be able to really drill down and see where those are going has been incredibly helpful to all of our conversations.

*Mr. Landsman. And this is just maybe a yes or no because I only got 40 seconds left. Do you think Congress is providing enough support investments?

Let me ask this in a less leading way. The same leading, but maybe it is a little easier to answer: Could Congress be investing more in states and their ability to go after fraud? Yes or no.

*Dr. Connolly. Yes, absolutely.

*Mr. Sadwith. Yes. There are a few key areas where Congress could enhance states and better equip them in this space.

*Mr. Bassiri. Yes.

*Mr. Landsman. Yes.

*Mr. Partika. Yes, we would never turn down additional help.

*Mr. Landsman. Yeah. It would just seem -- ten seconds -- it seems like the states that are really good at this have invested a lot of resources into it, and that is what we should be doing, among other things, is helping states invest in those efforts to go after fraud.

Thank you, I yield back.

*Mr. Joyce. The gentleman yields. The chair now recognizes the gentleman from Florida, Mr. Bilirakis, for his five minutes of questioning.

*Mr. Bilirakis. Thank you, Mr. Chairman, and I want to thank you for holding this hearing, a very important hearing protecting patients and safeguarding taxpayer dollars. Thank you for allowing me to waive on too, and I appreciate the testimony.

Every dollar lost to improper payments is a dollar that cannot be used to support seniors, children, individuals with disabilities, and other vulnerable populations who rely on these very critical programs. That is why I am pleased to introduce the Medicaid RAC Improvement Act this week, alongside with Senator Scott who is introducing the companion in the Senate.

Recovery adult [sic] contractors have served as an important payment integrity tool for Medicaid, but Medicaid itself has changed significantly since these programs were first established. Today much of Medicaid spending flows through managed care, while oversight has struggled to keep pace.

My legislation implements recommendations made by the Government Accountability Office by strengthening CMS oversight of Medicaid RAC programs, improving transparency and accountability, and helping ensure the payment integrity

efforts appropriately reflect the modern Medicaid program.

I appreciate the committee's continued focus on program integrity, and I thank the witnesses again for being here today. We really appreciate you all. You are adding so much to the discussion.

So my first question is for Director Sadwith and Director Bassiri and temporary Commissioner Connolly: So does your state have Medicaid recovery audit contractor programs; does it have a program that currently reviews payments made through Medicaid managed care organizations, or is it just fee for service?

We will start with Director Sadwith.

*Mr. Sadwith. Thank you, Representative. My understanding is that our RAC program is limited to fee for service. We have a number of additional tools in place to perform sort of integrated analytics to identify risk trends and patterns in our managed care delivery system, as well.

*Mr. Bilirakis. Thank you. Now, Director Bassiri, please.

*Mr. Bassiri. My understanding is that our RAC program is also specific to fee for service, but we have other oversight, overpayment, and improper payment mechanisms for managed care, particularly third-party liability.

*Mr. Bilirakis. Thank you. And then Commissioner Connolly.

*Dr. Connolly. Thank you, Representative Bilirakis, for the question.

My understanding -- I would have to confirm on the managed care side, bit my understanding is we absolutely, I can confirm, have a recovery -- a RAC contractor for the fee for service program, and we also implemented new managed care contract requirements with respect to staffing that they have for program integrity recovery timelines in addition to payment withhold timelines, as well, that are required in that contract.

*Mr. Bilirakis. Okay. The follow-up question: How often do you audit or validate whether encounter data submitted by managed care organizations accurately reflects actual payment made to providers?

And we will start again with Director Sadwith, please.

*Mr. Sadwith. Thank you, Representative.

So we have a number of processes in place to validate managed care encounter data, both internal processes as well as processes in place with external entities.

*Mr. Bilirakis. Thank you.

Director Bassiri?

*Mr. Bassiri. We have several mechanisms in place, including state laws and penalty programs to ensure completeness and accuracy of our managed care encounter data, and we use that encounter data for as much in rate setting as

the actuary will allow.

*Mr. Bilirakis. Very good. And Commissioner Connolly?

*Dr. Connolly. Similarly, we have very complete claims data from managed care plans that we use to analyze trends and different issues with those claims.

*Mr. Bilirakis. Very good. Another question, a follow-up question: If managed care payments are excluded from RAC audits, how are you independently validating the accuracy of those payments?

And again, you touched on it but let's elaborate if possible. If you don't mind, we'll start with Director Sadwith.

*Mr. Sadwith. Thank you, Congressman.

So we do have a number of processes in place to validate the accuracy and completeness of encounter data. We have been working with plans to sort of, you know, increase the rate to which encounter data are incorporated in managed care rate-setting processes, and we have a stoplight program that provides feedback and corrective action plans to improve their managed care encounter data submissions.

This is an ongoing process that's absolutely key to quality measurement, to data accuracy, and to rate setting.

*Mr. Bilirakis. Very good. Director Bassiri?

*Mr. Bassiri. In addition to what I mentioned before with the statute and penalty programs to ensure compliance,

we have a very -- our Medicaid model contract has a number of provisions around third-party liability, and our Office of Medicaid Inspector General works very closely with the plans to ensure appropriate coordination of benefits.

*Mr. Bilirakis. Thank you. Commissioner Connolly?

*Dr. Connolly. Thank you. Similarly, we have requirements with respect to claims and data collection from the plans. Our inspector general also works very closely with the plans and their program integrity staff to follow up on credible allegations of fraud.

*Mr. Bilirakis. Thank you very much. I have a question for Director Partika, but I will submit it for the record.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Bilirakis. I appreciate it and I will yield back, Mr. Chairman. Thanks for giving me the extra time.

*Mr. Joyce. The gentleman yields. Seeing there are no further members wishing to ask questions, I would like to thank our witnesses again for being here.

I ask unanimous consent to insert into the record the documents included on the staff hearing documents list.

Without objection, so ordered.

[The information follows:]

**********COMMITTEE INSERT**********

*Mr. Joyce. Pursuant to committee rules, I remind members that they have 10 business days to submit additional questions for the record, and I ask our witnesses to submit their response within 10 business days upon receipt of those questions. Members should submit their questions by the close of business on Friday, July 10.

Without objection, the subcommittee is adjourned.

[Whereupon, at 12:35 p.m., the subcommittee was adjourned.]