



June 25, 2026

## **House Energy and Commerce Subcommittee on Oversight and Investigations Holds Hearing on State Medicaid Program Integrity and Health Price Transparency**

### *Overview:*

On June 25, the House Energy and Commerce Oversight and Investigations Subcommittee held a hearing titled “State Medicaid Program Integrity: Examining Fraud Risks and Oversight Deficiencies.” The hearing featured state Medicaid program directors from Minnesota, California, New York, and Ohio, who testified to strategies they’ve implemented to insure Medicaid program integrity in their states. The hearing follows a series of significant CMS program integrity actions taken by the federal government, including a [six-month moratorium](#) on the enrollment of new Medicare hospice and home health agency providers, as well as historic state-specific deferments of federal Medicaid funding. Minnesota received a [\\$350 million deferment](#) in funding for past expenditures, while California faces what is likely the [largest deferral in CMS history](#) of \$1.3 billion in federal funding for past expenditures.

Republican committee members sought to establish a timeline of how fraud was identified, prevented, or allowed to proliferate under each program, with questions centering on the effectiveness of the Trump administration’s anti-fraud measures and the alleged failure of the Biden administration to prevent fraudulent activities. Members also sought commitments from Medicaid director witnesses on the submission of program integrity information as requested by prior committee letters. Committee Democrats accused the Trump administration of targeting political enemies under the guise of fighting fraud, as liberal-leaning states such as California and Minnesota face state-specific financial penalties while conservative-leaning states such as Florida have only received federal inquiries into program integrity. While state Medicaid director witnesses agreed that the deferment of funding by CMS and the administrative burden taken to implement the community engagement and provider verification requirements of the One Big Beautiful Bill ([H.R. 1](#)) place additional strain on limited state budgets, they were careful to express gratitude for the federal government’s partnership in combatting fraud. Each witness shared a willingness to continue collaboration with federal officials in maintaining Medicaid program integrity through high-risk provider type assessments, continued provider reverification, and information sharing arrangements with other states and CMS.

### *Witnesses: Oversight and Investigations Subcommittee Hearing*

- 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;
- Scott Partika, Director, Ohio Department of Medicaid



*Committee Leadership:*

- Oversight and Investigations Subcommittee Chair John Joyce (R-PA),
- Oversight and Investigations Subcommittee Ranking Member Yvette Clarke (D-NY)
- Full Committee Chair Brett Guthrie (R-KY)
- Full Committee Ranking Member Frank Pallone (D-NJ)

*Oversight and Investigations Subcommittee Question and Answer Highlights:*

Chair Joyce – Why has California's Medicaid agency classified all Medicaid-only providers as limited risk? Do all of these providers really reflect what you're seeing in the program? Are these programs showing limited risk as far as fraud goes?

Mr. Sadwith – Home and community-based care services are an effective program in California, which has been shown to lower the costs of care. Classical risk classification is one of the many tools we use to assess program integrity. We employ a number of safeguards to prevent bad actors from entering the program, including fingerprints and criminal background checks.

Chair Joyce – Have you previously designated any Medicaid-only provider types that were classified as moderate or high risk? Are you reassessing any provider risk designations?

Mr. Sadwith – Not to my knowledge, for Medicaid-only provider types. We're assessing opportunities to strengthen program integrity in all areas. We've developed provider risk profilers for certain services.

Chair Joyce – Does California license home health and hospices before they can operate in the state?

Mr. Sadwith – The partnership between California and the federal government is paramount for preventing fraud. Medicare is the primary payer for hospice care in California. The Department of Public Health performs licensure for hospice providers in the state.

Chair Joyce – Is a license required before they operate?

Mr. Sadwith – The Department of Public Health implemented a licensure moratorium in 2021. Just this week, they've implemented new regulations strengthening the standards for licensure.

Ranking Member Clarke – Dr. Oz sent you a letter stating three out of four Medicaid beneficiaries in NY received personal care services from 2023 to 2025. Was the statement accurate?

Mr. Bassiri – That information was inaccurate. We confirmed and stated that. There are 450,000 New Yorkers with some sort of personal care services, not the 4 million referenced. It's a little under 5%.

RM Clarke – Were you aware of the evidence that CMS used ChatGPT to research its own data?

Mr. Bassiri – I was not aware of that.

RM Clarke – Can you explain how the May referral announced by CMS differs from prior deferrals?

Mr. Sadwith – We value transparency and we do value the review process by CMS. Some of the deferrals are a result of California proactively reaching out to CMS. However, the billion dollar deferral for our in-home supportive services is unprecedented. We explained the growth, and how our strategy of keeping vulnerable patients at home can save taxpayer dollars. CMS decided to defer the payments and haven't provided any instances of fraud in their review.

Chair Guthrie – New York hasn't provided information requested by this committee. Why have you been unable to provide this information?

Mr. Bassiri – We've been as responsive as we can. We're handling many inquiries from the Committee, CMS, and HHS OIG.

Chair Guthrie – DOJ uncovered rampant fraud in Minnesota's early intensive development and behavioral intervention program. What are you doing to restore the program and provide services to those who it's intended for?

Dr. Connolly – Significant fraud happened. However, as the fraud became apparent to us, we took a number of actions. Our staff did an onsite audit of all service providers in the program. It was designated as a high-risk service. We also have a provisional licensure framework, with full licensure in 2027.

Ranking Member Pallone – You've described deferrals as catastrophic funding loss, and Vice President Vance recently announced a \$250,000,000 of Medicaid funding for the state of Minnesota. What does a deferral of these size mean for Minnesota children? Has CMS given any indication of if or when these payments will be released?

Dr. Connolly – Both the deferrals and annual withholding from CMS are a significant amount of money that threatens our state's ability to finance its services and benefits. We've also had a structural budget deficit in Minnesota, which adds another layer of pressure and risk. We've done everything CMS has asked for in their corrective action plan. No indication of when the payments will be released.

RM Pallone – You've said the effects of paperwork requirements could be catastrophic for New York. What impacts will these have on New York's Medicaid patients and providers?

Mr. Bassiri – I believe you're referring to implementation of the community engagement requirements, which we're set to do on January 1 of next year. The biggest challenge is communicating effectively and accurately. We're incurring a 20% increase in administrative costs to accommodate this. We don't want any disruptions in care.

Rep. Troy Balderson (R-OH) – This committee implemented robust Medicaid program integrity reform last year. How has the Ohio Medicaid Department benefited from these reforms?

Mr. Partika – Yes, one of the frequent audit findings we saw was inaccuracies around member eligibility. The law adds more frequent redeterminations, as well as work requirements and tools for identifying ineligible individuals.

Ranking Member DeGette – Is CMS collaborative with Ohio in pursuing antifraud initiatives. Has CMS sent Ohio a formal inquiry regarding the state’s antifraud policies?

Mr. Partika – Yes. I will have to confirm, we’ve had various inquiries.

RM DeGette – Dr. Connolly, CMS sent Minnesota a letter requesting a corrective action plan, correct? Later, Dr. Oz announced CMS would withhold \$2 billion from the state. Were you aware of that going into your meetings with CMS earlier that day.

Dr. Connolly – Yes. And no, we were not aware of CMS’ intentions.

Rep. Gary Palmer (R-AL) – Are your states sharing information between Medicare and Medicaid to prevent enrollment of bad actors? Do you share information across state lines?

Dr. Connolly – We are sharing information weekly with CMS.

Rep. Paul Tonko (D-NY) – How important is it to have CMS operate as a good-faith partner?

Mr. Bissiri – Partnership is paramount to our work in rooting out fraud, waste, and abuse. We have complex programs, and things can be in multiple areas, so federal partnership is key.

Rep. Rick Allen (R-GA) – You’ve all agreed that waste, fraud, and abuse exist in your programs. Should the taxpayer continue to fund this, or should they be able to demand a fix? What is your state doing to examine Medicaid providers to identify shared ownership with excluded providers?

Dr. Connolly – Fraud is unacceptable. We’ve fought hard to root it out. We’ve initiated a revalidation effort among high-risk services. Part of that work is to conduct a background check through the site visit and documentation of credentials.

Rep. Allen – Are elected officials in your state doing anything to uncover this fraud?

Mr. Bassiri – Under Governor Hochul, we implemented a provider services portal which is a new enrollment system in place. We agree that the front door to the program is an important safeguard.

Rep. Lori Trahan (D-MA) – Is it fair to say that the administrative burden of implementing H.R. 1 takes away from funding and power we could use to combat fraud?

Mr. Bassiri – We take compliance and implementation of legislation very seriously. The administrative costs associated with this implementation are significant. But I can’t speak to whether we’d use our time differently or elsewhere.

Rep. Diana Harshbarger (R-TN) – When your agency comes across fraud, what is the preliminary investigation process?

Dr. Connolly – There’s an intake process that determines if there is a credible allegation of fraud or waste. Once that happens, it’s reviewed by the Attorney General, Medicaid Fraud Control Office, and U.S. Attorney.

Rep. Kevin Mullin (D-CA) – How does MediCal exceed federal requirements for provider screening?

Mr. Sadwith – We collect and review info that CMS doesn’t require, such as data on an established place of business. We require managed care plans to conduct monthly screening of state and federal exclusionary lists. We exceed requirements for provider revalidation. Any time a provider changes ownership or address, we revalidate.

Rep. Randy Weber (R-TX) – Is there a reason why fraudsters target the 14 services you’ve designated as high risk?

Dr. Connolly – It starts with the design and policy of the program, such as requirements and billing parameters. We implemented enhanced prepayment review to vet claims before they go out to providers. We do post-payment investigations and utilize data analytics. We have a list of all providers with credible allegations of fraud.

Rep. Greg Landsman (D-OH) – Could you list the assessments you’ve made in fighting fraud?

Dr. Connolly – We implemented high-risk assessments, enhanced prepayment review, 450 new staff, and data analytics.

Mr. Sadwith – Strengthening eligibility determination processes. Another example is data analytics in our pharmacy benefit.

Rep. Gus Bilirakis (R-FL) – I’m proud to introduce the Medicaid RAC Improvement Act, alongside Senator Scott. Recovery Audit Contractors are an important payment recovery tool for Medicaid. My bill strengthens CMS oversight of Medicaid RAC programs. Does your state have Medicaid RAC programs that review payments made through Medicaid managed care organizations, or is it just fee-for-service?

Mr. Sadwith – Our RAC program is limited to fee-for-service. We have tools in place to determine risk patterns in our managed care system.

Mr. Bissiri – Our RAC program is also specific to fee-for-service, but we have systems for the managed care side.

Dr. Connolly – I’m not sure on managed care but we have for fee-for-service and implemented new contract standards for our managed care plans.

*Oversight and Investigations Subcommittee Hearing Recording:*

- <https://energycommerce.house.gov/events/o-and-i-subcommittee-state-medicaid-program-integrity-examining-fraud-risks-and-oversight-deficiencies>