



# DAVE YOST

OHIO ATTORNEY GENERAL

Policy & Legislation  
Office 614-728-2279

**The Attorney General's Role in Combatting Medicaid Fraud, Waste, and Abuse**  
**Dave Yost, Ohio Attorney General**  
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Chairwoman Gross, Chairman Romanchuk, and members of the House and Senate Medicaid Committees—

Thank you for inviting me to testify today about our daily fight to combat fraud, waste, and abuse within the Medicaid system.

Here with me today is Health Care Fraud section chief Benjamin Karrasch. Mr. Karrasch is an expert on our investigations into Medicaid fraud and can answer specific questions that you may have.

A little background: Ohio's Medicaid Fraud Control Unit, or MFCU, exists within our office under the Health Care Fraud Section.

Our MFCU aggressively investigates Medicaid provider fraud as distinct from recipient fraud and is among the best in the nation at rooting out fraud. Any entity that provides Ohio Medicaid services falls under our office's investigative authority.

Some examples of the providers under our investigative scope are hospitals, nursing facilities, pharmacies, doctors, dentists, home health providers, medical equipment companies, and behavioral health counselors.

For the past 10 years in a row, Ohio's MFCU was first or second in the nation for securing fraud indictments and convictions. And in 2022, my team won the Health and Human Services Office of Inspector General's Award for Excellence in Fighting Fraud, Waste, and Abuse.

Since I took office in 2019, our office has convicted 1,048 individuals for Medicaid fraud and recovered over \$228.6 million for the state.

HHS-OIG members have told us Ohio is the model unit for catching Medicaid fraud. We routinely host trainings to show other states how to investigate and prosecute fraud because we do it well.

We are catching the fraudsters, and we are convicting them.

In addition to the aggressive work of the Ohio MFCU, the strength of our prosecutions comes from our commitment to innovation.

The Health and Human Services Office of Inspector General granted our office a data mining waiver in October of last year. This allowed us to generate leads on new cases we may not have otherwise accessed.

With this waiver in hand, we began implementing AI to help generate leads for our fraud investigators and analysts more quickly and efficiently.

AI assists us in spotting irregular billing patterns for our investigators to manually vet the flagged providers. In the month of March, we announced our first indictments using data mining — bringing charges against 10 individuals for stealing \$578,000 in Medicaid benefits.

In addition to help from AI, our investigators are ramping up surveillance capabilities with more field deployable cameras.

We have the tools and technology necessary to catch fraud in the field. We use an array of undercover equipment to conduct surveillance.

In one case, a home health aide would pull up to a recipient's residence in her car, log in through the Electronic Visit Verification system, then leave. She would return 6 to 8 hours later, claiming payment for the entire time.

A surveillance camera outside the recipient's residence over the course of a month also revealed the provider didn't appear much on video for several days. She was only at the house for 15 minutes, maybe, for each claim.

GPS data showed that she was signing in from her home, showing up to do a simple check on the recipient, went home and signed out for the day.

The dedicated and thorough surveillance done in that case allowed us to secure a conviction.

Many of our investigations require field work, as in this example. But our agents are also resourceful when it comes to investigating through records and data, because they exercise the same techniques used by law enforcement.

Certain cases in the last few years are illustrative of the types of fraud we're seeing more as expansion continues:

- Behavioral Health: We secured a conviction against a woman who submitted false claims for day-habilitation and camp services for children with autism. Parents reported that they were not getting the services that this woman claimed to have provided. Email records proved to our investigators that she billed for services provided when the children weren't present, including weekends and holidays. In some claims, this woman alleged to provide services up until the middle of the night.
- Behavioral Health: In another behavioral health fraud case that happened more recently, our investigators scoured email records and ATM and bank footage to secure a conviction for a woman using fake identities to operate phony behavioral health counseling

agencies. One of her fake identities was flagged for high billing. The victim of her identity theft told our investigators that he never worked for her company. Nobody ever received any services. The woman in that case tried to get away with her crimes by fleeing the state, but our investigators were quick to track and locate her.

- Substance Abuse: We secured a conviction for a man submitting false claims for substance abuse treatment services. Investigators compared his notes and discovered lengthy patterns of copying and pasting for services provided. Some people did receive services, but far fewer than what he was billing. Our investigators also discovered he claimed to render services when he was traveling out of state. At one point investigators tracked down casino footage to prove he was gambling when he supposedly provided substance abuse treatment — using the funds he'd stolen.
- Durable Medical Equipment: We secured a conviction against a doctor billing for far more medical equipment than he was providing. He liked to bill for custom back braces. He claimed to order over 5,000 of them. Investigators found he ordered less than 500 for his patients.

Most of our fraud convictions come from two provider types: home health and behavioral health. These two provider types are considered a higher risk for fraud for multiple reasons:

- A low barrier to entry for these types of jobs.
- Providers operate in an unsupervised setting with limited oversight.
- Their patients tend to be more vulnerable to not noticing or challenging fraudulent billing, such as the elderly or individuals with cognitive impairments.

These challenges were exacerbated by Medicaid's expansion under the Affordable Care Act.

Ohio dramatically expanded eligibility in 2014 under the Affordable Care Act, and more than 700,000 Ohioans were added under Obamacare.

While the number of Medicaid recipients have hovered around 3 million these past 10 years, the number of claims increased by almost **12 million**. And as Medicaid expands to cover more services, that corresponds with a dramatic increase in providers.

Consider this: the provider population was 75,000 in 2012. **There are now more than 200,000 Medicaid providers.**

This combination of growth factors – more people, more services, more providers – increased the difficulty of locating fraud.

Despite these challenges, Ohio leads nationally when it comes to combatting health care fraud.

With all that laid out before you, I can confidently say that state scrutiny of Medicaid is not lacking in Ohio.

As with any system, there is room for improvement. But our office is limited by what the law allows us to do. Today, I offer several ways we can strengthen our laws to better curb fraud, waste, and abuse within the system.

- First, Medicaid fraud shouldn't be treated as less serious than theft. The statutory penalties for Medicaid fraud should mirror the theft statutes by allowing sentencing all the way up to first-degree felony instead of capping punishment at third-degree felony.
- Second, the GPS requirement needs to be required again in the Electronic Visit Verification system. Home health professionals use the system to log in and out the times for their services. Until about a year ago, GPS was required. Now, it's optional. We've found that some providers are taking advantage of the lax oversight. MFCU surveillance has revealed that home health professionals are not clocking in at recipients' homes; instead, they're clocking in from other places – like their own homes.
- Third, more services should require prior authorization. We shouldn't have to chase down our dollars after they're out the door. It is a preventable exhaustion of precious time and resources.
- And finally, granting Ohio MFCU subpoena authority. Civil subpoena authority would untie our hands when it comes to gathering evidence for civil cases. Other sections within my office have this power, and with the amount of money being spent on Medicaid, my team should have every tool possible to root out fraud. Even better would be grand jury authority. County prosecutors simply do not have the bandwidth or the expertise to investigate Medicaid fraud. I am content to give them the right of first refusal to prosecute these cases, but the investigative stage should be handled at the state level for this state program.

Chairwoman Gross and Chairman Romanchuk, thanks again for allowing me to testify before you today. I would be happy to take any questions at this time.