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Written Testimony of
The Honorable Michael D. Dovilla
State Representative, 17th Ohio House District
Submitted to the

Task Force on Defending Constitutional Rights and Exposing Institutional Abuses of the
U.S. House Committee on Oversight and Government Reform

“Universal Basic Fraud: Vulnerabilities in Medicaid Waiver Programs”

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Chairman Gill, Ranking Member Simon, and members of the Task Force, thank you for the opportunity to appear before you today.

My name is Mike Dovilla, and I represent the 17th District in the Ohio House of Representatives. I previously served in the House from 2011 to 2016, chairing the Oversight Committee and serving in leadership as Majority Whip. I have also served twice as a presidential appointee at the U.S. Office of Personnel Management and as a Professional Staff Member for the Senate Governmental Affairs Committee. For more than 25 years, I have worked to increase accountability and transparency in government as a steward of taxpayer dollars.

When I first served in the Legislature, I opposed Medicaid expansion. I believed then, as I do now, that expanding the program without adequate safeguards places taxpayers at risk and undermines the very people it was designed to serve. Medicaid must be preserved for those who genuinely need it – low-income families, expectant mothers, seniors, individuals with disabilities, and others who depend on a functioning safety net. But a safety net cannot work if it becomes a target for fraud, waste, and abuse.

My current work on this issue began the way many legislative investigations do: with a constituent. A concerned citizen from Strongsville, Ohio brought to my attention serious questions about eligibility verification within our state’s Medicaid program, particularly in the Aged, Blind, and Disabled (ABD) eligibility group. That concern led my office to begin asking basic questions.

In April 2025, I contacted 3rd-party vendors involved in Medicaid eligibility verification. My request was straightforward: provide information on how Ohio verifies eligibility, how data are used to detect ineligible recipients, and what happens when potential problems are identified. The responses raised more questions than they answered.

One vendor reported its asset verification tool had reviewed a portion of Ohio's Medicaid ABD population and identified a significant number of individuals whose assets appeared to exceed eligibility limits. To be clear, a data flag is not a final eligibility determination. Some assets may be exempt, and every individual deserves a proper review. But the obvious next question was: what did the Ohio Department of Medicaid (ODM) do with those flags? That is where oversight deficiencies became clear.

When my office pressed ODM, the answers were unsatisfactory. The department pointed to county-level determinations, federal rules, and the role of the Social Security Administration. Those factors are real, but they do not relieve the state of its obligation to know whether taxpayer dollars are being spent properly. At a minimum, the state should be able to track what happens when its own eligibility systems or vendors identify potential ineligibility. If a department cannot tell legislators what happened to flagged cases, cannot clearly identify why hundreds of thousands of people left the rolls, and cannot demonstrate a reliable statewide process for reconciling eligibility concerns, then we do not have program integrity. We have fragmentation.

That is why, in June 2025, I introduced House Bill 356. The bill required a data-sharing agreement between ODM and the Auditor of State and directed a full ABD audit. As a member of the biennial operating budget's conference committee, I was successful in inserting and retaining the provisions of my bill in the final report. While Governor DeWine used his line item veto on 67 budget items, to my surprise he did not veto this provision, allowing the audit to become law.

It is important to be candid about the nature of this work: an audit of Medicaid is not a quick exercise. It involves a large number of people, multiple data systems, sensitive personal information, eligibility categories, asset rules, county-level determinations, federal requirements, and historical records. It takes time to conduct the work properly.

It has also taken time because the Auditor has encountered the very problems this audit was meant to expose. In recent legislative testimony, Auditor Faber described significant challenges acquiring valid, comprehensive data to perform a reliable audit. This in itself is evidence of the oversight problem. If the data are hard to obtain, incomplete, inconsistent, or poorly organized, all of which has proven to be the case, then lawmakers, auditors, and taxpayers cannot have full confidence that eligibility and payment decisions are being properly monitored.

That is exactly why the audit is essential. It is not enough to exchange letters, make public statements, and move on. We need data, verification, and corrective action. And when public funds have been improperly paid, we need recovery and consequences.

Then, earlier this spring, the *Daily Wire* published a report that brought national attention to another dimension of the problem: personal services and home health entities billing Medicaid at extraordinary levels, often from clusters of office buildings in Columbus. According to that report, one group of seven buildings housed 288 Medicaid-registered companies that collectively billed more than \$250 million between 2018 and 2024.

These findings were disturbing not merely because of the dollar amount, but because of what they suggested about oversight. Medicaid dollars were flowing through entities that, in some cases, appeared to have little visible operational presence. The reporting described businesses providing or

claiming to provide services such as homemaking, companionship, and other low-acuity care, while the public was left to wonder whether anyone in government was adequately verifying the legitimacy of providers, services, and claims.

Since then, Speaker Huffman appointed me to the House Medicaid Committee, where I am working with colleagues on a comprehensive Medicaid integrity bill, including provisions to strengthen provider enrollment, improve electronic visit verification, impose additional safeguards on high-risk providers, enhance fraud reporting, and increase penalties for fraud. Our purpose is simple: verify eligibility and services, identify bad actors earlier, and ensure real consequences when people defraud taxpayers. This omnibus bill is on track for swift final passage next week.

This should not be a partisan issue.

Medicaid fraud harms taxpayers, certainly. But it also harms legitimate providers who follow the rules. It harms caseworkers and public servants whose work is undermined by weak systems. Most importantly, it harms the truly vulnerable Ohioans who depend on Medicaid and whose care is threatened when finite resources are diverted to those who do not qualify or to providers who exploit loopholes.

We can have a serious debate about the size and scope of Medicaid. We can have a serious debate about the proper relationship between federal and state governments. But there should be no debate about whether government has an obligation to prevent fraud, recover misspent dollars, and protect those whom the program is intended to serve.

My message today is simple: Medicaid is for the people who need it, not for those who have learned how to manipulate it. Oversight is not cruelty. Verification is not extremism. Accountability is not partisanship. It is the minimum taxpayers expect and the minimum our most vulnerable citizens deserve.

Thank you for the opportunity to testify before you today. I look forward to answering questions and working alongside you to improve accountability and transparency in the administration of the Medicaid program both for Ohio and the Nation.