

**RYAN A. BIZZARRO, CHAIRMAN**

116 MAIN CAPITOL BUILDING  
P.O. BOX 202003  
HARRISBURG, PA 17120-2003  
(717) 772-2297



**HOUSE MAJORITY POLICY COMMITTEE**

PAHOUSE.COM/POLICY  
POLICY@PAHOUSE.NET  
✕ f @ @PADEMPOLICY

**HOUSE OF REPRESENTATIVES**  
COMMONWEALTH *of* PENNSYLVANIA

***House Democratic Policy Committee Hearing***

**Safeguarding Taxpayer Programs**

Thursday, May 7, 2026 | 1:00 p.m.

**Rep. Pat Gallagher, Rep. Sean Dougherty**

**OPENING REMARKS**

**1:00 p.m.**

**Rep. Pat Gallagher, D-Philadelphia**  
**Rep. Sean Dougherty, D-Philadelphia**

**PANEL ONE**

**1:05 p.m.**

**Michelle A. Henry**  
*Pennsylvania Inspector General*

**Valerie A. Arkoosh, MD, MPH, Secretary**  
*Pennsylvania Department of Human Services*

***Q & A with Legislators***

**PANEL TWO**

**1:45 p.m.**

**Randall M. Fox, Partner, 2021 Whistleblower Lawyer of the Year**  
*Kirby McInerney LLP*

***Q & A with Legislators***



# Pennsylvania Office of State Inspector General

Michelle A. Henry, State Inspector General

**House Democratic Policy Committee**

**Public Hearing**

**Safeguarding Taxpayer Programs**

May 7, 2026

## **Testimony of the Pennsylvania Office of State Inspector General**

Chairman Bizzarro, Representative Gallagher, Representative Dougherty, and members of the House Democratic Policy Committee, thank you for the opportunity to testify today on behalf of the Pennsylvania Office of State Inspector General (OSIG). We are grateful to the Committee for convening this hearing on a topic that strikes at the heart of good governance: protecting the integrity of Medical Assistance, the Supplemental Nutrition Assistance Program (SNAP), and other public benefits programs for the Pennsylvanians who need them most.

My name is Michelle Henry, and I serve as Pennsylvania's State Inspector General. It is my honor to be joined in representing this important issue before the committee by Pennsylvania Department of Human Services (PA DHS) Secretary Dr. Val Arkoosh. Our agencies work in close partnership every day, and I am pleased that we can both testify before this Committee about the work we share and the work we still need to do.

I want to be clear at the outset about what this testimony is, and what it is not. It is not a story about the people who rely on Pennsylvania's benefit programs. The overwhelming majority of Pennsylvanians who receive Medical Assistance, SNAP, and other public benefits are honest, hardworking people navigating genuine hardship. Fraud in Pennsylvania's benefit system is real, but it is also frequently misunderstood, exaggerated, and exploited in ways that distort public policy and undermine the very programs that serve our most vulnerable neighbors.

I also want to emphasize a core principle that guides our work: program integrity is about protecting access to benefits. Every dollar lost to fraud is a dollar that cannot serve a Pennsylvanian who genuinely needs help. Strong integrity systems are essential to maintaining both public trust and the long-term sustainability of these programs.

### **A Prevention-First Model That Delivers Results**

OSIG, in close partnership with PA DHS, has built a prevention-first model that focuses on stopping fraud before it occurs, before benefits are improperly issued, and before taxpayer dollars are lost.

Since the beginning of the Shapiro Administration, OSIG and PA DHS have worked together to investigate 62,626 applications for Medical Assistance, SNAP, and other public assistance, preventing nearly \$179 million in public benefits from being distributed to those not entitled to them. In 2025 alone, after reviewing nearly 20,000 applications, this cross-agency partnership saved Pennsylvania taxpayers more than \$61 million.

To put the 2025 numbers in perspective: last year, PA DHS processed approximately 1.1 million applications for Medical Assistance, SNAP, or other public benefits. Of those, PA

DHS referred 19,800, or about 1.8 percent, for additional scrutiny by OSIG. Of the clients we reviewed, fewer than 8,000 received a reduction in benefits. That is less than three-quarters of one percent of all applicants. This is not a picture of widespread recipient fraud. It is a picture of a well-targeted, carefully calibrated fraud prevention system doing exactly what it is supposed to do.

The mechanism behind these results reflects the strength of the OSIG-PA DHS partnership. PA DHS refers applicants for additional review when its systems flag potential inconsistencies. OSIG conducts independent investigations. OSIG then provides an investigative report so that PA DHS can make accurate eligibility determinations. Fraud is stopped before payments go out the door, which means every dollar saved is a dollar that can continue to support Pennsylvanians who truly qualify for assistance.

This front-end, pre-payment approach is worth naming explicitly because it is not the national norm. Research that surveys fraud prevention practices across state SNAP agencies has consistently found that most state agencies focus their fraud detection efforts post-issuance: catching improper payments after benefits have already gone out. Pennsylvania operates differently. Our model is designed to stop fraud at the point of application, before a single dollar is incorrectly distributed. Experts have identified this kind of integrated, early-stage interagency detection as a best practice, and Pennsylvania is demonstrating what it looks like in operation. To OSIG's knowledge, the depth and scale of our pre-payment collaboration with PA DHS is without peer among state programs nationally.

The Shapiro Administration has made preventing benefit fraud a cornerstone of its approach to program integrity. Protecting these programs is the only way to ensure they remain available for the people who depend on them most.

Additionally, when OSIG investigations reveal that an applicant has deliberately misrepresented their circumstances to obtain Medical Assistance, SNAP or other benefits they knew they were not entitled to, OSIG pursues criminal prosecution. People who intentionally steal from these programs should face consequences, and we work to ensure that there are criminal consequences.

When cases do warrant criminal prosecution, OSIG pursues them deliberately and proportionately, carefully distinguishing intentional fraud from unintentional errors and reserving criminal referrals for matters involving clear evidence of intent. Prosecution deters misconduct and reinforces accountability, but it remains one tool among many.

## **Protecting Vulnerable Pennsylvanians from EBT Skimming**

One of the most significant forms of benefit fraud is Electronic Benefit Transfer (EBT) card skimming. Let me be direct: skimming is **not committed by benefit recipients**. It is committed **against** them.

Nearly two million Pennsylvanians rely on the Supplemental Nutrition Assistance Program (SNAP) to avoid hunger and make ends meet. For families with children, seniors on fixed incomes, and individuals with disabilities, these benefits are not supplemental in any practical sense. They are essential.

Skimming strikes at the heart of the security SNAP provides. The mechanics of the crime are deceptively simple: a criminal places a device – a “skimmer” – directly over the card-swiping machine at a grocery store checkout. It takes approximately four seconds to install. Criminals typically work in teams: one distracts the store clerk while the other attaches the device. When a customer swipes their EBT card to pay for groceries, the skimmer silently captures their card number and PIN. The device is designed to blend seamlessly with the legitimate card reader. Nothing looks wrong. The customer has no idea.

What happens next is equally brazen. The criminal does not need to return to the register to retrieve the stolen data. Using Bluetooth technology, they can stand up to twenty feet away, pretending to shop in the store. From there, they download every stolen account record to their phone without ever approaching the terminal again. That data is then used to create duplicate EBT cards or make online purchases. Criminals often make bulk purchases of high-value, easily resold goods: baby formula, energy drinks, and similar items that can be quickly converted to cash or sold overseas. In some cases, the stolen data itself is the product, sold to other criminal networks who carry out the transactions elsewhere.

The person harmed is the SNAP recipient. The next time they go to the grocery store to buy food for their family, they discover their account balance is zero. Federal reimbursement for SNAP theft has expired. With no recourse, families must turn to already-stretched food banks to make it through the rest of the month. These are Pennsylvania's most vulnerable residents. They did nothing wrong. They are the victims of an organized, premeditated crime, and right now, when it happens to them, they have no safety net.

Recognizing both the scale of the threat and the urgency of the harm, OSIG in 2025 launched a first-of-its-kind statewide initiative, creating Skimmer Response Teams, or SRTs, dedicated to providing a sustained, intelligence-driven response to EBT card skimming operations across the Commonwealth. The sophistication of what these teams confront is illustrated by a case this year in Northumberland County. A Bluetooth-enabled skimming device, built to be an exact replica of the store's legitimate payment terminal, was covertly installed at a 7-Eleven in Milton, Northumberland County. It remained in place for multiple days before store employees discovered it. The stolen EBT card data was then used to make fraudulent purchases at BJ's Wholesale and Sam's Club locations across Pennsylvania and New Jersey. Working with law enforcement partners across multiple states, OSIG helped bring charges against two individuals. These two defendants are charged with multiple felonies, and one had an outstanding warrant for attempted murder in Belgium. Cases like this one typify SNAP fraud schemes: EBT skimming operations are frequently linked to larger organized – and sometimes international – criminal networks.

What distinguishes Pennsylvania's approach is not just the enforcement activity, but what happens next. When a skimming device is identified, OSIG agents do not simply seize the device and open an investigation. Instead, they immediately coordinate with PA DHS to secure the benefit accounts of affected cardholders before theft can occur. This rapid interagency response – acting on intelligence to protect accounts rather than waiting to respond after families have already lost their benefits – is rare among state programs nationally. Most states are focused on consumer education, card-locking apps, or episodic sweep operations. Pennsylvania has built a standing, intelligence-driven operation with the goal of stopping theft before it happens.

The results are measurable. In the first year of this pilot initiative, OSIG's Skimmer Response Teams seized skimming devices across the Commonwealth, spanning rural, suburban, and urban communities. Through proactive intervention and close coordination with PA DHS to secure affected benefit accounts, these efforts protected more than \$8.3 million in SNAP and public assistance benefits from theft, safeguarding more than 16,700 individual EBT accounts. Those are more than 16,700 Pennsylvania households that kept the food assistance they depend on. These results were achieved in the first year of a pilot initiative, with a team still building its capacity and expanding its reach. The potential to protect more Pennsylvanians and disrupt more criminal networks grows with every investment in this work.

These are not just statistics. They represent food kept on the table for Pennsylvania families, protection against sudden and devastating loss for vulnerable households, and taxpayer dollars preserved for their intended purpose. OSIG's Skimmer Response Teams are fighting fraud perpetrated **against** recipients by organized criminal enterprises. These families are victims. They deserve protection, and OSIG's role, working alongside PA DHS and law enforcement partners, is to ensure these crimes are identified quickly, disrupted, and prosecuted.

## **Prevention Beyond Enforcement: Public Awareness and Partnerships**

Enforcement alone is not enough to prevent theft and misuse of public benefits. Prevention must also occur through education at the community level.

As part of the Skimmer Response Team initiative, OSIG has conducted in-person outreach to retailers across the Commonwealth, training store employees to identify skimming devices, providing practical guidance for routine terminal checks, and encouraging rapid reporting of suspicious activity. At the same time, OSIG works in close, real-time coordination with PA DHS when skimming threats are identified, ensuring that protective actions can be taken quickly to safeguard affected accounts and minimize harm to recipients.

This work has already produced results. Retailers have identified and reported skimmers shortly after receiving training, allowing devices to be removed before widespread harm occurred.

These efforts have been strengthened through coordination with partners such as the Pennsylvania Food Merchants Association (PFMA), AARP, and other interested parties, expanding both the reach and effectiveness of prevention efforts.

We have also worked to educate benefit recipients directly, encouraging regular PIN changes, use of tools like PA DHS's card lock and unlock feature to protect benefits between transactions, and prompt reporting of suspicious activity.

This is what modern program integrity should look like: a holistic approach involving the tools of government, law enforcement, and the private sector working together to prevent harm before it occurs.

## **Trafficking and Organized Crime**

In addition to skimming, OSIG continues to investigate benefit trafficking, the illegal exchange of SNAP benefits for cash or prohibited items.

SNAP trafficking typically occurs at the retail level, where store owners or employees exchange benefits for cash at a fraction of face value. The store is reimbursed the full benefit amount while pocketing the difference, profiting without providing food. In some cases, recipients participate willingly, while in others, they are manipulated or coerced.

In December 2025, OSIG and the Dauphin County District Attorney's Office announced charges against numerous individuals following a multi-year investigation into Quick Stop Convenience Store in Steelton. The store's owner, who had previously been permanently banned from the SNAP program, used a rogue payment terminal to process \$775,677 in fraudulent SNAP transactions over three years. Three employees were also charged, along with dozens of recipients who participated in the scheme.

This case reflects both the seriousness with which OSIG pursues trafficking and the complexity of how these schemes actually operate. The driving force behind the Quick Stop operation was a store owner with a prior history of program violations, using sophisticated technology to circumvent federal safeguards. The multi-year investigation required sustained collaboration between OSIG, the Dauphin County DA's Office, the Pennsylvania State Police, and PA DHS, and it produced real results.

## **A New Tool to Fight Fraud: a Pennsylvania False Claims Act**

Everything this testimony has described – our prevention work, our anti-skimming operations, our trafficking investigations, and our referrals for prosecution – addresses one category of benefit fraud: fraud by individuals or small networks exploiting the system from the outside.

For as much as OSIG is already doing to detect and prevent fraud, there are more tools that would allow Pennsylvania to better stop fraud committed by corporations, contractors, and providers who knowingly submit false claims to the Commonwealth.

This is not a hypothetical concern. There are healthcare providers who bill Medicaid for services never rendered, vendors who misrepresent the nature of their work, and contractors who falsify records to obtain government payments. This type of institutional fraud by entities with resources, lawyers, and sophisticated billing systems is potentially far larger in dollar terms than individual benefit fraud. While Pennsylvania led the nation in convictions secured for Medicaid fraud in 2025, unlike 31 other states, has no dedicated False Claims Act to bring more dollars back to the Commonwealth.

Governor Shapiro has proposed a Pennsylvania False Claims Act as part of his budget agenda. While the False Claims Act, as currently proposed, would primarily be an instrument of the Office of Attorney General, not OSIG, we support the Governor’s proposal for reasons grounded in our experience.

As Governor Shapiro's First Deputy Attorney General, I worked alongside him as he led the effort to enact a Pennsylvania False Claims Act, and when I became Attorney General, I continued that fight. In that role, I saw firsthand what Pennsylvania lacks without a False Claims Act. The gap was not theoretical. It was a recurring, frustrating constraint on what we could do for the people of Pennsylvania. I come to this Committee not simply as an agency head supporting an Administration priority, but as someone who has stood in the shoes of the chief law enforcement officer of this Commonwealth and felt the absence of this tool. Pennsylvania needs a False Claims Act.

Pennsylvania is the largest state in the nation without this protection. That is a distinction we should not keep.

## **Conclusion**

Medical Assistance, SNAP, and Pennsylvania’s other public benefit programs are a lifeline for millions of residents, and protecting them requires vigilance, innovation, and collaboration. OSIG’s work, in close partnership with PA DHS, reflects a proactive and prevention-focused approach to program integrity that emphasizes stopping fraud before it occurs whenever possible.

Through this partnership, OSIG has helped prevent hundreds of millions of dollars in improper payments, while also developing operational models that prioritize early

detection and rapid response. Efforts such as the Skimmer Response Team demonstrate the agency's ability to adapt quickly to emerging threats, combining investigative expertise, field outreach, and real-time coordination to protect vulnerable Pennsylvanians. This level of coordination, particularly the close, operational partnership with PA DHS, represents a model that is not commonly replicated and has proven critical in mitigating harm before it reaches recipients. The results described in this testimony were achieved with finite resources against a threat that continues to grow in sophistication and scale. OSIG is committed to meeting that threat wherever it leads.

By focusing on both accountability and prevention, the agency is committed to making sure that Medical Assistance, SNAP, and other public resources remain available for those who truly need them.

We appreciate the Committee's leadership on these issues and look forward to continuing to work together to protect both taxpayers and the Pennsylvanians these programs are designed to serve. Thank you, and I am happy to answer any questions.



Pennsylvania  
**Department of Human Services**

Dr. Val Arkoosh, MD, MPH, Secretary, Department of Human Services

House Democratic Policy Committee

Public Hearing: Safeguarding Taxpayer Programs

May 7, 2026

Good afternoon, Chairman Bizzarro, Representative Gallagher, Representative Dougherty, and Democratic House members. Thank you for the opportunity to share with the committee information about the Pennsylvania Department of Human Services' (PA DHS) work to protect the public resources that fund essential services to approximately 4 million Pennsylvanians. I am Dr. Valerie Arkoosh, and I have the honor of serving as the Secretary for PA DHS. I am joined by one of our essential partners in this work, PA State Inspector General Michelle Henry.

Every day, PA DHS works hard to administer life-sustaining, essential services to millions of Pennsylvanians. Programs like SNAP and Medical Assistance provide critical assistance to Pennsylvanians in need of support. At the same time, PA DHS is ensuring that the taxpayer dollars that fund these services are used as intended: by Pennsylvanians eligible for them, in accordance with all rules and policies that govern how these programs should be run. High quality service provision and program integrity can coexist – and Pennsylvania is proof of this.

The phrase “fraud, waste, and abuse” is one we hear frequently now in public discourse. It is typically framed as an accusation of either social service program mismanagement or misuse by individual public benefit recipients, and there are suggestions that states are inattentive to these concerns. These accusations bear no relationship to the reality of the work that the PA DHS does every day.

PA DHS is committed to ensuring that taxpayer-funded programs are supporting the people eligible to benefit from them. We have been successful in our daily work to prevent, identify, and stop fraud and misuse while partnering with other government agencies to bring to justice those who misuse these vital public resources. As you know, fraud is a criminal allegation. PA DHS actively monitors our programs and regularly makes referrals to law enforcement partners, as investigations and pursuit of criminal charges related to fraud is the responsibility of law enforcement.

Pennsylvania is a national leader in this space, and we are proud of our work to protect our public assistance programs and the taxpayer resources that make these services possible. Fraud can be perpetrated by individuals or providers. Providers are responsible for the majority of fraud. The following outlines the monitoring and oversight of individuals and providers that PA DHS employs to support robust program integrity and proper use of taxpayer resources. It is not meant to be fully inclusive of all program integrity efforts.

#### Recipient Application and Oversight

Pennsylvania has had robust processes in place for years to prevent fraud. All individual applications for benefits are checked against 15 databases to verify accuracy of information provided and screen for potential flags that may make a person ineligible.

Information we check includes income and assets, citizenship, residency, household composition, health or disability status, and more to ensure information is accurate and benefits are given only to those who qualify. We also check the Social Security Administration's Death Master File, the Department of Health's Bureau of Vital Statistics, and reports from managed care organizations. If information in any of these databases is contradictory or unverified, then we request more information from the individual before making an eligibility decision and providing any benefits.

Applications are also checked against federal and other states' databases to identify any possible duplication of benefits. These databases are managed by the federal government or applicable state, which means Pennsylvania is necessarily dependent on the quality of the federal government's and other states' systems. PA DHS performs the same extensive verification process before benefits are renewed, meaning that an individual's information is checked at minimum every 6-12 months.

For home and community-based and long-term services for disabled individuals, conflict of interest protections requires separation of eligibility determinations, functional assessments, and service authorization. In Pennsylvania each of these three critical functions is conducted by a distinct party who will not financially benefit from the results of their evaluation or determination.

If any of these checks trigger suspicions of fraud or intentional misuse, PA DHS will make referrals to the Office of State Inspector General (OSIG) and request verification from the individual before a final eligibility decision is made. OSIG supports our shared goals of program integrity by assisting with a deeper investigation when PA DHS staff identify potential concerns with an application, renewal, or with any other reported change. If, through this review, OSIG determines that criminal charges are necessary, the office can seek criminal charges and damages to the Commonwealth. OSIG's investigations into potential misuse of public benefits overwhelmingly start with referrals from PA DHS. In 2025, PA DHS staff processed over 3.3 million applications and maintained nearly 2.4 million open cases and of those referred 19,232 (~0.7%) cases to OSIG for additional review and verification. Of those, 10,149 (53%) resulted in no reduction of benefits. Additionally, thanks to our close partnership, OSIG also filed charges in 674 cases. This collaboration has prevented nearly \$179 million of benefits from being erroneously distributed since the start of the Shapiro Administration.

### Provider Monitoring

The majority of fraud in the Medicaid program is committed by providers – not individual benefits recipients. Because of this, PA DHS also has robust procedures in place for both provider enrollment and for ongoing monitoring once a provider is approved to provide services to Medicaid recipients.

Individuals or entities who are convicted of Medicaid or Medicare fraud are excluded from participation in Pennsylvania's Medical Assistance program. When providers apply to enroll in the Medical Assistance program, PA DHS staff ensure prospective Medical Assistance providers meet qualifications to operate in the program and are not barred from doing so federally or by other states. This review includes checks with state licensing boards, other states, and the federal government to verify that applications are accurate, the provider is allowed to participate in Medicaid, and there is no criminal or conduct history that would prevent participation. Applications are reviewed against the Social Security Administration's Death Master File, the Medicare Exclusion Database, and other sources. If concerns are raised, we can require a criminal background check and fingerprinting.

Our Bureau of Program Integrity (BPI) is at the center of our work protecting valuable taxpayer resources. BPI reviews and monitors for provider fraud or misuse. When issues of concern are identified, the Bureau works directly with law enforcement, coordinating referrals as appropriate to other state and/or federal entities so any concerns can be investigated, and further action can be taken when necessary.

PA DHS's BPI refers suspected provider Medicaid fraud to the Pennsylvania Office of Attorney General's Medicaid Fraud Control Section, currently ranked number one nationally in criminal convictions, and third overall in charges filed. The Bureau also refers certain matters, typically those involving licensure or practicing outside of a license, to the Pennsylvania Department of State's Bureau of Professional and Occupational Affairs. Where appropriate, data and assistance are also provided to the United States Department of Health and Human Services' Office of Inspector General, U.S. Attorneys' offices, the Federal Bureau of Investigation (FBI), and other federal law enforcement agencies. We are an active partner with local, state, and federal agencies in our shared goals of protecting public programs and rooting out fraud of resources.

Medicaid fraud monitoring also occurs through thorough and regular reviews of records, new reporting tools such as Electronic Visit Verification, and innovative practices like leveraging data analytics, predictive monitoring and AI assistance to review billing patterns for anomalies or concerning trends. Additional attention is given to services that are historically associated with fraudulent practice. The majority of Pennsylvania's Medical Assistance program is administered by managed care organizations (MCOs), and each MCO has their own internal program integrity unit providing an additional layer of claims monitoring, pre-payment reviews, audits, chart reviews, and more. When MCOs identify potential fraud, they make referrals to BPI and the Pennsylvania Office of Attorney General.

PA DHS can also impose administrative actions and penalties that prevent further program participation on individuals and providers who commit fraud, including corrective action plans, removal from the Medical Assistance program, a ban on future participation in the program, and referrals to professional licensing boards for further action. In the state 2024-25 fiscal year, we terminated 330 Medical Assistance providers from the program to prevent fraudulent charges and misuse. These actions saved taxpayers nearly \$36 million.

#### Medical Assistance Payment Error Rate

PA DHS staff also monitor benefits programs for unintentional misuse and errors by providers and recipients.

BPI reviews Medical Assistance claims for potential overpayments, underpayments, or errors in filing that could result in billing error and also looks for instances where other insurance coverage is available because Medicaid must be the payor of last resort. When an overpayment occurs or alternate insurance coverage is available, taxpayer funds can be reclaimed, or costs are avoided and redirected to a more appropriate source. This work to review billing accuracy saved the Commonwealth more than \$486 million in the state 2024-25 budget year alone.

Improper payments do not necessarily mean fraud or intentional misuse. For instance, information regarding additional insurance may not have been available at the time a claim was paid. Still, monitoring for accuracy is important to ensure PA's Medical Assistance program is operating efficiently and accurately. Based on recent performance, we are doing so. In fact, in 2025 Pennsylvania's Medicaid payment error rate was 0.26% -- an indicator of strong programmatic monitoring and oversight and well below the national average of 6.12%.

#### Pennsylvania False Claims Act

Pennsylvania is a leader in fighting fraud and public benefit misuse, and we are helping to ensure that vital public benefits programs continue to be available to Pennsylvanians who are eligible. We can build on this work by supporting Governor Shapiro's call for a Pennsylvania False Claims Act. Currently, the Commonwealth is able to prosecute only under the federal False Claims Act, which requires that the federal government also be defrauded. A state-level false claims law would allow both the government and private individuals with knowledge of fraud to sue an entity that is submitting a false claim. When a private individual with knowledge of the fraud blows the whistle by filing a lawsuit against a wrongdoer, it's called 'private right of action' and entitles the whistleblower who reported the fraud to a percentage of the recovery should they win, and allows the Commonwealth to collect additional damages and recoup more state dollars that would otherwise be lost to fraud. We commend the House for passing Representative Burns's HB1697 and look forward to working with the Senate on a final version that can come to the Governor's desk.

A Pennsylvania False Claims act is a common-sense tool to expand our resources to stop and prevent fraud. If the language is federally compliant, the Commonwealth would be able to recover stolen or misused funds, helping empower whistleblowers to come forward and deterring potential fraud because of the visible ramifications of these types of lawsuits. It is time that we take this step for our Commonwealth so we can use our taxpayer resources to focus on what they are intended to do: continue reinforcing the processes and systems we have that are proven to be working in fighting fraud and help our fellow Pennsylvanians build the better health, independence, dignity, and self-sufficiency that make our communities strong.

We commend your leadership on this issue and remain committed to our partnership as we strive to be good stewards of taxpayer dollars and the wellbeing of vulnerable Pennsylvanians receiving these essential services.

**Testimony of Randall M. Fox in Support of Pennsylvania House Bill 1697**

**House Democratic Policy Committee**

**May 7, 2026**

**POSITION: FAVORABLE**

Honorable members of the House Democratic Policy Committee:

My name is Randall Fox, I am a partner in the law firm of Kirby McInerney LLP in New York.

I am here to testify in support of HB 1697 (Taxpayer Prevention Against Fraud Act) whereby the State of Pennsylvania would enact a False Claims Act to put in place a powerful and effective tool to protect the integrity of state and local government dollars and make sure they are spent and collected as they are meant to be.

First, allow me to share my background, which focuses heavily on False Claims Acts.

I was a “Big Law” lawyer in New York for 16 years, including several years as a partner. I then joined the government, first in the New York Attorney General’s Medicaid Fraud Control Unit, where in 2007 I brought the State’s first government-initiated state False Claims Act case under the New York’s brand new law. In 2011, I became the founding Bureau Chief of the New York Attorney General’s Taxpayer Protection Bureau, which enforced the state False Claims Act in all areas other than Medicaid matters. In 2014, I joined Kirby McInerney where I represent whistleblowers. Many of my cases are under the federal and state False Claims Acts. I also represent clients in various government agency whistleblower programs such as the IRS, SEC and CFTC programs.

In 2021, I was honored to be named the Whistleblower Lawyer of the Year by the nation-wide association of whistleblower lawyers, The Ant-Fraud Coalition (or the “TAF” Coalition).

TAF recently established a State False Claims Act committee to be a resource for states concerning the enactment and administration of effective whistleblower programs to protect state and local government dollars. I am a co-chair of that committee.

**I. THERE IS FRAUD IN PENNSYLVANIA THAT A FALSE CLAIMS ACT CASE WILL ADDRESS**

A False Claims Act is a non-partisan law about protecting the integrity of government dollars. That is why the Federal law has prominent support from across the aisle, including having a champion in Senator Chuck Grassley.

The False Claims Act is pro-business because it protects businesses that follow the rules from competitors who do not.

The False Claims Act is pro-citizen because it promotes having government dollars spent as intended without being siphoned off by fraud.

The fundamental theme of any False Claims Act case is that government dollars have been knowingly ripped off. It is fair to say that there have been, are, and will always be persons and businesses willing to perpetrate those frauds and trying to stay under the radar when they do so.

Enacting a False Claims Act will give Pennsylvania enforcers a powerful tool to fight that fraud. It will help identify and prosecute the perpetrators, and it will deter frauds because would-be perpetrators will know that anyone with knowledge of a fraud will be incentivized to report it.

I have years of data showing this to be the case.

Without a False Claims Act, Pennsylvania will miss out on these benefits.

I can say from my own experience that I have seen matters where multi-state frauds were reported to New York and other states with False Claims Acts, but were not reported to Pennsylvania because it lacks the statute.

Pennsylvania is now in a position to make sure it does not miss out.

## **II. THE PROPOSED LEGISLATION**

In a nutshell, the proposed law prohibits contractors, suppliers, and others from knowingly making false claims for payment by the government and, further, prohibits knowingly misrepresenting or avoiding payments that must be made to the government. It imposes treble damages and per-violation penalties when liability is found.

The law can be used either by the government on its own or with the help of whistleblowers who are incentivized to come forward with concrete information. The whistleblower awards are between 15 and 30%, and whistleblowers are protected against retaliation. Even where a case is brought by a whistleblower, there is significant government involvement and oversight.

Importantly, the proposed law, and False Claims Acts in general, are enforcement tools. They are not about setting policy, but rather are about recovering the government dollars lost to violations of existing rules.

## **III. FALSE CLAIMS ACTS ARE A PROVEN MEANS OF PROTECTING THE INTEGRITY OF GOVERNMENT DOLLARS**

We are not operating on a clean slate. Rather, we have the well-developed history of the federal False Claims Act and many state False Claims Acts to show us how effective False Claims Acts have been.

Since 1986, the federal government has recovered more than \$85 billion under the False Claims Act. For just last year, the number was \$6.8 billion.

New York has recovered, just on the non-Medicaid side, more than \$841.7 million under its False Claims Act.

Key to these recoveries is the False Claims Act's positive financial incentive to whistleblowers with direct, concrete information about frauds that commonly would not have become known to government enforcers. The False Claims Act provides a positive financial incentive to battle against the negative financial incentives that fraudsters have.

The money recovered does not tell the full story of the effectiveness of False Claims Acts because the Acts also deter fraud. One academic study from 2023, for example, found that when New York added tax claims to its False Claims Act, the impact was greater tax compliance, which the authors measured to be the collection of an additional \$281 million dollars each year in New York State corporate franchise taxes, which represented a 7.7% increase in compliance.<sup>1</sup>

#### **IV. NEARLY 20 YEARS OF THE NEW YORK FALSE CLAIMS ACT DEMONSTRATE THE LAW'S SUCCESS IN FIGHTING FRAUD**

##### **A. Overview of the New York Law**

New York passed its False Claims Act in 2007. It is largely similar to the proposed Pennsylvania legislation.

One important distinction is that the New York law has some special provisions concerning cases about tax violations. In order to avoid claims such as neighbors suing neighbors about paying baby sitters off the books, it imposes a two-part thresholds for these cases: the person against whom the action is brought must have net income or sales of more than \$1 million for any tax year at issue, and the damages pled must exceed \$350,000.

The pending legislation does not include a threshold provision like this, and I urge the Pennsylvania Legislature to include a similar provision to keep the tax cases focused on the big-ticket matters.

##### **B. Lessons from the New York False Claims Act**

Both as Bureau Chief and then as a private whistleblower lawyer, I have closely tracked the non-Medicaid cases under the New York False Claims Act. I am pleased to share the lessons from that nearly two decades of on-the-ground experience.

I have submitted to the Committee a spreadsheet with detailed data on every one of the 190 public New York False Claims Act case on the non-Medicaid side. And from that data, I have extracted several lessons about the importance of the law.

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<sup>1</sup> Lee, et al., "The Deterrence Effects of Tax Whistleblower Laws: Evidence from New York False Claims Acts," *Management Science*, Aug. 14, 2024, <https://pubsonline.informs.org/doi/10.1287/mnsc.2023.02999>.

## 1. Lesson 1: The Nay Sayers Were Very Wrong

When the New York law passed, and then when it was amended to add tax claims, there were some who made sky-is-falling claims that the law would result in huge numbers of meritless cases.

The data shows that the nay-sayer's parade of horrors predictably did not happen.

### a. Only a Modest Number of Cases Have Been Filed

The flood gates did not open. In nearly 20 years, there have been 190 non-Medicaid cases that have gone public. That is an average of 10 per year.

In the spreadsheet I submitted, there is a table showing the breakdown of those 190 cases. 163 were brought by whistleblowers. 27 were brought by the government.

Those numbers do not include whistleblower cases that are still under seal, but there is reason to believe the number of those cases is also modest.

The New York Attorney General recently disclosed to Bloomberg Tax that there have been 224 tax whistleblower cases under the law since 2010, including cases that are under seal. That is an average of 14 cases a year. That is still a modest number.

The table below shows the breakout of the New York cases currently in the public record:

Number of Cases	All Cases	Qui Tams (Whistleblower cases)	Non-Qui Tams
All Case Types	190	163	27
By Subject Area			
Procurement	75	58	17
Tax	72	64	8
Financial	13	13	0
Education	10	10	0
Fees	6	6	0
Escheat	5	5	0
Labor	5	4	1
Grants	3	2	0
Unknown	1	1	0

### b. The Cases Have Not Been Frivolous

On the whole, the cases have been very successful, resulting in more than \$841 million in settlements on the non-Medicaid side. That record contradicts the predictions by some of only, or predominantly, meritless cases.

My spreadsheet shows the disposition of the 190 public cases: 86 were settled, and some of those were settled only after surviving motions to dismiss. Other cases are pending or were dismissed or withdrawn.

The table below shows the disposition of the public New York cases:

<b>Disposition of Cases</b>	<b>Total</b>	<b>Settled</b>	<b>Pending</b>	<b>Dismissed</b>	<b>Withdrawn</b>
All Cases	190	86	16	41	45
<b>By Subject Area</b>					
Tax	72	34	8	19	11
Procurement	75	39	4	14	15
Financial	13	1	1	3	8
Education	10	2	0	2	6
Fees	6	2	2	2	0
Escheat	5	2	1	0	2
Labor	5	5	0	0	0
Grants	3	1	0	0	2
Unknown	1	0	0	0	1

\* There is no record of the disposition of two cases.

## 2. Lesson 2: The State's Return on Investment Is Enormous

The data shows us that the State's return on its investment in applying the New York False Claims Act is 2,663.02%. That tells us that the False Claims Act is an extremely efficient and productive way to fight fraud.

The table below shows my calculation of the return on investment under the New York False Claims Act:

<b>Return on Investment</b>	
Number of Years since NYAG's Taxpayer Protection Bureau formed in 2011	15
Estimated Avg. Annual Cost of Bureau	\$ 1,700,000.00
Cost of Bureau since Inception	\$ 25,500,000.00
Settlements	\$ 841,745,525.55
Whistleblower Awards	\$ 137,174,935.15
Net Recoveries	\$ 704,570,590.40
Return on Investment (\$)	\$ 679,070,590.40
<b>Return on Investment (%)</b>	<b>2663.02%</b>

## 3. Lesson 3: The Cases Extend Beyond State Lines

The historical record also shows us that there have been several cases about fraud schemes that crossed state lines, where New York would have missed out if it did not have a False Claims Act.

Nearly all the Medicaid cases involve at least the state and the federal government, and many of them involve multiple states as well. On the non-Medicaid side, there are 47 cases that included

either the state and the federal government or a number of states plus the federal government. That number does not capture cases where similar suits have been brought in various state courts alleging similar violations of state False Claims Acts by the same defendants.

The table below shows the public New York False Claims Act cases (non-Medicaid) that cross state-lines:

<b>Levels of Government in Whistleblower Cases</b>	
NYS + USA Cases	17
USA + Multistate Cases	30

#### **4. Lesson 4: A Broad Variety of Frauds Has Been Uncovered**

The data also tells us that the cases cover a broad range of frauds committed against government dollars, and that many of these frauds will go on undetected without a False Claims Act.

The 190 public non-Medicaid claims in New York have consisted primarily of 75 procurement claims, 72 tax claims, and smaller numbers of cases about financial frauds mostly based on misleading government pension funds, escheatment frauds, and labor, education, and grant frauds.

#### **5. Lesson 5: The Biggest Recoveries of Government Dollars Are in Tax Cases**

The data shows that tax cases dominate in terms of the dollars recovered. About 80% of the recoveries in New York have been from tax violations. That compares to about 12% coming from cases about procurement fraud.

From my own involvement in many of these cases, I can report that the State would not have found out about the violations underlying some of the largest tax cases without whistleblowers. That includes the sales tax case against Sprint that settled for \$330 million, and the \$105 million settlement of a corporate income tax case against a hedge fund billionaire who falsely claimed to have moved his business out of New York even while it operated out of an office on Madison Avenue.

The table below shows the distribution of settlements across case types:

<b>Settlements</b>	<b>Settlement Amounts</b>	<b>Settlement Amounts as % of All Settlements</b>
All Settlements	\$ 841,745,525.55	
By Subject Area		
Tax	\$ 679,334,979.05	80.71%
Procurement	\$ 97,454,883.26	11.58%
Financial	\$ 12,500,000.00	1.49%
Education	\$ 42,000.00	0.00%

Fees	\$ 374,309.11	0.04%
Escheat	\$ 40,375,000.00	4.80%
Labor	\$ 11,606,756.13	1.38%
Grants	\$ 57,598.00	0.01%

## V. CONCLUSION

I wish to thank the Committee for this opportunity to testify, and respectfully offer my voice in favor of enacting a Pennsylvania False Claims Act.