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Subcommittee on Oversight and Investigations

Examining how Improper Payments Cost Taxpayers Billions and Weaken Medicare and Medicaid

Testimony of:
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Good morning, Chairman Griffith, Ranking Member Castor, and distinguished Members of the Subcommittee. I am Christi A. Grimm, Inspector General of the Department of Health and Human Services (HHS). Thank you for inviting me to testify about the Office of Inspector General's (HHS-OIG's) work to address improper payments in Medicare and Medicaid managed care programs. I also appreciate the invitation to testify about HHS-OIG's pressing need for increased investment so that we can continue critical work to protect patients and taxpayer dollars by preventing and detecting health care fraud, waste, and abuse.

INTRODUCTION

HHS-OIG provides independent, objective, evidence-based oversight for HHS's more than 100 programs. In keeping with the mandates of the Inspector General Act, HHS-OIG's nearly 1,600 dedicated professionals are laser focused on preventing and detecting fraud, waste, and abuse and on promoting the economy, efficiency, and effectiveness of HHS programs. HHS-OIG conducts criminal, civil, and administrative investigations of fraud and misconduct to protect and strengthen HHS programs. It also provides program officials and policymakers with data-driven findings and actionable recommendations to strengthen HHS programs and reduce the risk of improper payments, fraud, and other vulnerabilities.

HHS-OIG's oversight portfolio is vital, vast, and varied. HHS-OIG conducts oversight for HHS programs that provide health insurance, promote public health, protect the safety of food and medical products, respond to emergencies, care for children, provide for treatment of substance use disorders, and fund medical research, among others. Our vision is to drive positive change for these HHS programs that touch the lives of virtually every American.

In fiscal year (FY) 2023, HHS-OIG was responsible for overseeing more than $2 trillion in HHS expenditures—almost 24 percent of the Federal budget. HHS-OIG's final FY 2023 budget was $432.5 million to carry out this important responsibility. This is approximately two cents for every $100 of HHS spending. HHS is the Federal Government's largest grant-making agency and the fourth largest contracting agency, with obligations of $773.6 billion in total grants and $31 billion in total contracts obligated in FY 2023.

HHS-OIG's accomplishments and return on investment illustrate the value of oversight and enforcement. HHS-OIG's health care work consistently yields a positive return on investment of around $10 returned to every $1 invested, including expected and actual recoveries of funds to HHS programs. In FY 2023, HHS-OIG's investigative work yielded approximately $3.16 billion in expected investigative recoveries and resulted in 1,453 criminal and civil actions. HHS-OIG excluded 2,112 untrustworthy individuals and entities from participation in Federal health care programs, including bad actors convicted of patient abuse, neglect, and fraud. Additionally, our audit work identified nearly $283 million in expected recoveries, as well as nearly $1.5 billion in questioned costs. HHS operating divisions implemented 493 HHS-OIG recommendations,

including recommendations that improve the safety of foster care children, increase access to treatment for substance use disorder, correct safety issues at long-term care facilities, ensure the security of the Nation's drug supply, and enhance the cybersecurity of departmental programs.

Effective oversight of Medicare and Medicaid requires significant expertise, thoughtful design and execution, and substantial resources. Medicare and Medicaid are the Nation's largest health care programs, covering about 40 percent of the U.S. population, with combined annual expenditures of more than $1.7 trillion. HHS-OIG's work reflects the difficulties in detecting fraud and reducing payment errors in these sprawling, constantly changing, complex programs. The results of HHS-OIG's work consistently demonstrate the compelling need for program officials, policymakers, and industry stakeholders to prioritize integrity of the Medicare and Medicaid programs by investing in oversight and activities that protect against improper payments. More must be done to implement effective prevention measures and reduce barriers to more effective program integrity. Failing to do so often costs more in the long run.

HHS-OIG scrutinizes all corners of the Medicare and Medicaid programs, with a focus on promoting sound financial stewardship, ensuring access to high quality and safe care, and holding wrongdoers accountable. HHS-OIG work has identified critical program integrity challenges across all parts of the Medicare and Medicaid programs.

Today, my testimony focuses on managed care, a fast-growing sector with significant emerging risks and practical opportunities for improvement. You also invited me to testify about the legislative proposal in the President's FY 2025 Budget Request that would increase funding for HHS-OIG and our health care program integrity partners to combat fraud, waste, and abuse in Medicare and Medicaid.

My testimony speaks to three important themes:

- First, Medicare and Medicaid managed care have grown dramatically over the last decade, raising the risk of improper payments. For this reason, HHS-OIG has increased oversight and enforcement of managed care programs and has urged the Centers for Medicare & Medicaid Services (CMS) to continue taking steps to shore up protections for these programs.
- Second, better data and data analytics are among the most critical tools that help the Government stop fraud, waste, and abuse that lead to improper payments. Many solutions HHS-OIG recommends to reduce program risk involve more effectively collecting, sharing, and using timely, relevant, and accurate data to identify noncompliance with rules and pinpoint vulnerabilities for further scrutiny.
- Third, more investment in oversight and enforcement will pay dividends for American taxpayers. HHS-OIG delivers excellent results for HHS and the public at current funding levels, but much more can and needs to be done.

MEDICARE MANAGED CARE (MEDICARE ADVANTAGE/PART C)

Medicare Advantage—Medicare's managed care program (also known as Medicare Part C) — now serves most Medicare beneficiaries, surpassing enrollment in traditional Medicare. Managed care is an alternative way Medicare enrollees get health care benefits. In traditional fee-for-service Medicare, the Government covers health care by paying health care providers for

each medically necessary, covered item or service provided to an enrollee. In managed care, the Government pays private health insurance plans a fixed monthly payment per enrollee (a capitated payment) to provide coverage for Medicare enrollees. The plans pay health care providers to provide items and services for the patients enrolled in their plan. Broadly speaking, plans stand to benefit financially if the costs of items and services for an enrollee are less than the per-enrollee monthly payment. A plan must pay for all covered items and services, as applicable, even if the items and services cost more than the monthly payment.

Annual expenditures for Medicare Advantage grew from $147 billion in 2013 to $450 billion in 2023. Preventing and detecting improper payments in Medicare Advantage—whether those payments result from fraud, waste, or abuse—has become a top priority for HHS-OIG. Our work focuses on ensuring that the Medicare Advantage program operates efficiently, offers quality care for enrollees, and delivers value for taxpayers. HHS-OIG's work has revealed critical gaps between the promise of managed care to deliver cost-effective, high-quality care and how it often operates in practice. These gaps endanger the financial integrity of the Medicare program and the health of its enrollees. Improving the Medicare Advantage program so that it operates as intended will require close coordination between CMS, its contractors, plans, providers, and other key stakeholders, such as law enforcement.

While our portfolio of Medicare Advantage work covers a range of topics, I will highlight two areas where HHS-OIG has identified significant risk and opportunities to better protect the program from improper payments: risk adjustment and emerging durable medical equipment (DME) fraud.

Significant Vulnerabilities Exist With Risk Adjustment in Medicare Advantage

One concerning gap between Medicare Advantage as it should operate and its operation in practice is risk adjustment. CMS increases the fixed monthly payment when Medicare Advantage plans enroll people who are expected to require more health care services than other enrollees. These are called risk adjustment payments and are designed to ensure that Medicare Advantage plans are paid appropriately based on the health status of enrollees who may need more care due to significant health conditions and to discourage plans from preferential enrollment of healthier individuals. CMS bases these risk adjustment payments on enrollee diagnoses contained in encounters or claims Medicare Advantage plans submit.

Our work has demonstrated significant problems with risk adjustment in Medicare Advantage, raising concerns about improper payments and patient care. One troubling concern is the potential for plans to game risk adjustment by overstating how sick enrollees are so the plans can receive higher payments than they should. A 2021 HHS-OIG report examined practices by plans and vendors to identify enrollees' diagnoses through tools known as health risk assessments and chart reviews. These diagnoses are then reported to CMS for purposes of risk adjustment payments. Health risk assessments and chart reviews are allowable practices that can be helpful for plans and patients. However, they are particularly vulnerable to misuse by Medicare Advantage companies, and our report raises serious questions when health risk assessments or chart reviews are the sole source of diagnoses driving higher risk adjustment payments.

We found that Medicare Advantage companies received more than $9 billion in risk adjustment payments in 1 year for serious medical conditions that only appeared on health risk assessments

or chart reviews and not on any service records. Twenty Medicare Advantage companies accounted for $5 billion of that $9 billion. The most common diagnoses driving these payments included vascular disease, serious mental illness, chronic obstructive pulmonary disorder, and congestive heart failure. In our review of service records, we did not find any records of treatment indicating these serious conditions. This raised three troubling possibilities: (1) the diagnoses codes and, therefore, payments to plans are inaccurate; (2) plan enrollees have serious unmet health care needs; or (3) Medicare Advantage companies are not reporting all service records as required.

Potential Solution—Restrict Use of Diagnoses That Appear Only on Health Risk Assessments or Chart Reviews

HHS-OIG's work demonstrates an urgent need for CMS to fortify Medicare Advantage risk adjustment. Although CMS has taken important steps to improve the integrity of Medicare Advantage risk adjustment through additional regulation that supports stronger oversight of plans and recovery of misspent taxpayer dollars, more can and should be done to ensure that risk adjustment operates as intended. Based on our oversight and enforcement experience with risk adjustment, HHS-OIG recommends that use of diagnoses that appear only on health risk assessments or chart reviews, without evidence of appropriate health care services or meaningful actions by plans to connect enrollees to those services, should be restricted for purposes of risk adjustment calculations.

HHS-OIG Holds Medicare Advantage Plans Accountable for Overpayments

HHS-OIG audits have revealed that plans consistently receive substantial risk adjustment overpayments. For example, across 33 audits issued since 2019, HHS-OIG identified more than $588 million in overpayments Medicare made to plans for unsupported risk adjustment payments. These are misspent taxpayer funds.

We also hold Medicare Advantage plans accountable through enforcement actions for fraud involving their risk adjustment practices, in collaboration with our law enforcement partners. For example, last year The Cigna Group, which owns and operates Medicare Advantage plans across the country, agreed to pay $172 million to resolve allegations that it violated the False Claims Act. The Cigna Group was accused of knowingly submitting and failing to withdraw inaccurate and untruthful diagnoses codes based on health risk assessments and chart reviews for its Medicare Advantage Plan enrollees to increase its risk adjustment payments.

Combating Fraud Affecting Medicare Advantage Plans and Enrollees is Critical

Decades of HHS-OIG enforcement and oversight prove the adage that fraudsters follow the money. With the tremendous growth of Medicare Advantage enrollment and expenditures, a corresponding increase in fraud in Medicare Advantage is predictable. Fraud schemes in traditional Medicare have migrated to Medicare Advantage.

HHS-OIG has a proven track record of working with our partners within the Department of Justice (DOJ), Medicaid Fraud Control Units, State and local law enforcement agencies, other OIGs, and CMS to investigate, shut down, and hold criminals accountable for health care fraud. To protect the safety of our agents, avoid tipping off targets, and ensure the integrity of an investigation, it is important that we not comment on any investigative matter that might be

ongoing. Accordingly, much of our investigative work necessarily happens behind the scenes, out of public view. My testimony today is limited to investigative matters that have been resolved or unsealed and general observations gleaned from our decades of enforcement experience.

HHS-OIG uncovers and investigates fraud in a wide range of Medicare benefits, including, for example, DME, home health, hospice, and laboratory services. DME (also referred to as "durable equipment, prosthetics, orthotics, and supplies") includes a broad range of medical equipment and supplies used in a patient's home and is only covered if it is medically necessary and ordered by a provider. DME fraud has long been among the most intransient fraud problems. It has persisted in traditional Medicare for decades and is growing in Medicare managed care. Twenty years ago, most types of fraud were geographically concentrated and often used false storefronts, direct mail campaigns, and local television ads. Today, HHS-OIG and our law enforcement partners combat health care fraud schemes that use sophisticated techniques and technology that expand the reach and complexity of the fraud. New schemes maximize the scale of the fraud—they are designed to be efficient, and fast moving and to generate higher returns. By manipulating technology, fraudsters can take a local scheme, activate it in all 50 States, and sometimes involve criminals operating internationally.

Operation Brace Yourself, a major, nationwide law enforcement operation that shut down a billion-dollar scheme in 2019, demonstrated how quickly fraud can jump from traditional fee-for-service Medicare to managed care. After the law enforcement action, Medicare fee-for-service claims for orthotic braces dropped by 9 percent. Shortly after that, claims billed to Medicare Advantage plans for the same types of braces increased by 22 percent. Criminals migrated from perpetuating fraud on traditional fee-for-service Medicare to Medicare Advantage not *years* later, but *weeks* later. In one case, our enforcement shut down fraud by a DME supplier billing CMS. The fraudster opened a new company at the same address and started billing Medicare Advantage plans instead.

Through data analytics, we are detecting large increases in DME billing in Medicare Advantage, and these increases are cause for concern. From 2020 to 2023, DME billing in Medicare Advantage increased by 59 percent. Increases of this magnitude signal a need for heightened scrutiny to ensure that increased billings result from legitimate DME claims and not from fraud. Plans may incur losses if they pay the fraudulent DME supplier. Losses, however, are not limited to Medicare Advantage plans. Ultimately, fraud against plans costs taxpayers through higher capitated rates (fixed monthly payments per enrollee) in the future. Because capitated payment rates are set, in part, based on historical costs, if plans' costs are inflated by fraudulent billings, these increased costs may be passed along to the Medicare Advantage program through future, higher capitated payments.

HHS-OIG data analytics, combined with investigative techniques, have detected a trend indicating that DME suppliers have been shifting into a type of fraud known as a bust-out scheme. The general operation of this scheme is to open fast, bill a lot of fraudulent claims, then shut down before the fraud is spotted. To do this, the typical DME bust-out scheme involves straw owners of shell companies and the use of stolen beneficiary and physician identification numbers to bill a payer for millions of dollars in DME claims over a short period of time, sometimes within days. The DME is not needed, ordered, or delivered.

In some bust-out schemes, the fraudulent actor may have purchased a legitimate, ready-to-bill DME supplier already enrolled with Medicare. Such a purchase can result in the seller's Medicare identification number, provider agreement, and customer list transferring to the fraudulent actor. The fraudulent purchaser may then redirect payments through a change to the purchased DME supplier's electronic funds transfer instructions. The scheme often involves circumvention of the requirement for reporting change of ownership to CMS. Regardless of how the fraudster perpetrates the bust-out scheme, as soon as one bust-out DME supplier is detected, the fraudulent actor has another one ready to repeat the pattern.

In addition to enforcement, and while not specific to Medicare Advantage, HHS-OIG has deep experience conducting audits and evaluations to identify vulnerabilities in the Medicare DME benefit. Prior HHS-OIG work identified inappropriate payments for orthotic braces that were not medically necessary, not documented in accordance with Medicare requirements, or fraudulent. We are conducting followup work that is analyzing data to identify trends in payment, compliance, and fraud vulnerabilities, and we will offer CMS recommendations to improve detected vulnerabilities. In addition, we have ongoing reviews of Medicare payments for intermittent urinary catheters and remote patient monitoring.

Potential Solution—Better Data to Detect and Stop Fraud

We cannot arrest our way out of the complex DME fraud problem. To this end, HHS-OIG coordinates with CMS and law enforcement partners to accelerate early identification of fraud indicators so that fraud is stopped in its tracks, before large sums of money go out the door. HHS-OIG's data scientists use sophisticated analytics and monitor claims data to flag outliers and anomalies for HHS-OIG and other law enforcement agents. Agents then follow up with investigative work in the field, establishing that a data anomaly resulted from fraud and compiling the evidence needed for civil, criminal, or administrative actions. For example, these actions include payment suspensions implemented by CMS, often at the request of and in coordination with law enforcement.

Claims for payment in Medicare Advantage are submitted to plans directly, rather than to CMS or CMS's contractors. Fraud schemes orchestrated by DME suppliers can be difficult for plans to detect. This is because individual plans can see only a slice of the overall fraud scheme—the part that is being billed to and paid by them. HHS-OIG is working closely with plans and other law enforcement partners to detect and stop fraud. Unlike individual plans, HHS-OIG can better see the full picture.

Still, the full picture has gaps that can be fixed. A lack of National Provider Identifiers (NPIs) for ordering providers in Medicare Advantage data hinders the Government's use of data analysis to detect patterns of inappropriate billings. HHS-OIG work has found that ordering NPIs, which indicate who is ordering items and services, are largely absent from managed care data despite evidence that many plans can and do collect the information. NPIs are essential to ensure proper payment for high-risk services and for investigating fraud and abuse. For example, an NPI can be used to determine whether the provider ordering an item or service has had a prior encounter with the same patient. We have seen that many fraud schemes involve providers ordering DME for patients they have not seen before. HHS-OIG has recommended that CMS require plans to include ordering NPIs in plan data submitted to CMS. We further recommend that CMS encourage plans to perform their own oversight using ordering NPIs.

MEDICAID MANAGED CARE

Medicaid is a joint Federal and State program that provides health care to more than 77.9 million Americans, including eligible children, pregnant women, parents, seniors, and individuals with disabilities. Most Medicaid enrollees (81 percent) receive at least some coverage through managed care arrangements. Under Medicaid managed care, States contract with insurance companies to make available all or a portion of covered services for people enrolled in Medicaid. States typically pay plans a capitated payment for each plan enrollee. Oversight of Medicaid is particularly complex because there are effectively 56 different programs, one for each State, territory, and the District of Columbia. States have latitude in establishing eligibility standards, covered benefits, payment policies, and administrative processes.

Reducing improper payments is crucial to protect the financial integrity of Medicaid. Not all improper payments are fraud—or even overpayments. Some improper payments may result from mistakes or insufficient documentation of medically necessary services for which the Government would otherwise pay. For example, documentation is deemed to be insufficient because a doctor forgets to write a progress note that is required as a condition of payment by Medicaid. The current level of improper payments indicates considerable risk to Medicaid. In FY 2023, estimated improper Medicaid payments totaled more than $50 billion.

My testimony highlights three risk areas for improper payments: (1) Medicaid eligibility determinations, (2) Medicaid payments to managed care organizations (MCOs) for people enrolled in more than one State Medicaid program, and (3) Medicaid payments to MCOs for people who are deceased. Our work has shown that States continue to struggle to ensure that payments are made in the right amount and on behalf of the right eligible individual.

Ensuring Accurate Medicaid Eligibility Determinations is Essential

As Medicaid becomes predominantly a managed care program with monthly payments to plans based on enrollment, ensuring that States make correct eligibility determinations is essential. Correctly determining whether individuals are eligible for Medicaid prevents the program from making improper payments for people who are not entitled to participate in the program. HHS-OIG work has shown that Medicaid eligibility errors are a longstanding problem.

Prior to the COVID-19 public health emergency (PHE), HHS-OIG conducted audits of four States' Medicaid eligibility determinations (California, Colorado, Kentucky, and New York). We found that these States made an estimated $6.3 billion in payments on behalf of individuals who were not eligible, or who may not have been eligible, for Medicaid. Most frequently, eligibility determination errors were due to the State agencies not properly verifying income. HHS-OIG's audits showed that these errors were caused by both human and system errors, such as failure to consider all relevant information, caseworker errors, or failure to maintain supporting documentation.

As an example of human error, for one sampled enrollee, a caseworker noted that the Medicaid applicant attested to a monthly household income, supported by two monthly pay stubs. This income exceeded the Medicaid income limit. The caseworker reported the monthly household

income as being equal to one of the pay stubs and, as a result, within the Medicaid income limit. Due to the caseworker's error, the applicant was improperly enrolled in Medicaid.

HHS-OIG also conducted recent work related to Medicaid eligibility determinations in connection with the end of the PHE. The Families First Coronavirus Response Act (FFCRA) provided States with a temporary increase in the Federal share of Medicaid funding. To receive the increased funding, the FFCRA required States to ensure that most individuals who were enrolled in Medicaid when the PHE began were continuously enrolled through the end of the month in which the PHE ended (continuous enrollment condition). The Consolidated Appropriations Act, 2023 (CAA) ended the continuous enrollment condition on March 31, 2023. The CAA required States to initiate all renewals, post-enrollment verifications, and redeterminations for all Medicaid enrollees as of March 31, 2023.

HHS-OIG recently issued the first in a planned series of four audits to determine whether selected States (Ohio, California, Massachusetts, and Utah) completed Medicaid eligibility actions required by the end of continuous enrollment, including both renewals and terminations, in accordance with Federal and State requirements. The first report was issued to Ohio on April 9, 2024. HHS-OIG found that the State agency generally completed Medicaid eligibility actions in accordance with Federal and State requirements. We found that 9 of 140 enrollees in our sample had their Medicaid enrollment incorrectly determined. For enrollees that had their eligibility renewed, Ohio made 6 incorrect eligibility actions. For enrollees that had their eligibility terminated, Ohio made 3 incorrect eligibility actions. These deficiencies occurred because caseworkers failed to use information that was available, made mistakes while completing manual income calculations, or did not follow internal policies and procedures. Based on our sample results, we estimated that the State agency incorrectly determined eligibility actions for 6.5 percent of the State's Medicaid enrollees.

Reducing Duplicate Capitation Payments Could Save Approximately $1 Billion

A 2022 HHS-OIG audit examined Medicaid capitation payments for people enrolled in more than one State Medicaid program and found potential monthly savings to the Medicaid program that, if annualized, would amount to approximately $1 billion in program savings (Federal and State share). Concurrent enrollments can occur when a person moves from one State to another and enrolls in the new State's Medicaid program. Current systems do not identify enrollees who move from one State's program to another's in a timely manner. Our audit found that nearly all States made capitation payments for people who were enrolled in Medicaid in two States at the same time (i.e., were concurrently enrolled in more than one State).

Potential Solution 1—Leverage Transformed Medicaid Statistical Information System Data

We recommended that CMS provide matched Transformed Medicaid Statistical Information System (T-MSIS) data to States to help identify people who are potentially enrolled in two States. CMS did not agree with our recommendation.

CMS and the States have devoted a significant amount of time and resources to establish, improve, and maintain T-MSIS data, which provides information specific to the Medicaid

program. However, States do not have access to any Medicaid data from other States. Providing States with access to T-MSIS data could significantly enhance their ability to identify people with concurrent Medicaid enrollment and reduce the number and amount of duplicate capitation payments. For example, CMS could provide States with T-MSIS capitation payment data that would indicate to the State whether any payments were made in another State on behalf of its enrollees and the timeframes when those capitation payments were made.

In its comments, CMS pointed to its PARIS system as a tool States can use to identify duplicate recipients of public assistance, including Medicaid. Given the size and scope of the improper payments associated with beneficiaries enrolled in Medicaid managed care in two or more States, PARIS does not appear to be effective in spotting duplicate enrollees. States should have access to relevant enrollment information contained in T-MSIS.

Potential Solution 2—National Enrollment Database

Prevention controls are more effective than a retrospective detection process. Having a national enrollment database that leverages HHS's experience with T-MSIS and the data hub for the health insurance marketplaces could provide States with a centralized repository of enrollment data. States could use this during the enrollment process to ascertain whether an applicant is enrolled in another State's Medicaid program.

Potential Solution 3—Allow Recoupment of Duplicate Capitation Payments

Contracts between the State and MCOs generally allow for recoupment of capitation payments made for people who are deceased. Similarly, States could be required to develop specific language in their managed care contracts that provides for recoupment of capitation payments for instances in which a person is no longer a resident of that State.

Reducing Medicaid Capitation Payments for People Who Are Deceased Would Save Millions of Dollars

HHS-OIG has conducted a large body of work to determine whether State agencies made Medicaid capitation payments to MCOs for people who were deceased. HHS-OIG has issued audit reports to 16 individual States and 1 audit report to CMS. We identified total overpayments of more than $270 million ($187 million Federal share) in 16 States. Our results generally show that States struggle with identifying and stopping these types of improper payments. Our audits found that States made unallowable Medicaid capitation payments for a variety of reasons, including that they did not always identify and process death information. For example, in Michigan, our audit identified that, for some payments, the dates of death were not entered into the claims processing system until more than 24 months after the person died. In addition, States did not regularly use all available sources to identify, verify, or determine dates of death.

We recommended that States refund the Federal portion of the unallowable payments identified in our audits and made a variety of procedural recommendations including strengthening or

developing policies and procedures for identifying people who are deceased. States have generally concurred and have been acting on our recommendations.

Potential Solution—Data Matching

CMS could be required to develop a process to match enrollment and payment information in T-MSIS with data from the Social Security Administration and provide the results of that match to States to help reduce improper Medicaid capitation payments made to MCOs on behalf of people who are deceased.

HHS-OIG's portfolio of ongoing Medicaid oversight is extensive and will continue to prioritize Medicaid oversight in coordination, as appropriate, with CMS and State agencies. We are committed to ensuring that Medicaid pays the right amount on behalf of the right person.

INCREASING INVESTMENT IN HEALTH CARE ENFORCEMENT AND OVERSIGHT

At Current Funding Levels, HHS-OIG Faces Significant Challenges in Keeping Up With Increasing Threats to CMS Programs, Enrollees, and Taxpayer Funds

HHS-OIG works diligently and effectively, in coordination with our partners, to safeguard Federal program dollars and enrollees, but more oversight and enforcement are needed to keep pace with the size, scope, and complexity of the health care industry, HHS programs, and fraud schemes. At current funding levels, HHS-OIG experiences shortfalls in resources to meet enforcement and oversight needs. The President's FY 2025 Budget Request contains a legislative proposal that, if enacted, would enable HHS-OIG and its partners to ramp up fraud-fighting and other critical program integrity activities. This new investment would pay dividends for the American taxpayer.

Notwithstanding rigorous oversight by HHS-OIG and support from Congress, the Administration, and HHS for HHS-OIG's work, serious fraud, waste, and abuse continue to threaten CMS programs and the people they serve. HHS-OIG needs more agents and digital evidence experts to work fraud cases, as well as auditors, data scientists, and analysts to detect improper payments, trends, outliers, and program vulnerabilities and to recommend solutions. Despite our extensive reviews and enforcement, our limited resources do not allow us to provide the level of comprehensive oversight of Medicare and Medicaid that is needed and should be expected by the American public.

Every day HHS-OIG makes tough choices on cases and issues to decline for lack of resources. HHS-OIG has been turning down between 300 and 400 viable criminal and civil health care fraud cases each year. In addition to these cases, for the past several years, OIG has been turning down more than half of the referrals of potential fraud CMS's contractors make as part of OIG's major case coordination effort with CMS. Uninvestigated cases represent real, potential unchecked fraud; the potential for patients to be put in harm's way; and missed opportunities for deterrence and monetary recoveries.

HHS-OIG investigators reviewed and evaluated more than 2,698 Hotline complaints in FY 2022 and more than 4,501 complaints in FY 2023 that might have developed into viable cases, but we

lacked resources to follow up. I do not want to leave a misimpression that we are not addressing serious fraud and abuse. We are, and our statistics and return on investment show it. We take a data-driven, risk-based approach to address the most egregious cases of harm and abuse to hold bad actors accountable, protect people, and identify misspent funds and potential savings. However, with current resources, we cannot keep up with the level of threat to HHS, patients, and taxpayer dollars.

For example, we have declined referrals involving the opioid epidemic, such as doctors providing medically unnecessary prescriptions in exchange for cash or fraudsters making false promises of treatment to patients to obtain medical identity information used to bill for unnecessary urine drug screenings. We have also declined referrals of nursing homes that may be medically sedating residents inappropriately and hospice fraud cases involving patients receiving false diagnoses of terminal illnesses for which hospice providers received millions of dollars in reimbursement. In addition, HHS-OIG's agents and digital investigators are in high demand by prosecutors for their unparalleled expertise in HHS's complex health care programs and the fraud schemes that exploit them. We cannot meet this demand.

Increased Funding for the Proven Health Care Fraud and Abuse Control Program Would Enable HHS-OIG and Its Partners To Better Protect Against Fraud and Improper Payments

The entirety of HHS-OIG's funding for oversight and enforcement for Medicare and Medicaid—approximately 80 percent of HHS-OIG's total funding—comes from the Health Care Fraud and Abuse Control (HCFAC) Program, established by the Health Insurance Portability and Accountability Act of 1996 to detect, prevent, investigate, and prosecute health care fraud, waste, and abuse. The HCFAC Program also provides critical funding for our partners at HHS, CMS, DOJ, and the Federal Bureau of Investigation. The last time Congress increased the mandatory funding streams was in 2010 as part of the program integrity provisions of the Affordable Care Act.

The President's FY 2025 Budget Request proposes a legislative fix that would increase investment in mandatory HCFAC funding for all partner agencies in outyears by approximately 20 percent (phased in over 3 years) relative to current baseline levels.[1] This mandatory funding would provide stable long-term resources that can better keep pace with CMS program and health care spending growth, as well as with increasingly sophisticated fraud schemes. The HCFAC Program has generated a positive return on investment for American taxpayers since its inception. If the HCFAC legislative fix were enacted, HHS-OIG and our HCFAC partners would build upon existing interagency collaboration through successful models such as the Medicare Strike Forces to achieve even greater results for the American public.

In FY 2024, HHS-OIG received $236.3 million post-sequester in mandatory HCFAC funding, as well as $107.7 million in discretionary HCFAC funding that is appropriated annually. For FY 2025, the increased investment in HCFAC mandatory funding would provide OIG with more than $30 million in additional funding. Increased HCFAC mandatory funding would go a long way toward addressing HHS-OIG's shortfall in resources to combat fraud, waste, and abuse in

[1] A small portion of the funding, known as the HHS Wedge, would increase by 10 percent.

Medicare and Medicaid. With these resources, in the first year, HHS-OIG intends to begin hiring more than 100 additional law enforcement personnel, including agents and digital investigators, to tackle the backlog of fraud allegations and expand our capacity to open new cases.

With adequate HCFAC resources, we could conduct urgently needed oversight to better ensure that the Government and taxpayers are getting what they are paying for. We see significant opportunities to use our independent oversight to strengthen program operations, combat fraud, and identify improper payments in Medicare and Medicaid. Top priorities of mine include: combating fraud; identifying wasteful spending; and improving managed care, nursing homes, home- and community-based services, and drug affordability. For example, with additional resources, HHS-OIG could expand work examining critical issues in Medicare Advantage, including additional work examining the issues I have discussed in my testimony, such as increased oversight of the billions in dollars in risk adjustment payments, and additional targeted efforts to root out fraud that threatens the Medicare Advantage program. OIG could increase its efforts to protect nursing home residents and hold perpetrators accountable for abuse and neglect of residents including, as appropriate, criminal investigations and fraud enforcement for providing worthless services to nursing home residents.

CONCLUSION

Thank you for the opportunity to discuss HHS-OIG's mission-critical oversight and enforcement to safeguard and strengthen Medicare and Medicaid. As Inspector General for HHS, I am committed to using our resources as efficiently and effectively as possible to prevent, detect, and combat fraud, waste, and abuse. However, at current funding levels, HHS-OIG risks falling further behind. We will be unable to keep pace with the health care industry that is now one-fifth of the economy. The vast sums of money at stake heighten the risk of improper payments and attract criminals. We must counter sophisticated threats to HHS programs and meet an ever-rising demand for the oversight and enforcement that is needed to identify and mitigate risks of improper payments, protect programs and people from harm, and hold wrongdoers accountable.

I look forward to working with the members of this Subcommittee to continue to protect the Nation's health care programs from improper payments and address unmet enforcement and oversight needs for the benefit of the American taxpayers and the millions served by HHS programs. HHS-OIG appreciates the Committee's support for our work and resources. We welcome the opportunity to provide more information on HHS-OIG's oversight and enforcement work and on the proposal to increase investment in fraud-fighting and program integrity activities through the HCFAC Program. Thank you for your ongoing leadership and affording me the opportunity to testify today.