Subcommittee on Oversight of the House of Representatives Committee on Energy and Commerce

Hearing: Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid

Testimony of Jessica Gay, on behalf of Integrity Advantage Solutions, LLC

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Chairman Dr. Joyce, Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee: Thank you for having me. My name is Jessica Gay, I'm an Accredited Healthcare Fraud Investigator (AHFI), a Certified Professional Coder (CPC), and a Certified Fraud Examiner (CFE). I'm a Co-Founder and the Vice President Integrity Advantage; a Small Women Owned Business and the President of the Maryland Chapter of Certified Fraud Examiners. Our company provides outsourced Special Investigations Services to payers across the country and across lines of business. These lines of business include Medicare, Medicaid, FEHBP, Tricare and Commercial. Most of our work is done through Managed Care Organizations (MCOs) and Medicare Advantage (MA) plans, rather than directly with state and federal entities.

I have spent the past 15 years of my career, dedicated to the fight against Healthcare Fraud Waste and Abuse (FWA), I've partnered with more than 60 payers, training them on and conducting FWA detection analysis, prevention techniques, investigations, statistical sampling, case documentation, medical record reviews and program set up. Healthcare, as many of us know, is a complex and ever-changing landscape, with many nuances impacting all the parties involved.

Prior to proceeding, it is important to clarify my use of FWA over Fraud. Neither I nor Integrity Advantage serve as law enforcement or governmental authorities; thus, while we support and investigate allegations of fraud, we do not definitively determine its occurrence. Establishing fraudulent intent falls outside our purview and is ultimately adjudicated by a court of law.

Today I'd like to provide insights into the following five (5) areas:

1. Size and Scope of Healthcare FWA
2. Victims of Healthcare FWA
3. Coverage benefits and schemes in Medicaid and Medicare
4. Challenges across the industry
5. Considerations for change

Size and Scope of Healthcare FWA

Let's talk about the size and scope of the problem. Before diving into the complexities of healthcare fraud, I want to take a moment to ground us in the scale of the challenge we're dealing with. Industry experts estimate that Healthcare FWA accounts for a 3–10% of our total healthcare spending. Many think it's much higher. For perspective, U.S. healthcare spending reached about $5.3 trillion in 2024, which accounted for roughly 18% of the nation's gross domestic product (GDP) and is up 7.2% over 2023, according to my research. That's a minimum of $159 billion and potentially upwards of $530 billion in annual spending that is attributed to FWA. September 2025 the GAO estimated fraud between $233 billion to $521 billion.

Now, most people cannot conceptualize a billion dollars. Most Americans — people who don't see the large-scale aggregated numbers of a nation, but rather that of their own bank accounts or even business accounts — billions of dollars are abstract. For illustration, to bring home 1 billion dollars in a year, 83.33 million dollars a month, over 19 million a week or $480,769 dollars an hour for a full-time employee.

The impact of that money is real, and it affects every single one of us. But money isn't the only issue, not by a long shot. Healthcare FWA is not a victimless crime.

Victims of Healthcare FWA

The victims are patients (that's all of us), taxpayers (most of us) and honest providers, which represent most of those providing care.

Patients are victims in multiple ways; there is patient harm where it literally impacts the health and lives of patients. There is the misallocation of resources that impacts a patient's access to care and the administrative burden of receiving care. And then there is the direct cost of care that so many patients struggle to afford for themselves and their families.

Fraud can manifest in the form of medically unnecessary services—procedures, tests, prescriptions, and treatments that patients never needed. These are not benign administrative errors. They expose individuals to risks ranging from adverse drug reactions to life altering- surgical complications. While using resources for these services, or services not rendered at all, has a lasting financial impact in addition to the physical health of the American people.

When providers render unnecessary services simply because they can profit from them, they undermine both patient safety and public trust in the healthcare system. Additionally, ethical providers become collateral damage, as widespread abuse erodes confidence in genuine medical professionals who strive to deliver appropriate care.

According to the Center on Budget and Policy Priorities [1] taxpayers paid 1.7 trillion dollars (24%) of the budget to Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and Affordable Care Act (ACA) marketplace health insurance subsidies. We all know healthcare is expensive. But when that money is being misallocated to FWA, much of which is being perpetrated by transnational organizations and sent out of the country, this demands attention.

[1] Where Do Our Federal Tax Dollars Go? | Center on Budget and Policy Priorities

Next, I'd like to discuss prevalent areas of risk, and the underlying schemes we see in Medicaid and Medicare. These are industry-wide topics, commonly discussed in the anti-fraud community and should be monitored in all states. Of note, state Medicaid programs vary in naming conventions, coverage determinations, and levels of regulatory policy and support for each of these. I can only speak to the states that we, at Integrity Advantage, have supported.

Coverage Benefits and Schemes in Medicaid and Medicare

Applied Behavioral Analysis Services (ABA)

You cannot talk about Medicaid EWA today without talking about ABA. ABA services are rendered mostly to children, that have a diagnosis of autism spectrum disorder. The concerns around these services and misuse of millions of dollars of resources are discussed at every program integrity conference I've attended for the past several years. It should be on every state's radar; we started working ABA cases in the CHIP spaces 6 years ago. If a state isn't monitoring ABA services closely, they are likely missing a considerable area where FWA is committed.

What we see:

- Insufficient or no documentation to support services
    - Significant tracking and billing discrepancies were found
    - Technician training and oversight were insufficient
    - Interventions were often not tailored to individual member needs
- Service delivery did not always match authorizations
- Treatment plans showed major inconsistencies
- Cloned or non-specific medical records

Non-Emergency Medical Transportation (NEMT)

Non-Emergency Medical Transportation (NEMT) refers to transportation services for people who need help getting to medical appointments but *do not* require an ambulance or emergency care. It's a core Medicaid benefit and a major operational area in healthcare access, especially for seniors, people with disabilities, and patients with chronic conditions. It's intended to transport members to and from medical appointments, although the rules and regulations for every state vary.

What we see:

- Trips to nowhere – transport without a corresponding medical visit, prescription refills, etc.
- Billing for cancelled / not rendered services
- Inflated mileage
- Upcoding - Inflated levels of transportation – ambulatory patients receiving transport from a vehicle designed for non-ambulatory members, translator needed upcharge, etc

Home and Community Based Services

Home and Community Based Services (HCBS) are Medicaid programs that allow people to receive long- term care in their homes or communities instead of nursing homes or institutions. These services support older adults, people with disabilities, and individuals with behavioral health needs by providing assistance that helps them live independently[2]. These services range from state to state and Managed Care Organizations (MCOs) often have discretion in participation. Some of these services include personal care (bathing, dressing, eating), homemaker/chore services, home health aides, respite care for caregivers, supported employment, assistive technology & home modifications, case management, and more.

[2] Home & Community Based Services | Medicaid

What we see:

- No ordering physician or physician oversight
- Non-credentialled providers rendering services
- Round the clock services for patients with diagnoses such as hypertension, diabetes or homelessness
- Billing for 1:1 care, when rendering services to a house full of patients
- Insufficient documentation to support services / services not rendered
- Misrepresentation of ownership
- Falsified state authorization numbers

Laboratory Services - Genetic Testing, Drug Screening, Respiratory Panel, COVID Testing

Labs, of all sorts, are services we need but have proven to be hard to manage. Like any service a lab should be ordered based on the care of your practitioner, individualized for each person, the results should be returned to your practitioner and leveraged in your care.

What we see:

- Large panel genetic testing that is often not needed or leveraged in patient care
- Telemarketing to solicit participants in testing, not ordered by a practitioner
- Insufficient documentation – no orders, no results, no feedback loop
- Services not rendered
- Pass through billing
- Duplicate billing
- Upcoding
- Unbundling

Skin Substitutes

A skin substitute is a medical product designed to replace, repair or support damaged skin. It's typically used for chronic wounds, burns, diabetic ulcers and surgical reconstruction. They are billed under either Q or A HCPCS codes. There are rampant cases of misuse of this surgical supply for nearly every payer, and it is a very expensive product.

What we see:

- Excessive units billed
- Unnecessary applications
- Billing for products not applied
- Using high-cost grafts without medical necessity

Durable Medical Equipment (DME)

Durable medical equipment, which are the tangible items that support your health such as walkers, wheelchairs, braces, diabetic supplies, catheters, foot orthotics, etc. At one point or another, it seems we've encountered a wave of all of these items. Catheters and skin substitutes are two of the more recent large DME fraud trends.

What we see:

- Billed but not supplied
- Not medically necessary supplies
- No physician orders
- Telemarketing, items solicited participants, not order by a practitioner
- Upcoding – supplying an OTC brace, billing a custom orthotic, billing for huge amounts of skin substitutes, when using a small amount for wound care

These are just some of the areas of concern and schemes we see with the plans we support. All payers, including state and Federal payers, should be aware of these major national schemes, even if they

haven't surfaced locally yet. We see these continually discussed at conferences such as the National Health Care Antifraud Association (NHCAA) and the National Association of Medicaid Program Integrity (NAMPI) among others.

Challenges Across the Industry

Medicare and Medicaid face significant FWA due to high claim volumes, varied coverage areas, and evolving regulations. Prompt pay guidelines ensure providers are paid timely, but this can conflict with the need for thorough payment oversight. Unlike other industries where proof of work is standard before payment, healthcare claims are often paid without verification. Reviewing every claim is not practical; even advanced SIUs typically audit only about 1% of claims.

Medicaid in particular, has some challenges in that every state has varied programs. There are some areas of consistency as laid out by CMS regarding what needs to be covered, yet often the specifics of that coverage are left to state decision makers.

Further complication occurs as sometimes states expect MCOs to implement new initiatives and place much of the responsibilities, such as with the establishment of policies, on the MCOs directly. And allowing or expecting plans to set their own policies adds another layer of confusion and difficulty not only for investigators, but also on providers to know the differences across so many different payers. There can be so many different players here making rules that may be conflicting, or that don't get made at all because everyone expects another player to make the rules.

Generally, we see the following challenges:

- **Inadequate Policy Frameworks:** Many states lack sufficient policy guidance. Without clear regulatory direction, investigative units cannot enforce compliance or pursue administrative remedies effectively.

- **Severely Under Resourced Program Integrity Units / Medicaid Fraud Control Units:** Many states lack the necessary staffing, tools, or specialized expertise. Whether the challenge is too few personnel, misaligned skill sets, or outdated systems, the result is the same: fraudsters move faster than the state can respond.
- **Fragmented Oversight Between States and MCOs:** Ambiguity regarding who is responsible for policy, eligibility, credentialing, monitoring, or enforcement results in gaps where fraud thrives.
- **Insufficient Emphasis on People, Process, and Technology:** Program integrity requires all three components to be in balance. Too often, institutions focus on one area at the expense of the others, leaving a structurally unsound system.
- **Quantification of Value:** We tend to value efforts based on financial recoupment, when there is significant value in prevention that is difficult to quantify.

Considerations for Change

The complexity of healthcare and ever-changing landscape of FWA requires our attention. As we strive to make improvements to our healthcare programs, we should consider the following suggestions for change:

- **Clarify and Strengthen Policy Frameworks:** Where state policy is weak or nonexistent, federal defaults should apply. Policy gaps translate directly into enforcement gaps. We need better defined services with clear guidelines for what the service entails, what codes are used and what documentation to support the services should include. Without this clarity you hamstring both program integrity efforts and quality of care.
- **Strengthen Education and Awareness:** Healthcare payer institutions must invest in training for investigators, auditors, analysts, and leadership. Awareness of national schemes is essential. Policy makers at the health plan, state and federal level need to include fraud professionals in

decision making. Benefit coverage policy decisions often take down barriers to care, while well intentioned, they open the flood gates for perpetrators of fraud on our healthcare system.

- **Improve Inter-Agency and Cross-Organization Collaboration:** Siloed operations allow fraud to flourish. Data-sharing, joint investigations, and coordinated communication must be normalized across state, federal and commercial payers. Operations should be reviewed for duplicative effort, inefficiencies and potential shared resources.
- **Conduct Comprehensive Assessments of People, Process, and Technology:** Every state should evaluate its program integrity structure and identify where imbalances exist. An imbalance of these resources results in waste; we can't overcompensate any one of these areas without compromising one of the others.
- **Modernization of the Credentialing and Oversight Systems:** Credentialing processes remain a major vulnerability across the board. Enhanced verification, ongoing monitoring, and real-time alerts could significantly reduce fraud. A typical plan will recredential every 3 years, the NPI database relies on self-reporting. The FWA problem in this country is too big to rely on such methods. Furthermore, as we authorize varying levels of credentials to render care, we need a way to see who is rendering a service, not just who we are paying. Many fraud flags and indicators are undetectable due to limitations in IDs for non-clinical providers, such as home health aides, behavioral technicians, nurses and more.
- **Implement Stronger Data Management and Integration:** We must develop or adopt systems that consolidate NPI data, sanctions, billing histories, and other identifiers into an accessible, central platform. Data in healthcare is messy at best and unusable more often than acceptable. Also state reporting requirements vary significantly, streamlining these reporting guidelines would allow better consumption, aggregation and analysis.

Healthcare FWA is complex, multifaceted, and deeply entrenched. It harms patients, undermines honest providers, drains taxpayer resources, and increasingly benefits sophisticated criminal networks. However, with appropriate investment in education, collaboration, infrastructure, data, and policy, significant improvement is not only possible, it is critical.

Thank you for the opportunity to provide this testimony.