Testimony of

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

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Chairman Joyce, Ranking Member Clarke, Chairman Guthrie, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for inviting me to testify today on Medicare and Medicaid fraud and program integrity.

I am Jessica Tillipman, the Government Contracts Advisory Council Distinguished Professorial Lecturer in Government Contracts Law, Practice & Policy at the George Washington University Law School. In addition to leading the law school's Government Procurement Law Program, I teach our foundational course on integrity, ethics, and compliance in government procurement law. My testimony reflects my own views and does not represent those of the George Washington University.

I welcome this hearing and share the Committee's concern about fraud in Medicare and Medicaid. The programs' size and complexity make them attractive targets for fraud, and protecting program integrity is essential to preserve taxpayer resources and ensure that beneficiaries receive the care to which they are entitled.

Given the risks of fraud, waste, and abuse in federal health programs, the federal government has established a multi-layered enforcement and oversight structure that has generated significant enforcement activity and recoveries. In FY2025, the Department of Justice (DOJ) reported a record $6.8 billion in False Claims Act (FCA) settlements and judgments, with more than $5.7 billion arising from the healthcare sector.[1] According to DOJ reports, the

[1] *See* Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), available at https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025 (reporting total FCA recoveries exceeding $6.8B for FY2025; "over $5.7B" involving the health care industry).

"2025 National Health Care Fraud Takedown" resulted in criminal charges against 324 defendants with alleged intended losses[2] exceeding $14.6 billion.[3]

My testimony today addresses four issues, focusing on structural vulnerabilities and oversight design rather than on any specific fraud scheme, provider category, or beneficiary population:

1. **Oversight architecture:** Medicare and Medicaid rely on intentionally redundant oversight institutions. Their deterrent value depends on continuity, coordination, and stable capacity.

2. **Terminology and measurement:** "Fraud" is a legal conclusion. Oversight is more accurate and effective when it distinguishes fraud from improper payments, waste, and administrative errors.

3. **Prevention versus pay-and-chase:** Recent enforcement results indicate that existing tools can work, but durable deterrence requires shifting resources toward earlier verification and implementing outstanding GAO/OIG recommendations.

4. **Technology and governance:** Advanced analytics and Artificial Intelligence (AI) can strengthen detection, but only when paired with reliable data infrastructure, clear governance, and procedural safeguards, including transparency and an opportunity to appeal adverse determinations.

I. The Federal Healthcare Fraud Oversight Architecture

The United States has built a robust institutional architecture to prevent, detect, and punish healthcare fraud: independent Inspectors General (IGs), Government Accountability Office (GAO) oversight, DOJ enforcement, specialized fraud-control strike forces, and private-sector whistleblower incentive programs.[4] The system recognizes fraud risk as a persistent feature of large healthcare programs and addresses this risk through oversight and enforcement mechanisms tailored to different categories of misconduct: criminal prosecution for intentional fraud, civil penalties for recklessness, and administrative remedies for noncompliance.

A. Core Oversight Institutions

[2] "Intended loss" is defined as "the pecuniary harm that the defendant purposely sought to inflict; and . . . includes intended pecuniary harm that would have been impossible or unlikely to occur (*e.g.*, as in a government sting operation, or an insurance fraud in which the claim exceeded the insured value)." U.S. SENT'G GUIDELINES MANUAL § 2B1.1 (U.S. SENT'G COMM'N 2025).

[3] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at http://justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146 (324 defendants; over $14.6B attempted loss; more than doubles prior $6B record).

[4] *See generally* Jessica Tillipman, *U.S. Federal Government Contracts: Anti-Corruption 101*, GW: BEYOND THE FAR, https://blogs.gwu.edu/law-govpro/u-s-federal-government-contracts-anti-corruption-101/ [perma.cc/DL98-AK57] (citing Jessica Tillipman, United States, in ROUTLEDGE HANDBOOK OF PUBLIC PROCUREMENT CORRUPTION 519–20 (Sope Williams & Jessica Tillipman eds., 2024)).

This architecture relies on multiple overlapping institutions—an intentional redundancy designed to avoid a single point of failure. The system's credibility depends on independent institutions, each with distinct authorities and reporting requirements.

Department of Health and Human Services, Office of Inspector General (HHS-OIG). HHS-OIG provides independent oversight of Medicare and Medicaid, the two largest drivers of HHS spending.[5] In FY2025, HHS-OIG reported a cumulative monetary impact exceeding $19 billion and a return on investment (ROI) of $12.70 for every dollar spent.[6] During the Fall 2025 semiannual reporting period (April 1 through September 30, 2025), HHS-OIG investigations resulted in hundreds of criminal and civil actions and the exclusion of more than 1,000 individuals and entities from federal health care programs.[7] HHS-OIG also oversees and funds the fifty-three Medicaid Fraud Control Units (MFCUs) and works jointly with them on program integrity matters.[8]

Government Accountability Office. GAO is an independent, nonpartisan agency that works for Congress and is often described as the "congressional watchdog."[9] GAO conducts performance and financial audits, evaluations, and other reviews of federal healthcare programs. The agency has also developed a "Fraud Risk Management Framework" that provides a government-wide methodology for managing fraud risks through prevention, detection, and response.[10] GAO's audit work is performed in accordance with generally accepted government auditing standards (GAGAS), known as the "Yellow Book."[11] In FY2024, GAO reported $67.5 billion in financial benefits, about a $76 return for every dollar invested in the

[5] JESSICA TOLLESTRUP, ADA S. CORNELL, & KAREN E. LYNCH, CONG. RSCH. SERV., R48060, DEPARTMENT OF HEALTH AND HUMAN SERVICES: FY2025 BUDGET REQUEST 3 (2024), available at https://www.congress.gov/crs-product/R48060 ("Two mandatory spending programs—Medicare and Medicaid—are expected to account for 85% of all estimated HHS outlays in FY2025").

[6] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., FALL 2025 SEMIANNUAL REPORT TO CONGRESS ii (2025), available at https://oig.hhs.gov/documents/sar/11445/Fall_2025_SAR--508.pdf (criminal actions, civil actions, exclusions, and MFCU joint investigations). The report defines the return on investment (ROI) "using a 3-year rolling average methodology of expected recoveries and receivables to calculate the annual dollars returned to taxpayers for every dollar invested in OIG oversight," and "Total Monetary Impact " as the "[t]otal amount of potential savings from investigative receivables, audit and evaluation receivables, and recommendations that funds be put to better use." *Id.* at 33.

[7] *Id.* at 2–4.

[8] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., OEI-09-25-00090, MEDICAID FRAUD CONTROL UNITS ANNUAL REPORT: FISCAL YEAR 2024 1 (2025), available at https://oig.hhs.gov/documents/evaluation/10227/OEI-09-25-00090.pdf (describing 53 MFCUs operating in 50 states, DC, Puerto Rico, and the U.S. Virgin Islands**,** and OIG's oversight role).

[9] *About*, U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/about (last visited Feb. 1, 2026).

[10] U.S. GOV'T ACCOUNTABILITY OFF., GAO-15-593SP, A FRAMEWORK FOR MANAGING FRAUD RISKS IN FEDERAL PROGRAMS 6 (2015), available at https://www.gao.gov/assets/gao-15-593sp.pdf.

[11] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106786, GOVERNMENT AUDITING STANDARDS: 2024 REVISION 1–2 (2024), available at https://www.gao.gov/assets/d24106786.pdf; *Yellow Book: Government Auditing Standards*, U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/yellowbook (last visited Feb. 1, 2026).

agency.[12] GAO's "High-Risk List" has included Medicare and Medicaid program integrity for decades, reflecting the persistent challenges in these areas.[13]

Department of Justice. DOJ, primarily through U.S. Attorneys' Offices, prosecutes criminal health care fraud and brings civil False Claims Act cases involving federal health care programs.[14] The Medicare Fraud Strike Force is a multiagency enforcement program that uses analytics and coordinated teams led by DOJ and HHS-OIG, working with U.S. Attorneys' Offices, the FBI, and state and local partners, to target and prosecute major health care fraud schemes.[15] The Health Care Fraud and Abuse Control (HCFAC) program, established by the Health Insurance Portability and Accountability Act, provides the dedicated funding stream that sustains this enforcement infrastructure and produces an annual report to Congress documenting results.[16]

Medicaid Fraud Control Units. MFCUs are state-based units, often housed in state attorneys' general offices (or another statewide prosecutorial entity), that conduct statewide investigations and prosecutions of Medicaid provider fraud and also investigate and prosecute patient abuse or neglect in Medicaid-funded facilities.[17] MFCUs are financed primarily through federal grant awards of seventy-five percent, with a twenty-five percent state match.[18] In FY2024, fifty-three MFCUs reported $1.4 billion in recoveries, an estimated return of $3.46 per dollar spent, and 1,151 convictions (817 fraud; 334 patient abuse or neglect).[19]

False Claims Act *Qui Tam* Relators. The FCA is strengthened by a distinctive whistleblower mechanism. The statute's *qui tam* provisions allow private relators to file on the government's behalf and, if successful, typically receive fifteen to thirty percent of the recovery.[20] By deputizing private enforcement in this way, the FCA has

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[12] U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-900570, PERFORMANCE AND ACCOUNTABILITY REPORT, FISCAL YEAR 2024 iii (2025), available at https://www.gao.gov/assets/gao-25-900570.pdf.

[13] U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-107743, HIGH-RISK SERIES: HEIGHTENED ATTENTION COULD SAVE BILLIONS MORE AND IMPROVE GOVERNMENT EFFICIENCY AND EFFECTIVENESS 4, 8, 39, 244–51 (2025), available at https://www.gao.gov/assets/gao-25-107743.pdf.

[14] *See Fraud Section Practice Areas*, U.S. DEP'T OF JUST., CIVIL DIV., https://www.justice.gov/civil/practice-areas-0 (last updated Sept. 30, 2025); *Fraud Section*, U.S. DEP'T OF JUST., CIVIL DIV., https://www.justice.gov/civil/fraud-section (last visited Feb. 1, 2026).

[15] *Medicare Fraud Strike Force*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., https://oig.hhs.gov/fraud/strike-force/ (last visited Feb. 1, 2026).

[16] *See generally* U.S. DEP'T OF HEALTH & HUM. SERVS. & U.S. DEP'T OF JUST., HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM FY 2023 (2024), available at https://oig.hhs.gov/documents/hcfac/10087/HHS%20OIG%20FY%202023%20HCFAC.pdf; Ctrs. for Medicare & Medicaid Servs., *The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud*, CMS.GOV (Jan. 18, 2017), https://www.cms.gov/newsroom/fact-sheets/health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers-combating-health-care-0.

[17] 42 U.S.C. §§ 1396b(q)(1)(A), (3)–(4).

[18] *About the Medicaid Fraud Control Units*, NAT'L ASS'N OF ATT'Y'S GEN., https://www.naag.org/about-naag/namfcu/about-the-medicaid-fraud-control-units/ (last visited Feb. 1, 2026).

[19] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., OEI-09-25-00090, *supra* note 8, at 1.

[20] *See* False Claims Act, 31 U.S.C. §§ 3729–3733.

become an exceptionally powerful tool, with annual recoveries frequently exceeding one billion dollars. In FY2025, DOJ reported more than $5.3 billion in settlements and judgments from *qui tam*-initiated cases, out of total FCA recoveries exceeding $6.8 billion.[21]

Notably, independence and stable resourcing are design features that make oversight credible and durable across administrations. Oversight capacity depends on institutional stability—continuity of leadership, adequate resourcing, and public access to findings. When these conditions are disrupted, fraud detection may suffer, and public confidence in oversight findings erodes.

II. Clarifying Key Terminology: Fraud, Improper Payments, and Program Integrity

In health program oversight, labels drive remedies. Treating 'fraud' as a catchall for fraud, waste, abuse, and error distorts measurement and misdirects enforcement and compliance resources.

A. Defining "Fraud" Under Federal Law

Integrity failures operate on a spectrum. Federal law uses distinct legal regimes that turn on different scienter requirements and decision-making forums, ranging from criminal prosecution to administrative remedies. Oversight reporting should use terms that reflect those legal distinctions, because the label attached to an issue can shape the enforcement pathway, the consequences that follow, and the resulting public impression of any action taken.

Criminal Fraud. The primary criminal tool for addressing healthcare fraud is 18 U.S.C. § 1347, which makes it a federal crime to "knowingly and willfully execute[], or attempt[] to execute, a scheme . . . to defraud a health care benefit program."[22] Criminal fraud and false-statement offenses are punitive and require proof beyond a reasonable doubt of a culpable mental state, not merely inaccurate information. Violations carry a maximum penalty of ten years' imprisonment, increasing to twenty years if the offense results in serious bodily injury and potentially life imprisonment if it results in death.[23] GAO describes fraud as obtaining a thing of value through willful misrepresentation and emphasizes that whether conduct is "fraud" can only be determined through the judicial or other adjudicative system.[24]

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[21] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), available at https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025 (*qui tam* relator share fifteen to thirty percent; $5.3B *qui tam* recoveries; $6.8B total; $5.7B health care; priority areas including managed care, prescription drugs, and medically unnecessary care; state Medicaid recoveries).

[22] 18 U.S.C. § 1347(a)(1).

[23] *Id.* § 1347(a)(2).

[24] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, IMPROPER PAYMENTS AND FRAUD: HOW THEY ARE RELATED BUT DIFFERENT 1, 3 (2023), available at https://www.gao.gov/assets/d24106608.pdf.

False Claims Act Liability. The FCA[25] is a civil statute that imposes liability when a person acts "knowingly," a standard that includes reckless disregard and does not require proof of specific intent to defraud.[26] The FCA creates civil liability for, among other things, knowingly presenting (or causing to be presented) false claims, using false records or statements material to false claims, conspiring to violate the Act, and knowingly concealing or improperly avoiding obligations to pay the government.[27] The statute defines "knowingly" to include actual knowledge, deliberate ignorance, and reckless disregard.[28] The FCA is not aimed at "honest mistakes or incorrect claims submitted through mere negligence."[29] A defendant found liable under the FCA is subject to treble damages and per-claim civil penalties.[30] The FCA's *qui tam* provisions allow private citizens to file suit on the government's behalf and receive fifteen to thirty percent of any recovery.[31]

Administrative False Claims Act. Formerly the Program Fraud Civil Remedies Act (PFCRA), the Administrative False Claims Act authorizes agencies to adjudicate certain false-claim and false-statement matters through administrative proceedings (subject to DOJ approval, monetary limits, and judicial review), providing a potential off-ramp for smaller-dollar cases that do not warrant full FCA litigation.[32]

Anti-Kickback Statute and Physician Self-Referral Law. The health care Anti-Kickback Statute, 42 U.S.C. § 1320a-7b, criminalizes knowingly and willfully paying or receiving remuneration to induce or reward referrals for items or services reimbursable by federal health care programs and supports administrative sanctions.[33] The Stark Law, 42 U.S.C. § 1395nn, generally imposes strict liability for physician referrals of designated health services to entities with which the physician has a financial relationship, unless an exception applies.[34]

Exclusion from Federal Health Programs. Beyond criminal prosecution and civil liability, HHS-OIG has the authority to exclude individuals and entities from participation in Medicare, Medicaid, and other federal health care programs.[35] Exclusion is a powerful administrative remedy and, depending on the statutory basis,

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[25] *See* False Claims Act, 31 U.S.C. §§ 3729–3733.

[26] 31 U.S.C. §§ 3729(a)(1), (b)(1).

[27] *Id.*

[28] 31 U.S.C. §§ 3729(b)(1)(A)(i)–(iii). DOJ's annual Civil Division statistics provide a public benchmark for FCA enforcement volume and recoveries.

[29] S. REP. NO. 99-345, at 7, 22 (1986), available at https://www.justice.gov/sites/default/files/jmd/legacy/2013/10/31/senaterept-99-345-1986.pdf.

[30] 31 U.S.C. § 3729(a)(1); *see also The False Claims Act*, U.S. DEP'T OF JUST., CIVIL DIV., https://www.justice.gov/civil/false-claims-act (last updated Jan. 15, 2025).

[31] 31 U.S.C. §§ 3730(b)(1), (d)(1)–(2) (2022); U.S. DEP'T OF JUST., THE FALSE CLAIMS ACT: A PRIMER 2 (2011), available at https://www.justice.gov/d9/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf.

[32] 31 U.S.C. §§ 3801–3812.

[33] 42 U.S.C. § 1320a-7b(b).

[34] 42 U.S.C. § 1395nn(a)(1).

[35] 42 U.S.C. §§ 1320a-7(a)–(b) (mandatory and permissive exclusion authority); *see also Exclusion Authorities*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., https://oig.hhs.gov/exclusions/authorities.asp (last visited Feb. 1, 2026).

may be imposed even in the absence of a criminal conviction. In FY2025, OIG excluded 1,336 individuals and entities from participation in federal health care programs.[36] This authority parallels the suspension and debarment framework in federal procurement, where agencies may exclude contractors from future awards based on evidence of fraud, serious misconduct, or lack of present responsibility.[37]

Corporate Integrity Agreements. Beyond monetary recoveries, HHS-OIG may require Corporate Integrity Agreements (CIAs) in settlement resolutions that impose ongoing compliance obligations. Functionally, CIAs are analogous to DOJ non-prosecution or deferred prosecution agreements and to administrative agreements in suspension and debarment practice, as they use prospective compliance commitments to strengthen program integrity.[38]

B. Administrative and Oversight Failures Distinguished from Fraud

Conduct that does not meet the legal definition of fraud can still trigger serious consequences. Federal law authorizes agencies to terminate provider participation, recover improper payments, impose civil penalties, and take adverse action against personnel responsible for waste, mismanagement, or abuse. These administrative enforcement mechanisms often yield faster, more certain accountability than criminal prosecution.

Improper Payments. Improper payments constitute a statutory category broader than fraudulent payments.[39] Under the Payment Integrity Information Act framework, an "improper payment" is one "that should not have been made or was made in an incorrect amount, including an overpayment or underpayment," as well as payments to "ineligible" recipients, "duplicate" payments, and other statutorily identified payment errors.[40] Agencies also treat payments as improper when the payment's propriety cannot be determined because supporting documentation is lacking or insufficient.[41] GAO explains that "while all fraudulent payments are considered improper, not all improper payments are due to fraud."[42] Non-fraud improper payments may arise from unintentional administrative errors, payments made in the correct amount but without compliance with applicable legal requirements, or documentation deficiencies.[43] GAO reports that "since fiscal year 2003, cumulative improper payment estimates by executive branch agencies have totaled about $2.8

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[36] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., FALL 2025 SEMIANNUAL REPORT TO CONGRESS, *supra* note 6, at 4.

[37] *See generally* FAR 9.4.

[38] *See Corporate Integrity Agreements*, U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., https://oig.hhs.gov/compliance/corporate-integrity-agreements/about-corporate-integrity-agreements (last visited Feb. 1, 2026).

[39] *See* U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, *supra* note 24, at 1–3.

[40] 31 U.S.C. § 3351(4); *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107482, IMPROPER PAYMENTS: KEY CONCEPTS AND INFORMATION ON PROGRAMS WITH HIGH RATES OR LACKING ESTIMATES 1–3 (2024), available at https://www.gao.gov/assets/gao-24-107482.pdf.

[41] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107482, *supra* note 40, at 2.

[42] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, *supra* note 24, at 2.

[43] *Id.*

trillion, and the actual amount of improper payments may be significantly higher."[44] This figure reflects reported improper payment estimates, which are not synonymous with proven fraud losses and can include a range of payment errors and documentation failures.

Waste. GAO defines waste as "squandering money or resources, even if not explicitly illegal."[45] Examples include buying overpriced equipment, buying unnecessary equipment, or paying for goods or services that go unused.[46] Waste often reflects inefficiency or poor stewardship and, unlike fraud, does not necessarily involve a legal violation.[47]

Mismanagement. Mismanagement involves "creating a substantial risk to an agency's ability to accomplish its mission."[48] Examples GAO uses include continuing to pay utility bills for formerly leased office space, stockpiling equipment beyond its shelf-life, or renewing technical support for software an agency no longer uses.[49] Mismanagement concerns deficient management practices that can occur without the willful misrepresentation characteristic of fraud.

Abuse. GAO distinguishes between abuse, fraud, and improper payments.[50] Abuse occurs when someone "behaves improperly or unreasonably, or misuses a position or authority."[51] Abuse can be serious and may signal fraud risk, but GAO defines fraud as obtaining something of value through willful misrepresentation; conduct characterized as abuse is not necessarily fraud absent willful misrepresentation.[52]

C. Why the Distinctions Matter

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[44] U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-107753, IMPROPER PAYMENTS: INFORMATION ON AGENCIES' FISCAL YEAR 2024 ESTIMATES 1 (2025), available at https://www.gao.gov/assets/gao-25-107753.pdf; *see also* U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107482, *supra* note 40, at 6 (explaining improper payment estimates are not intended to reflect the extent of fraud in a program).

[45] U.S. GOV'T ACCOUNTABILITY OFF., FRAUD, WASTE, ABUSE, AND MISMANAGEMENT (Apr. 2020), https://www.gao.gov/assets/2020-04/FraudNet_Infographic_0420-update.pdf [hereinafter GAO FRAUDNET INFOGRAPHIC].

[46] *Id.*

[47] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-107198, GAOVERVIEW: UNDERSTANDING WASTE IN FEDERAL PROGRAMS (2024), available at https://www.gao.gov/assets/gao-24-107198.pdf; *see also Fraud & Improper Payments*, U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/fraud-improper-payments (last visited Feb. 1, 2026).

[48] FRAUDNET INFOGRAPHIC, *supra* note 45.

[49] *Id.*

[50] *Fraud & Improper Payments*, U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/fraud-improper-payments (last visited Feb. 1, 2026).

[51] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106458, GAOVERVIEW: UNDERSTANDING ABUSE OF FEDERAL RESOURCES 1 (2023), available at https://www.gao.gov/assets/d24106458.pdf; *see also* FRAUDNET INFOGRAPHIC, *supra* note 45.

[52] *See id.* at 1 (noting abuse can be an indicator of further malfeasance); U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, *supra* note 24, at 1 (defining fraud as obtaining a thing of value through willful misrepresentation).

These categories require different responses. Criminal fraud warrants prosecution. FCA violations warrant civil enforcement and treble damages. Improper payments require corrective action and improved controls. Abuse warrants corrective action. Waste and mismanagement require management reform.

When oversight findings conflate these categories—such as labeling documentation gaps as 'fraud' or treating all improper payments as criminal conduct—the result distorts reality, misallocates enforcement resources, unfairly stigmatizes program participants, and hinders the actual reforms needed to improve program integrity. GAO has been explicit: "improper payment determinations are made by agency officials while fraud determinations can only be made through the judicial or other adjudicative system."[53]

For context, CMS estimates that FY2025 improper payments across the major federal health programs it reports totaled around $96 billion.[54] These figures are significant, but CMS emphasizes that improper payment measurement does not constitute a measure of fraud; improper payments include overpayments, underpayments, and payments that cannot be verified due to missing or insufficient documentation.[55] In Medicaid specifically, CMS reports that 77.17% of FY2025 improper payments "were the result of insufficient documentation, which is generally not indicative of fraud or abuse."[56] Conflating improper payment estimates with fraud overstates the criminal problem and understates the administrative reforms required.

III. Recent Enforcement Results Show the Value of Existing Tools

The record enforcement results of the past year demonstrate that the existing oversight architecture, when properly resourced and supported, can detect and punish even sophisticated fraud schemes.

> **Record False Claims Act Recoveries.** In FY2025, DOJ reported $6.8 billion in FCA settlements and judgments.[57] Health care investigations largely drove the results: DOJ reported over $5.7 billion in recoveries from health care matters, restoring funds to Medicare, Medicaid, and TRICARE and, in many cases, protecting patients from medically unnecessary or potentially harmful conduct.[58] DOJ highlighted continued enforcement strength in managed care, prescription drugs, and medically unnecessary

[53] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106608, *supra* note 24, at 3.

[54] *See* Ctrs. for Medicare & Medicaid Servs., *Fiscal Year 2025 Improper Payments Fact Sheet* , CMS.GOV (Jan. 15, 2026), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet ($28.83 billion in Medicare Fee-for-Service; $23.67 billion in Medicare Part C; $4.23 billion in Medicare Part D; $37.39 billion in Medicaid; $1.37 billion in Children's health Insurance Program; $657.46 million in Advance payment of the Premium Tax Credit Program).

[55] *Id.* ("While CMS' improper payment reporting programs are designed to protect the integrity of CMS programs, improper payment measurement is not a measure of fraud, and not all improper payments are attributable to fraud or abuse").

[56] *Id.*

[57] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), available at https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025.

[58] *Id.*

care, and noted that federal recoveries in these matters often supported additional recoveries for state Medicaid programs.[59]

The 2025 National Health Care Fraud Takedown. This operation resulted in charges against 324 defendants across fifty federal districts—including nearly 100 doctors, nurses, pharmacists, and other licensed professionals.[60] DOJ and HHS-OIG described the 2025 National Health Care Fraud Takedown as the largest in DOJ history, alleging more than $14.6 billion in intended losses, more than double the prior $6 billion record.[61] The operation highlighted telehealth fraud schemes, durable medical equipment (DME) fraud, and the involvement of transnational criminal organizations.[62]

Operation Gold Rush. According to the DOJ, one of the matters investigated as part of the 2025 National Health Care Fraud Takedown, known as "Operation Gold Rush," involved charges in what the DOJ described as among the largest intended-loss health care fraud cases brought to date.[63] DOJ alleges that a transnational criminal organization used a network of "straw owners" who were sent to the United States to purchase dozens of medical supply companies.[64] These entities then allegedly "submitted $10.6 billion in fraudulent health care claims to Medicare for urinary catheters and other durable medical equipment by exploiting the stolen identities of over one million Americans spanning all 50 states and using their confidential medical information to submit the fraudulent claims."[65] DOJ further reported that CMS and HHS-OIG took steps to stop payments and pursue recovery of funds identified in connection with the scheme.[66] Authorities also reportedly arrested twelve defendants, including four apprehended in Estonia through international cooperation.[67]

These successes should be understood as evidence that the existing oversight infrastructure works when it is resourced and supported. The challenge is not a lack of tools; rather, it is the need to continue investing in the capacity to use them effectively.

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[59] *Id.*

[60] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[61] *Id.*

[62] *Id.*

[63] *Id.*; Press Release, U.S. Dep't of Just., U.S. Att'y's Off., E.D.N.Y., *11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice* (June 30, 2025), available at https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

[64] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[65] *Id.*

[66] *See id.*

[67] *Id.*

IV. The Double-Edged Sword of Artificial Intelligence

AI presents both a challenge and an opportunity for the integrity of Medicare and Medicaid programs. In my new article on AI governance in federal procurement, I explore how generative AI technologies significantly amplify traditional fraud risks in government programs.[68] Generative AI systems can now produce highly realistic fabricated documents, images, audio recordings, and video content.[69] Unlike traditional fraud, which often leaves detectable patterns, AI-generated fraud can produce sophisticated fabrications with minimal human involvement.[70]

This is not a hypothetical concern. In the 2025 National Health Care Fraud Takedown, DOJ charged defendants who allegedly used AI to create fake audio recordings of Medicare beneficiaries consenting to receive medical products.[71] The fabricated consent recordings were then allegedly used to generate false claims submitted to Medicare.[72] The FBI and the Treasury Department's Financial Crimes Enforcement Network (FinCEN) have issued broader warnings about AI-enabled fraud schemes, including the use of generative AI to falsify documents and circumvent identity verification controls.[73]

At the same time, advanced analytics and machine learning are now core capabilities in fraud detection. CMS's Fraud Prevention System uses these technologies to screen millions of Medicare fee-for-service claims each day.[74] But detection tools are only as effective as the data infrastructure that supports them, and GAO and HHS-OIG have repeatedly identified data quality and integration challenges as limiting factors.[75] The policy challenge is to ensure that detection capabilities keep pace with AI-enabled claim generation and that these tools are paired with procedural safeguards, including transparency and an opportunity to appeal decisions made in reliance on automated or algorithmic outputs.

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[68] Jessica Tillipman, *Buying Blind: Corruption Risk and the Erosion of Oversight in Federal AI Procurement, forthcoming* Public Contract Law Journal, Vol. 55, No. 2, *35–*63 (Winter 2026), available at https://ssrn.com/abstract=6043674.

[69] *Id.*

[70] *Id.*

[71] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[72] *Id.*

[73] *FBI Warns of Increasing Threat of Cyber Criminals Utilizing Artificial Intelligence*, FED. BUREAU OF INVESTIGATION (May 8, 2024), https://www.fbi.gov/contact-us/field-offices/sanfrancisco/news/fbi-warns-of-increasing-threat-of-cyber-criminals-utilizing-artificial-intelligence ("By manipulating and creating audio and visual content with unprecedented realism, these adversaries seek to deceive unsuspecting victims into divulging sensitive information or authorizing fraudulent transactions."); U.S. TREASURY: FIN. CRIMES ENF'T NETWORK, FINCEN ALERT ON DEEPFAKES AND DIGITAL IDENTITY 2–3 (2024), https://www.fincen.gov/system/files/shared/FinCEN-Alert-DeepFakes-Alert508FINAL.pdf.

[74] Ctrs. for Medicare & Medicaid Servs., *Fraud Prevention System 2.0 (FPS 2.0) Privacy Impact Assessment*, CMS CYBERGEEK, (date signed, May 22, 2024), https://security.cms.gov/pia/fraud-prevention-system-20 (stating the system monitors 4.5 million claims daily),

[75] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-26-108850, FRAUD AND IMPROPER PAYMENTS: DATA QUALITY AND A SKILLED WORKFORCE ARE ESSENTIAL FOR REALIZING ARTIFICIAL INTELLIGENCE'S BENEFITS (2026), available at https://www.gao.gov/assets/gao-26-108850.pdf.

V. Continuing Challenges and the Path Forward

While recent enforcement results are encouraging, GAO and HHS-OIG have identified persistent challenges that warrant continued attention. The common thread is that payments move faster than verification: at enrollment, at the point of service, and across the many organizations involved in administering care. The result is an environment in which fraud losses can accumulate before post-payment controls detect the pattern.[76]

Provider Verification Gaps. Before a doctor, medical supplier, or other provider can bill Medicare, they must enroll in the program and pass screening checks.[77] During the COVID-19 pandemic, CMS temporarily relaxed certain screening requirements to ensure continued access to care.[78] GAO found that these flexibilities introduced program-integrity risks and that CMS had not completed certain delayed screening work, including follow-up background checks.[79] GAO recommended that CMS increase the pace and prioritize that work.[80] Recent cases involving foreign straw owners and shell companies underscore the importance of verifying the identities of the entities that bill the program and of stopping improper payments before claims are paid.[81]

Service Verification Challenges. Some services are harder to verify than facility-based care. Telehealth encounters occur without a physical presence. Home health and personal care visits take place in private residences, where institutional controls are weaker. Mail-order medical equipment is shipped to a home address, and confirming medical necessity and receipt often depends on documentation maintained by the supplier. In each case, traditional verification mechanisms are limited, and review often relies heavily on records generated by the billing party or its agents.[82]

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[76] U.S. GOV'T ACCOUNTABILITY OFF., GAO-16-394, MEDICARE: CLAIM REVIEW PROGRAMS COULD BE IMPROVED WITH ADDITIONAL PREPAYMENT REVIEWS AND BETTER DATA 1–7 (2016), available at https://www.gao.gov/products/gao-16-394.

[77] *Id.* at 31; U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105494, MEDICARE: CMS NEEDS TO ADDRESS RISKS POSED BY PROVIDER ENROLLMENT WAIVERS AND FLEXIBILITIES 6–7 (2022), available at https://www.gao.gov/assets/gao-23-105494.pdf.

[78] U.S. GOV'T ACCOUNTABILITY OFF., GAO-23-105494, *supra* note 77, at 1–6.

[79] *Id.* at 1–6, 29–29.

[80] *Id.* at 1–2, 25–30.

[81] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[82] U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-104454, MEDICARE TELEHEALTH: ACTIONS NEEDED TO STRENGTHEN OVERSIGHT AND HELP PROVIDERS EDUCATE PATIENTS ON PRIVACY AND SECURITY RISKS, (2022), available at https://www.gao.gov/assets/gao-22-104454.pdf; U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., OEI-02-22-00150, INSIGHTS ON TELEHEALTH USE AND PROGRAM INTEGRITY RISKS ACROSS SELECTED HEALTH CARE PROGRAMS DURING THE PANDEMIC (2022), available at https://oig.hhs.gov/documents/evaluation/2717/OEI-02-22-00150-Complete%20Report.pdf; CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID INTEGRITY INST. CTR. FOR PROGRAM INTEGRITY, VULNERABILITIES AND MITIGATION STRATEGIES IN MEDICAID PERSONAL CARE SERVICES (2018), available at https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/downloads/vulnerabilities-mitigation-strategies.pdf; *White Paper: Fraud,*

These settings can cause claims to accumulate quickly because a single remote encounter may generate multiple downstream claims. GAO has urged stronger oversight as telehealth use grows,[83] and DOJ has described telemedicine schemes involving brief or sham remote encounters that trigger downstream orders for tests or equipment.[84]

Diffuse Responsibility in Managed Care. More than seventy percent of Medicaid beneficiaries now receive care through managed care plans paid on a per-enrollee basis,[85] which distributes responsibility for program integrity across states and plans. A 2025 OIG report found significant gaps in fraud-referral activity: many plans made few or no referrals, and half received no training or feedback from states on the referral process.[86] Separately, an OIG audit found that states paid over $207.5 million to enrollees who were already deceased, a failure that highlights the importance of timely eligibility and death-data matching.[87] Medicare Advantage and Medicaid managed care share common managed-care vulnerabilities, but Medicaid's federal-state design can introduce an additional layer of fragmentation, making oversight more variable and accountability harder to enforce consistently.

VI. Recommendations for Strengthening Oversight

If Congress's objective is durable deterrence and detection of fraud in Medicare and Medicaid, the path is clear. These recommendations align with the challenges identified above: strengthening front-end verification, improving delegated accountability, investing in data infrastructure, and preserving enforcement incentives.

First, implement outstanding GAO and HHS-OIG recommendations. GAO and HHS-OIG have issued hundreds of recommendations addressing Medicare and

Waste, and Abuse Related to Durable Medical Equipment in Medicare U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., https://oig.hhs.gov/reports/work-plan/browse-work-plan-projects/white-paper-fraud-waste-and-abuse-related-to-durable-medical-equipment-in-medicare/ (last modified Aug. 15, 2025) (Work Plan Project No. OEI-02-24-00311, announced Aug. 15, 2025, estimated completion in FY2027).

[83] U.S. GOV'T ACCOUNTABILITY OFF., GAO-22-104454, *supra* note 82, at 40–41.

[84] *See, e.g.*, Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud* (June 30, 2025), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-146.

[85] U.S. GOV'T ACCOUNTABILITY OFF., GAO-24-106627, MEDICAID MANAGED CARE: ADDITIONAL FEDERAL ACTION NEEDED TO FULLY LEVERAGE NEW APPEALS AND GRIEVANCES DATA 1 (2024), available at https://www.gao.gov/assets/gao-24-106627.pdf.

[86] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., OEI-03-22-00410, SOME MEDICAID MANAGED CARE PLANS MADE FEW OR NO REFERRALS OF POTENTIAL PROVIDER FRAUD 5–10 (2025), available at https://oig.hhs.gov/documents/evaluation/10912/OEI-03-22-00410.pdf.

[87] *See* U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., A-04-23-09010, MEDICAID AGENCIES MADE MILLIONS IN UNALLOWABLE CAPITATION PAYMENTS TO MANAGED CARE ORGANIZATIONS ON BEHALF OF DECEASED ENROLLEES 6–8 (2025), available at https://oig.hhs.gov/documents/audit/11433/A-04-23-09010.pdf.

Medicaid program integrity, many of which remain outstanding.[88] These recommendations span the challenge areas identified above: provider enrollment and screening, service verification, managed care oversight, and data infrastructure.[89] Implementing them would strengthen fraud prevention without requiring new legal authorities. The roadmap exists; the task is execution. Congress can accelerate this process through sustained oversight pressure and, where necessary, by mandating implementation timelines.

Second, strengthen managed care accountability. HHS-OIG's 2025 findings on managed care referrals of potential fraud, waste, or abuse[90] should concern this Committee. In 2022, ten percent of plans reported making no referrals of potential provider fraud, waste, or abuse, and another eight percent could not report whether they had made any referrals.[91] Among plans that did refer, more than half made two or fewer referrals per 10,000 enrollees.[92] The same report found that seventy-eight percent of plans shared fraud-referral personnel across lines of business rather than dedicating staff to Medicaid, a notable finding because plans with dedicated staff reported nearly twice the referral rate.[93] It also identified significant process gaps: approximately half of the plans reported receiving no training on the referral process, and fifty-nine percent reported receiving no feedback from states regarding referral quality or volume.[94] Although these findings are Medicaid-specific, the broader point is general: delegated managed care models can diffuse responsibility for program integrity unless referral and accountability pathways are explicit and enforced.

In a delegated system, oversight depends on basic visibility into whether required safeguards are operating as intended. A low referral rate does not prove that a plan is inactive internally, but it is a warning sign that the detection and escalation pathway may not be functioning reliably or may not be well integrated into operations Because Medicaid managed care is administered through contracts, this is primarily a contract oversight issue: state requirements, training, and feedback mechanisms shape whether referrals are made and whether they are usable for state action. The objective is not to increase referral volume, but to ensure a consistent, auditable process that surfaces credible leads and routes them for appropriate review.

Congress should treat these findings as evidence of material inconsistency and gaps in the plan-to-state referral pipeline that warrant structural reinforcement. Congress need not prescribe every metric, but it can require standardized definitions and baseline reporting to ensure performance is comparable across plans and states and to trigger

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[88] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-107743, *supra* note 13; *High Risk List*, U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/high-risk-list (last visited Feb. 1, 2026); *Recommendations Tracker*, U.S. DEP'T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., https://oig.hhs.gov/reports/recommendations/tracker/?view-mode=report-grouped&hhs-agency=all (last updated Jan. 15, 2026).

[89] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., GAO-25-107743, *supra* note 13.

[90] U.S. DEP'T OF HEALTH & HUM. SERVS. OFF. OF INSPECTOR GEN., OEI-03-22-00410, *supra* note 86.

[91] *Id.* at 5.

[92] *Id.* at 5–6.

[93] *See id.* at 7.

[94] *Id.* at 8.

targeted review when reports show zero referrals or an inability to report referral activity. Plans should maintain program-integrity governance commensurate with enrollment and risk, and report referral activity and basic outcomes, including disposition, using common definitions. States should provide routine training and feedback and treat repeated breakdowns in the referral pipeline as a contract-management issue. CMS should monitor these indicators across states and follow up where the data suggest that referral pathways may not be operating reliably. CMS's managed care fraud-referral toolkit already points states toward these steps, including training plan personnel and reinforcing prompt referral expectations.[95]

Third, continue investment in data analytics and the infrastructure that supports it. Federal health program integrity depends on timely, interoperable data, reliable provider and beneficiary identifiers, and the capacity to link claims, enrollment, and utilization data across programs and contractors. Whether the government is using analytics to flag anomalies or technology-enabled prior authorization to focus review on higher-risk services,[96] these tools are only as good as the underlying data and operational infrastructure, including data quality, access, and governance.

Fourth, preserve *qui tam* authority. The FCA's *qui tam* provisions account for the majority of FCA recoveries, including $5.3 billion of the $6.8 billion in settlements and judgments in FY2025.[97] A constitutional challenge to these provisions (*United States ex rel. Zafirov v. Florida Medical Associates, LLC*[98]) currently pending in the Eleventh Circuit could significantly impact the government's ability to detect healthcare fraud. Given the central role of *qui tam* relators in surfacing misconduct, Congress should preserve strong whistleblower incentives.

Fifth, protect independent oversight capacity. Oversight is far less effective when independence is weakened, leadership continuity is disrupted, or coordinating bodies such as the Council of the Inspectors General on Integrity and Efficiency (CIGIE) are not adequately supported.[99] The Inspector General community has repeatedly demonstrated a high return on investment, including an estimated $18 in savings for every dollar spent in FY2024.[100] Protecting that investment requires preserving IG

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[95] CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AND CHIP MANAGED CARE PROGRAM INTEGRITY TOOLKIT: 42 CFR 438 SUBPART H PROMPT REFERRALS OF POTENTIAL FRAUD, WASTE, OR ABUSE § 438.608(A)(7) 6–7 (2025), available at https://www.cms.gov/files/document/managed-care-fraud-referral.pdf.

[96] *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., *CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare*, CMS.GOV (June 27, 2025), https://www.cms.gov/newsroom/press-releases/cms-launches-new-model-target-wasteful-inappropriate-services-original-medicare.

[97] Press Release, U.S. Dep't of Just., Off. of Pub. Affs., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), available at https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025.

[98] *See United States ex rel. Zafirov v. Florida Medical Associates, LLC, et al.*, No. 24-13581 (11th Cir. 2025).

[99] 5 U.S.C. § 424(a)(2).

[100] *See* COUNCIL OF THE INSPECTORS GEN. ON INTEGRITY & EFFICIENCY, ANNUAL REPORT TO THE PRESIDENT AND CONGRESS: FISCAL YEAR 2024 1, 7 (2025), available at https://www.ignet.gov/sites/default/files/files/CIGIE%20Annual%20Report%20to%20the%20President%20FY

independence, minimizing leadership gaps, and ensuring that CIGIE and the IG community have stable funding and the ability to publish findings transparently. This is ultimately a design issue. Oversight deters fraud only when it is credible, continuous, and protected from undue interference.

VII. Conclusion: Modernizing the Fraud-Fighting Toolkit

Medicare and Medicaid fraud are serious problems that warrant the Committee's attention.

A point I have consistently emphasized in my scholarship bears repeating here: no entity is immune to misconduct.[101] The question is not whether fraud will occur (it will), but whether the oversight architecture can prevent avoidable losses, identify actionable leads, and impose consequences that deter future misconduct.

Recent enforcement results underscore the continued value of independent oversight, coordinated enforcement, and tools such as the False Claims Act. But enforcement alone cannot replace verification. As delivery models shift and fraud schemes adapt, oversight must keep pace at points where payment often outpaces verification: provider enrollment and ownership transparency, high-volume services that are difficult to verify, and managed care arrangements in which detection and referral responsibilities are diffuse.

The reforms I have recommended are pragmatic. Even so, fraud schemes evolve. As enforcement closes one avenue, bad actors seek others. This dynamic requires continuous adaptation of oversight tools and priorities, along with sustained investment in the institutions that enable prevention, detection, and response.

Thank you for the opportunity to share these thoughts.

2024_FINAL.pdf ("With the OIG community's aggregate FY 2024 budget of approximately $3.9 billion, these monetary accomplishments represent an approximate $18 return on every dollar invested in OIGs.").

[101] *See, e.g.*, Jessica Tillipman, *United States*, in Routledge Handbook of Public Procurement Corruption 519–20 (Sope Williams & Jessica Tillipman eds., 2024).