



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

**Testimony Before the
United States House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

***Insights From the HHS Inspector General on
Oversight of Unaccompanied Minors,
Grant Management, and CMS***

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 today regarding insights from our oversight of HHS's Unaccompanied Children (UC) Program, grants management with a focus on National Institutes of Health (NIH) grants, and the Centers for Medicare & Medicaid Services (CMS), including unwinding the COVID-19 public health emergency (PHE).

INTRODUCTION

The Office of Inspector General at HHS (HHS-OIG) is at the forefront of the Nation's efforts to fight fraud, waste, and abuse. We provide independent, objective, evidence-based oversight and conduct criminal, civil, and administrative investigations of fraud and misconduct to protect and strengthen HHS programs. As mandated by the Inspector General Act, HHS-OIG's nearly 1,600 dedicated professionals are laser focused on preventing and detecting fraud, waste, and abuse, and promoting the economy, efficiency, and effectiveness of HHS's more than 100 health and human services programs.

HHS-OIG's oversight portfolio is vital, vast, and varied. In fiscal year (FY) 2022, HHS-OIG was responsible for oversight of more than \$2.4 trillion in HHS expenditures. HHS is the Federal Government's largest grant-making agency and the fourth largest contracting agency, with obligations of \$126.6 billion in non-CMS grants (\$740.3 billion in total grants including CMS) and \$38.9 billion in total contracts obligated in FY 2022. With a FY 2023 enacted budget of \$432.5 million, OIG has about 2 cents to oversee every \$100 of HHS spending. Of note, from 2020 through 2022, HHS was appropriated more than \$462 billion for COVID-19 pandemic response programs, including \$186.5 billion for the Provider Relief Fund. HHS-OIG received \$19 million in supplemental funding to oversee these funds.

HHS's wide-ranging programs provide health insurance for seniors, disabled persons, and low-income individuals and families; operate and subsidize private market health insurance; support public health; respond to emergencies; protect the safety of food and medical products; promote the well-being of children and other vulnerable populations; provide health care to American Indians and Alaska Natives; address mental health; combat substance abuse; and fund medical research, among other activities. OIG's oversight is meant to protect these HHS programs that touch the lives of virtually every American.

Through independence, objectivity, and transparency, and by holding wrongdoers accountable, HHS-OIG's mission-critical work helps ensure that HHS programs better serve the American people and that taxpayer dollars are properly spent. OIG's data-driven findings and actionable recommendations help ensure that HHS programs effectively and efficiently achieve their goals for the people they serve and deliver value to taxpayers.

OIG's statistical accomplishments and return on investment provide a snapshot of our work in preventing, detecting, and combating fraud, waste, and abuse. In FY 2022, HHS-OIG's work resulted in approximately \$2.7 billion in expected investigative recoveries and 1,446 criminal and civil actions. HHS-OIG excluded 2,332 untrustworthy individuals and entities from

participation in Federal health care programs, including those convicted of patient abuse, neglect, and fraud. We issued more than 150 reports that included 445 new recommendations to strengthen HHS programs. Last year, our audit work identified nearly \$1.2 billion in expected recoveries as well as nearly \$2.2 billion in questioned costs. HHS operating divisions implemented 424 prior recommendations. HHS-OIG's work consistently yields a positive health care return on investment of around \$11 returned to every \$1 invested, including expected and actual recoveries of funds to HHS programs.

My testimony will focus on the three important topics about which you have invited me to testify: unaccompanied minors (also known as unaccompanied children); grants management, with a focus on NIH grants; and CMS, including unwinding of the COVID-19 PHE.

KEEPING CHILDREN SAFE: UNACCOMPANIED CHILDREN

Overview of OIG Oversight of the Unaccompanied Children Program

OIG's oversight of the UC Program is part of our commitment to keeping children safe across HHS programs, including Medicaid, Foster Care, the Childcare Development Fund, and Head Start. The UC Program, which is run by the Administration for Children and Families' (ACF's) Office of Refugee Resettlement (ORR) within HHS, is charged with caring for minors who have no lawful immigration status in the United States and do not have a parent or legal guardian available to provide care and physical custody.

To help ensure that the UC Program keeps unaccompanied children safe and provides required services, OIG has conducted expansive oversight of the UC Program since responsibility for caring for unaccompanied children was transferred to HHS by the Homeland Security Act of 2002. In the past 6 years, we have produced 27 reports and 1 toolkit, based on site visits to ORR-funded care provider facilities, interviews with staff from those facilities and HHS, and reviews of HHS documents and systems, including ORR's case management system, known as the UC Portal.

As our oversight work demonstrates, caring for fluctuating numbers of children entering the UC Program has been a continuing challenge for HHS. Key findings and recommendations from our body of work have highlighted, for example, the need for improving interagency communication and coordination to better prepare for taking unaccompanied children into HHS custody; better planning for sufficient bed capacity; and improved management of influx care facilities and emergency intake facilities. In May 2021, we published a toolkit¹ summarizing key risk areas that require HHS's attention and outlining consequential actions that HHS can take to better ensure the health and safety of unaccompanied children in its care.

Our work has identified concerns with hiring and screening facility employees; ensuring facility safety and security; and reporting and tracking significant incidents. Moreover, our past work has underscored the need for HHS to be prepared to address the medical and mental health needs of unaccompanied children.

¹ Toolkit: Insights From OIG's Work on the Office of Refugee Resettlement's Efforts To Care for Unaccompanied Children, May 2021, OEI-21-00220. Available at <https://oig.hhs.gov/oei/reports/OEI-09-21-00220.pdf>.

In addition, OIG has key law enforcement functions related to the UC Program. We receive and review certain allegations related to the safety of children in ORR's care and custody. We work closely with State and local law enforcement, as well as Federal partners when warranted.

OIG Review of the Emergency Intake Site at Fort Bliss

In September 2022, we published a report, [Operational Challenges Within ORR and the ORR Emergency Intake Site at Fort Bliss Hindered Case Management for Children](#). This report focused specifically on the Fort Bliss emergency intake site (EIS), one of 14 EISs established by ORR between March 2021 and May 2021 in response to a severe shortage of beds in ORR's licensed care provider network and influx care facilities. This review focused specifically on the provision of case management services, given the concerns raised by ORR staff, child welfare agencies, and members of Congress.

Our report found that from the opening of the EIS at Fort Bliss in March 2021 through June 2021, operational challenges within ORR and at the Fort Bliss EIS hindered case management, raising concerns related to children's safety and well-being. First, ORR and facility staff reported that the rushed opening of the Fort Bliss EIS impeded ORR's ability to bring in experienced case managers and provide them with adequate and timely training.

Second, we identified concerns related to the safe release of children. Specifically, ORR issued guidance to expedite children's release, which removed several safeguards from ORR's process for screening potential sponsors. For example, for sponsors who are an unaccompanied child's parent, guardian, or close relative, guidance eliminated the need to conduct background checks of sponsors' adult household members. Although the purpose of the guidance was to reduce delays, the removal of these safeguards may have increased children's risk of release to unsafe sponsors. As noted in the report, although ORR must ensure that children do not experience unnecessary delays in release, it must also ensure that children are safely released to thoroughly vetted sponsors. Further, we noted that deficiencies with ORR's online case management system—the UC Portal—contributed to case management delays and potentially increased children's risk of release to unsafe sponsors. Finally, we heard from staff that they were reticent to report problems for fear of retaliation.

We recommended that ACF assist ORR in taking a range of actions, including securing qualified case managers during an influx, providing case managers with timely and comprehensive training and support, and creating an emergency policy development protocol that provides for adequate staff input. ACF concurred with our recommendations.

However, much more remains to be done to protect children in the UC Program, which is why oversight of the UC Program is a continuing priority for HHS-OIG. We have work underway examining sponsor screening in greater depth. We also have ongoing work looking at ACF's awarding and monitoring of contracts, employee background checks, facility placements and transfers, and cybersecurity controls to protect the UC Portal. We remain steadfast in our dedication to doing all we can to ensure that UC Program is operating as intended and with the best interests of children at the forefront.

PROTECTING TAXPAYER INVESTMENTS: GRANTS MANAGEMENT

Overview of OIG Oversight of Grants Management

HHS is the largest grant-making agency in the United States. OIG oversight helps ensure that the substantial amount of taxpayer dollars awarded through HHS grants is used in accordance with Federal requirements and that HHS programs effectively and efficiently serve the people who depend on them. OIG has identified risks to HHS grants, including fraud, unallowable costs charged to HHS programs, and inadequate systems of internal control to provide reasonable assurance that the grant recipient is managing the award in compliance Federal requirements.

Fraud is intentional deception for personal gain or to cause harm. In grant programs, fraudsters may lie, cheat, and steal. For example, fraudsters may falsify information in award applications, lie about the work they performed, or misuse grant funding. Grant fraud can be hard to identify for a multitude of reasons, including that fraudsters scheme to keep their actions undetected, fraud schemes can be complex and difficult to unravel, and grants are usually governed by complex terms and conditions.

Effectively fighting grant fraud requires sustained resources focused on preventing problems from occurring in the first place, detecting problems promptly when they occur, and rapidly remediating detected problems through investigations, enforcement, and corrective actions. In coordination with the Department of Justice and HHS, as appropriate, OIG pursues criminal actions, civil fraud remedies, and administrative actions to combat misuse of grant funds, help restore stolen funding, prevent bad actors from continuing harm, and deter future fraud.

Unallowable costs are costs that do not comply with regulations or are excessive, unreasonable, or unsupported. Across our work, OIG has commonly identified unallowable charges to HHS grants for salary, travel, donations, supplies, construction and renovation, and rent. In addition, HHS recipients have improperly used funds to pay for expenditures unrelated to the grant or for personal purposes. We have found that some grant recipients lack robust financial management systems, did not always adhere to Federal requirements, and did not maintain adequate documentation of expenditures. OIG has also identified deficiencies in internal controls at the recipient level (e.g., ensuring that grant costs are supported by documentation) and the operating division level (e.g., timely grant closeout).

Identifying and referring bad actors for suspension and debarment when appropriate is an important tool for sound grants management. If bad actors and poor performers are not prevented from receiving additional Federal awards in a timely manner, beneficiaries of grant and other programs may suffer, and taxpayer funds may be misused. A January 2022 OIG evaluation highlighted the importance of the suspension and debarment program to protect Federal programs and funds but identified opportunities to improve the timeliness, efficiency, and effectiveness of the program.² Two recommendations from this report remain open related to improving case management and tracking of referrals and ensuring more consistent senior leadership and sufficient staffing.

Oversight of National Institutes of Health Grants Management

² *HHS's Suspension and Debarment Program Helped Safeguard Federal Funding, But Opportunities for Improvement Exist*, OEI-04-19-00570, January 2022. Available at <https://oig.hhs.gov/oei/reports/OEI-04-19-00570.pdf>.

Since 2019, OIG has increased its oversight of NIH using supplemental funding that Congress has provided specifically to oversee NIH grant programs and operations. HHS-OIG has conducted, and continues to conduct, extensive oversight of NIH programs, with reviews focused on NIH's management of grants, contracts, and operations; award recipients' compliance with Federal requirements; and cybersecurity protections. Our work has highlighted how NIH can make progress by improving fundamental aspects of its grants programs and operations that any grant-making agency should strive to get right.

For example, a recent report that examined monitoring of grants at the NIH and EcoHealth Alliance found that NIH did not exercise rigorous oversight over potentially high-risk research.³ Our January 2023 report, [*The National Institutes of Health and EcoHealth Alliance Did Not Effectively Monitor Awards and Subawards, Resulting in Missed Opportunities To Oversee Research and Other Deficiencies*](#), builds on a larger body of work examining NIH's oversight and monitoring of recipients to ensure that grant funds are appropriately used and managed. Although the type of research and related issues raised by the EcoHealth Alliance grants are complex, many of our findings are about common failures of routine grant oversight, such as failing to follow up on progress reports.

I want to be very clear that our report was not designed to determine whether the research conducted by EcoHealth Alliance, or its subrecipients, involved gain-of-function or led to enhanced potential pandemic pathogens (ePPPs). In addition, our report was not designed address the origins of the COVID-19 virus. Rather, it examined whether and how NIH and EcoHealth Alliance performed essential grants oversight.

Our report found that although NIH established some guardrails, they were not always used effectively to oversee its award to EcoHealth Alliance. We further found that although NIH raised concerns with EcoHealth Alliance that its research could result in the use or creation of certain risky pathogens, NIH did not follow through with better oversight. NIH did not effectively use routine tools, such as annual progress reports, to monitor EcoHealth Alliance. Using its policy discretion, none of EcoHealth Alliance's awards were referred under the Department's HHS P3CO Framework³ specifically established to review research for ePPPs. NIH determined that EcoHealth Alliance's proposed research did not meet specific scientific definitions that required further review by the Department.

In the case of the EcoHealth Alliance grants, NIH took at least one step to implement enhanced oversight. NIH required EcoHealth Alliance to notify NIH immediately of certain research results that might have triggered additional scrutiny of the research. Yet, this guardrail did not work. According to NIH, EcoHealth Alliance's year 5 progress report indicated that EcoHealth Alliance should have provided immediate notification for research that triggered this special reporting condition. However, EcoHealth Alliance never provided such notice.

NIH generally concurred with the audit's nine recommendations to address causes of our findings and ways to improve NIH oversight going forward. The recommendations include improving how NIH staff assess research for review under the HHS P3CO Framework, defining

³ The HHS Framework for Guiding Funding Decisions about Proposed Research Involving Enhanced Potential Pandemic Pathogens (HHS P3CO Framework).

what it means to get immediate notification from a grantee, and implementing enhanced oversight for foreign subrecipients. We recommended that NIH consider referring the Wuhan Institute of Virology (WIV) for debarment by HHS. NIH provided documentation that one recommendation related to recovering unallowable costs is likely implemented and there is evidence that NIH is implementing another recommendation related to ensuring that NIH employees are following NIH internal policy to refer research for review under the HHS P3CO Framework.

The report also includes findings related to EcoHealth Alliance's ability to obtain documentation from WIV. Since 2021, EcoHealth Alliance has been unable to obtain such documentation because WIV is no longer cooperating. This finding raises questions about how to address real challenges with oversight of subrecipients. Our audit recommends that NIH enhance its monitoring, documentation, and reporting requirements to mitigate risks and ensure that NIH can appropriately oversee the use of NIH funds by foreign recipients and subrecipients.

Our report also made six recommendations for EcoHealth Alliance to improve its compliance with NIH grant requirements and its oversight of subrecipients and recommended that EcoHealth Alliance refund certain unallowable costs of approximately \$90,000.

This audit demonstrates the importance of sound grants management. Although it may seem bureaucratic, grants management is a fundamentally important role of NIH and its recipients. It is one way NIH ensures that the public and the scientific community get the benefit of research funded by American taxpayer dollars. It is crucial for potentially high-risk research. With good grants management, NIH can mitigate potential serious risk associated with such research. Although the issues related to specific types of research and science may be complex, improving grants management—getting the basics right—need not be.

PROTECTING HEALTH CARE: CMS

Overview of OIG Oversight of CMS

HHS-OIG's oversight of CMS helps protect health care for more than 150 million individuals who are covered by Medicare and Medicaid, or nearly 45 percent of all Americans, including seniors, individuals with disabilities, low-income families and individuals, and individuals with end-stage renal disease. Effectively and efficiently managing these complex health care programs is a top challenge for CMS. These programs use multiple delivery models; cover a broad array of health conditions, providers, services, settings, and insurance plans; and operate pursuant to intricate statutory directives and regulatory structures. Spending on these programs is massive, totaling more than \$1.6 trillion in FY 2021, with \$875 billion and \$752 billion, respectively, spent on Medicare and Medicaid, the Nation's two largest health insurance programs.

Decades of HHS-OIG enforcement and oversight prove the adage that fraudsters follow the money. Our work reflects the difficulties in reducing errors in claims filing and payment in sprawling, complex programs. CMS's programs rapidly change and evolve, and some programs are administered collaboratively with States and private insurance companies. The complexity, breadth, and rapid change in CMS programs make effective oversight complex, challenging, and resource intensive.

In short, CMS's responsibilities are broad, with correspondingly critical needs for rigorous oversight and enforcement. Approximately 80 percent of OIG's resources are appropriated for oversight of CMS. We target prevention of problems in the first instance, prompt detection when problems occur, and rapid enforcement when problems rise to the level of fraud or abuse. OIG work examines how CMS programs are designed and whether they achieve their goals, such as cost-effectiveness and quality of care. We identify harmful behavior (e.g., upcoding, stinting on care, or misreporting of data). Our work consistently shows that program risks in Medicare and Medicaid can have huge impacts on enrollees and their access to necessary care and potentially result in improper payments that cost taxpayers hundreds of millions of dollars.

OIG's oversight of the Medicare Advantage program is a key example. Over the past 10 years, Medicare Advantage enrollment has increased significantly. It now covers more than 30 million Medicare enrollees and is expected to cover 50 percent of all enrollees soon. Rapid expansion has come with growing pains that have strained managed care program integrity and highlighted compliance weaknesses in managed care plans. For example, OIG's audits, evaluations, and investigations have examined aspects of Medicare Advantage risk adjustment, including potentially inflated payments to plans and concerns that plans' risk adjustment data indicate enrollees with serious medical conditions may not be receiving needed care. Our work has also raised concerns regarding improper denials of Medicare covered services. Our work demonstrates that risks of fraud, waste, and abuse in managed care are real and significant. These risks not only threaten the financial integrity of Medicare, but also potentially affect enrollees' health care.

OIG's broad portfolio of CMS oversight includes work aimed at improving nursing home care; protecting people from abuse and neglect in institutional settings; identifying misspent funds and reducing improper payments; improving hospice and home and community-based services; improving quality of care; combating the opioid crisis; increasing equitable access to needed treatment and services, including for substance abuse and serious mental illness; reducing spending on prescription drugs; ensuring effectiveness of new technologies; and strengthening program integrity. Although our oversight is extensive and we continue to improve our efficiency with modern data tools and approaches, our capacity is not commensurate with all that should be done to provide effective oversight of Medicare and Medicaid.

Combating Fraud and Abuse in Medicare and Medicaid

Across Medicare and Medicaid, HHS-OIG is aggressively combating fraud and abuse to protect taxpayer dollars from theft and misuse and to protect patients from harm. Combating fraud in Medicare and Medicaid has been a longstanding and continuing challenge. Pinpointing the total amount of health care fraud is difficult. According to research estimates, between 3 percent and 10 percent of total health care spending in the United States—roughly \$129 billion to \$430 billion—is lost to fraud each year.⁴

Twenty years ago, most types of fraud were geographically limited and often used false storefronts, direct mail campaigns, and local television ads. More recently, OIG and our law enforcement partners have seen health care fraud schemes that use sophisticated telemarketing

⁴ *Journal of the American Medical Association*, [Waste in the US Health Care System: Estimated Costs and Potential for Savings](#); [Eliminating Waste in US Health Care](#); and Federal Bureau of Investigation, 2009 Financial crimes report (available at <http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009>).

scams and other methods to expand the reach of the fraud. These schemes are designed to maximize the scale of fraud, be efficient and fast moving, and generate higher returns. By manipulating technology, fraudsters can take a local scheme, make it active in all 50 States, and sometimes involve criminals operating internationally.

For example, in an enforcement action dubbed Operation Double Helix, OIG, the Department of Justice, and other law enforcement partners took swift action to disrupt one of the largest fraud schemes in history, involving more than \$1.4 billion in suspect billing. Fraudsters deliberately targeted Medicare patients and expensive genetic cancer tests, for which Medicare typically paid between \$10,000 to \$18,000 per test. A combination of aggressive telemarketers, sham telemedicine companies, doctors, and laboratories worked together to operate this scheme nationwide. The investigation started when OIG received a tip. OIG's subsequent data analysis found what appeared to be an excessive amount of billing for expensive genetic cancer tests. Boots-on-the ground agents followed up on these data to uncover the underlying fraud. Just 9 months after receiving the tip, OIG and our law enforcement partners took action against 35 defendants to shut down this scheme.

Operation Double Helix demonstrated the dramatic difference in fraud-fighting speed from just 5 or 6 years ago. These faster efforts also have a deterrent effect. In the 3 months after this operation, there was a 35-percent reduction in billings for the affected genetic cancer tests. The operation was accompanied by the publication of a Special Fraud Alert to warn the public about the fraud scheme and the aggressive marketing tactics being used.

This is just one example from a large body of OIG's work to fight health care fraud. Each year, HHS-OIG and our law enforcement partners conduct hundreds of criminal, civil, and administrative investigations of a wide range of conduct that threatens the health and welfare of individuals and the integrity of Federal health care programs. For example, fraud investigations related to Medicare and Medicaid address patient harm, unlawful kickback schemes, submission of false claims for payment, and illegal billing, sale, and diversion of prescription drugs. HHS-OIG conducts investigations regarding organized criminal activity, including medical identity theft and other schemes established for the sole purpose of stealing Medicare and Medicaid dollars. Fraudsters face heavy fines and jail time. OIG has and uses its authority to exclude convicted perpetrators and other untrustworthy actors from participation in Federal health care programs.

Investigating fraud is not HHS-OIG's only tool to combat fraud. Detecting program integrity risks in new or changing programs helps mitigate potential fraud schemes before they can significantly affect Medicare and Medicaid. For example, OIG assessed fraud and abuse risks associated with the significant increase in the use of telehealth as a covered service in Medicare during the public health emergency. Our report identified 1,714 providers (out of 742,000) whose billing for telehealth services posed a high risk to Medicare. We recommended that CMS provide targeted oversight of such providers to reduce risk. This report and other HHS-OIG oversight work informs policymakers and stakeholders about potential program vulnerabilities so that they can take steps to mitigate the risk of fraud before it becomes a widespread problem.

Unwinding the PHE

HHS faces substantial, ongoing challenges in ensuring accountability for pandemic response funding. In the coming weeks, CMS must be attentive to unwinding certain aspects of its

response to the PHE. CMS must plan for and manage risks associated with termination of the waivers and flexibilities it afforded health care providers and States as they revert to pre-pandemic rules.

OIG has started an audit to examine a potential risk to Medicaid during the unwinding of the PHE: redeterminations of Medicaid eligibility. As a condition for receiving a temporary increase in Medicaid funding as authorized under the Families First Coronavirus Response Act (FFCRA), as amended by the Consolidated Appropriations Act, 2023, States were required to maintain enrollments of most people enrolled in Medicaid as of March 18, 2020, through March 31, 2023. States are beginning the process to redetermine eligibility for millions of people covered through Medicaid and the Children's Health Insurance Program. CMS issued guidance to States to complete redeterminations by the end of 2023. OIG's new work builds on prior OIG audits that identified problems with the accuracy of Medicaid eligibility determinations before the PHE. Problems included human and system errors that resulted in inaccurate eligibility determinations, such as a caseworker not assessing required income documentation and improperly determining an individual eligible, or system errors that prevented a State from verifying information from other Government agencies.

LOOKING FORWARD: KEEPING PACE WITH FRAUD, WASTE, AND ABUSE IN HHS PROGRAMS

Notwithstanding rigorous efforts by OIG and support from Congress, the Administration, and HHS for OIG work and resources, serious fraud, waste, and abuse continue to threaten HHS programs and the people they serve. HHS-OIG lacks a sufficient number of agents to work cases and auditors, data scientists, and analysts to detect trends, outliers, and program vulnerabilities. OIG is turning down between 300 and 400 viable criminal and civil health care fraud cases each year. Each case means unaddressed potential fraud and missed opportunities for deterrence. OIG's Regional Offices reviewed and evaluated more than 1,780 Hotline complaints in FY 2021 and more than 3,562 in FY 2022 that might have developed into viable cases, but we did not have resources to open additional cases. In addition to the cases noted above, last year OIG turned down 648 cases from the major case coordination effort we have with CMS, a nearly 10-percent increase in the percentage of cases declined from the prior year. These uninvestigated cases represent real, potential unchecked fraud and the potential for patients to be put in harm's way.

I do not want to give the impression that we are not addressing serious fraud and abuse. We are, and our statistics and return on investment show it. However, with current resources we cannot keep up with the level of threat to HHS, patients, and taxpayer dollars. Every day we make tough choices on cases and issues to decline. For example, we have declined referrals from the Drug Enforcement Administration for cases tied to the opioid epidemic, including allegations of a physician providing medically unnecessary prescriptions that led to overdose deaths, and hospice fraud cases involving patients receiving false diagnoses of terminal illnesses for which hospice providers received millions of dollars in reimbursement. 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.

The FY 2024 President's Budget requested resources for OIG that, if enacted, would go a long way toward addressing this shortfall, particularly with respect to combating fraud, waste, and abuse in Medicare and Medicaid, for which the President's Budget requests approximately

\$52.5 million in additional funding for OIG in FY 2024. The President's Budget also requests urgently needed funding for oversight of HHS's emergency preparedness and response.

Looking beyond FY 2024, we foresee a need for significant additional resources to oversee other HHS programs, including the UC Program and NIH grant programs I have focused on today, as well as other grant programs operated by NIH, the Health Resources and Services Administration, ACF, and other agencies. Current funding allows OIG to audit and evaluate only a small portion of HHS grant outlays and limits our ability to hold wrongdoers accountable. Our work consistently demonstrates that rigorous oversight uncovers where HHS's awarding process and its awards are improperly managed, funds are misspent, and health and safety are put at unnecessary risk. The size of HHS grants programs underscores the urgency of uncovering and sealing gaps in integrity.

The massive spending on HHS grants makes them an attractive target for fraud. However, OIG lacks the resources to do essential investigative work in programs with significant fraud risk. Over the past 5 years, there has been a more than sevenfold increase in the number of complaints to OIG's Hotline related to programs other than Medicare and Medicaid that OIG declined to investigate due to lack of resources. With more resources, OIG would better detect and root out fraud in HHS's grant programs, returning stolen money to the American people and enhancing the integrity of HHS programs.

CONCLUSION

I appreciate the opportunity to discuss OIG's mission-critical oversight and enforcement across three important topic areas that well illustrate both the range and complexity of programs HHS-OIG is responsible for overseeing and the broad spectrum of risk areas and actionable recommendations we have identified. 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 in HHS programs. However, at current funding levels, HHS-OIG risks falling behind, unable to keep pace with threats to HHS programs or deliver the volume of oversight and enforcement needed to identify and mitigate risks, protect people from harm, and hold wrongdoers accountable. I look forward to working with the members of this Subcommittee and HHS to continue to address unmet oversight needs for the benefit of the American taxpayers and the people served by HHS programs.

I would be happy to take questions.