Department of Health and Human Services

**Office of Inspector General**

# Semiannual Report to Congress

**April 1, 2025–September 30, 2025**

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# A Message From the Inspector General

I am pleased to submit this *Semiannual Report to Congress*, my first as Inspector General, summarizing the activities of the Department of Health and Human Services (HHS or the Department), Office of Inspector General (OIG) for the 6-month period ending on September 30, 2025. During this period, OIG remained steadfast in its resolve to root out fraud, waste, and abuse and to promote economy, efficiency, and effectiveness in HHS programs and operations.

With a firm grounding in professional standards, OIG's independent, objective oversight delivered important results. OIG stopped brazen health care fraud schemes and held wrongdoers accountable; issued timely reports with reliable findings and actionable recommendations to improve program operations and prevent funds from being misspent; and helped to strengthen patient safety, enhance public health and well-being, and address cybersecurity risks.

Key statistics encapsulate OIG's accomplishments. For fiscal year 2025, the return on the Nation's investment in OIG climbed to $12.70:$1. During this 6-month reporting period, OIG added $2.43 billion to its monetary impact, which cumulatively exceeded $19 billion for the fiscal year. OIG partnered with Federal and State law enforcement in the largest health care fraud takedown in the Department of Justice history, involving more than $14.6 billion in intended losses, an amount that was more than double the previous takedown record.

To fulfill its unique oversight role, OIG leveraged advanced analytic tools and the collaborative skills of its innovative, multidisciplinary workforce, which includes law enforcement agents, auditors, evaluators, attorneys, program analysts, and digital and technology specialists. In doing so, OIG provided decisionmakers with well-informed, data-driven recommendations. Such recommendations from previous OIG work align with provisions in 2025 legislation for Medicaid that are projected by the Congressional Budget Office to result in $265 billion in savings over 10 years. These recommendations address duplicate enrollment, payments for people who are deceased, a reduction of excess payments, eligibility redeterminations, and health care provider taxes.

In my new role, I am committed to using OIG's investigative oversight tools and authorities to help ensure that HHS delivers the high-quality programs and services that are implemented in compliance with requirements and congressional intent and operate free from fraud, waste, and abuse. I appreciate the continued support of Congress and HHS for OIG's important work.

/s/

T. March Bell
Inspector General

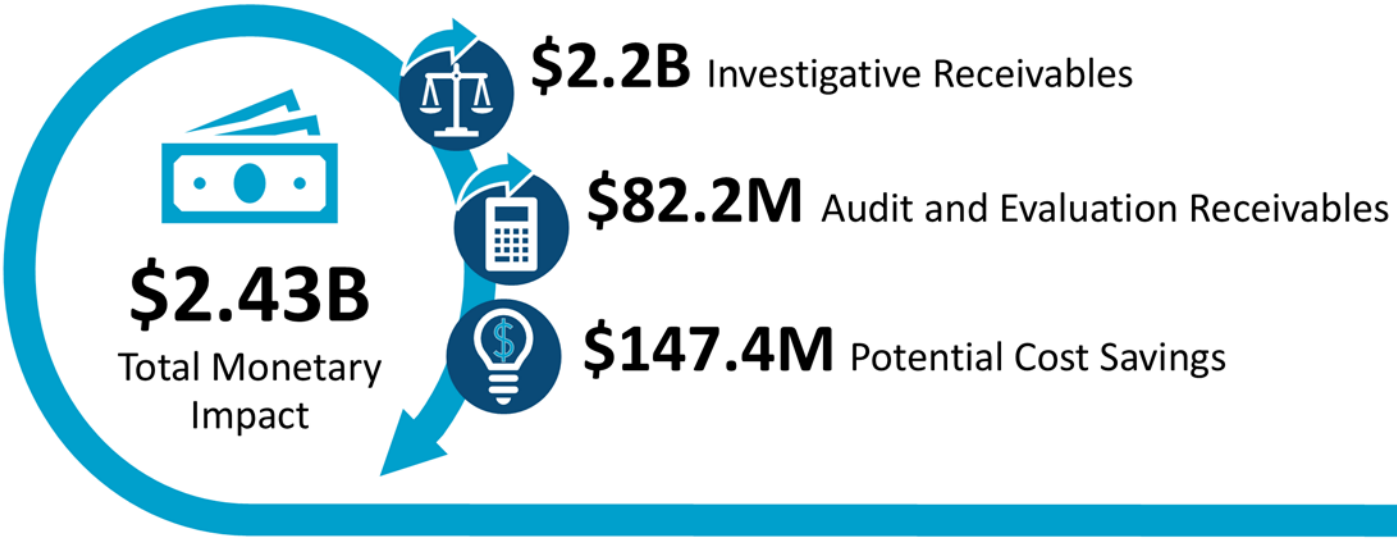
At a Glance:

# OIG Accomplishments

April 1, 2025–September 30, 2025

## MONETARY IMPACT*†

**OIG's work returns $12.70 in expected recoveries and receivables for every $1 invested.**




## OVERSIGHT ACTIVITIES

**94** Reports Issued

**195** Recommendations Issued

**909** Investigations Completed

**165** Recommendations Implemented

## ENFORCEMENT ACTIONS

**1,336** Excluded Individuals and Entities

**440** Criminal Informations and Indictments

**1,451** Criminal Referrals

**352** Criminal Actions

**481** Civil Actions

*Totals in appendices may differ and numbers in figures may not sum due to rounding.

†See Appendix F for an explanation of terms.

# Introduction

The Inspector General Act of 1978 (codified at 5 U.S.C. chapter 4), as amended, requires that the Inspector General report semiannually to the head of the Department of Health and Human Services (HHS or the Department) and to Congress on the activities of the Office of Inspector General (OIG). This fall 2025 semiannual report is intended to keep the Secretary and Congress fully informed of significant oversight work completed during the reporting period (April 1, 2025–September 30, 2025). To do so, this report highlights and summarizes select examples of significant oversight and enforcement actions completed during the reporting period. The report appendices also provide comprehensive data related to all of OIG's work completed in this reporting period, including a full list of OIG audits and evaluations issued to HHS.

For more information about all of OIG's work and accomplishments, please visit:

- OIG's website: Includes the full breadth of OIG's oversight and enforcement work, including all reports available by issue area and HHS agency
- OIG's Recommendations Tracker website: Includes all OIG recommendations to improve Department programs and reduce vulnerabilities, including those OIG has identified as top unimplemented recommendations
- OIG's Enforcement Actions website: Includes all criminal, civil, or administrative legal actions relating to fraud and other alleged violations of law that OIG and its law enforcement partners have initiated or investigated

# 1 | Combating Health Care Fraud

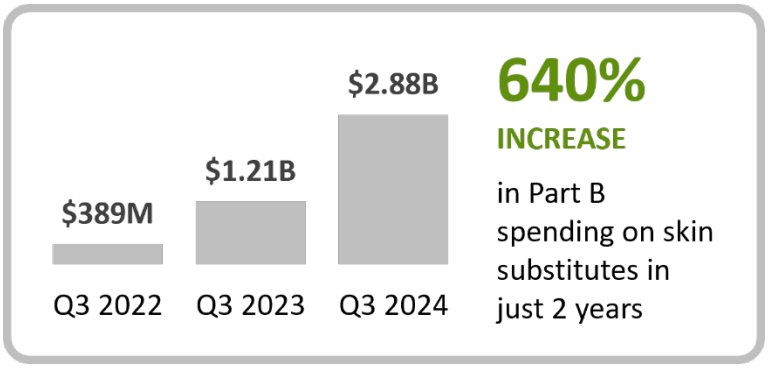
Millions of American seniors, individuals with disabilities, individuals in low-income households, and individuals with diseases and other complex health needs rely on Medicare and Medicaid for health care coverage. Given the importance of Medicare and Medicaid, protecting these programs from fraud, waste, and abuse is a critical priority. OIG is the leading Federal agency focused on combating health care fraud. OIG works in every State and actively coordinates with the Department of Justice (DOJ) and other Federal, State, Tribal, and local law enforcement agencies. OIG's ability to fight fraud is possible because of cutting-edge technology and the specialized skills of investigators, auditors, evaluators, data scientists, attorneys, and other experts.

## Preventing and Detecting Potential Fraud

A key aspect of combating fraud involves preventing or stopping fraud schemes before they escalate. OIG uses advanced data analytics to detect alarming trends that warrant additional followup from HHS programs or investigators. Selected examples are below.

### Skin Substitutes

OIG found that Medicare Part B expenditures for wound care products (known as skin substitutes) provided in noninstitutional settings have skyrocketed over the last 2 years, surpassing $10 billion annually at the end of 2024. OIG also identified several aspects of Part B spending trends that raise serious concerns, such as a massive gap in spending between Part B and Medicare Advantage (OEI-BL-24-00420).



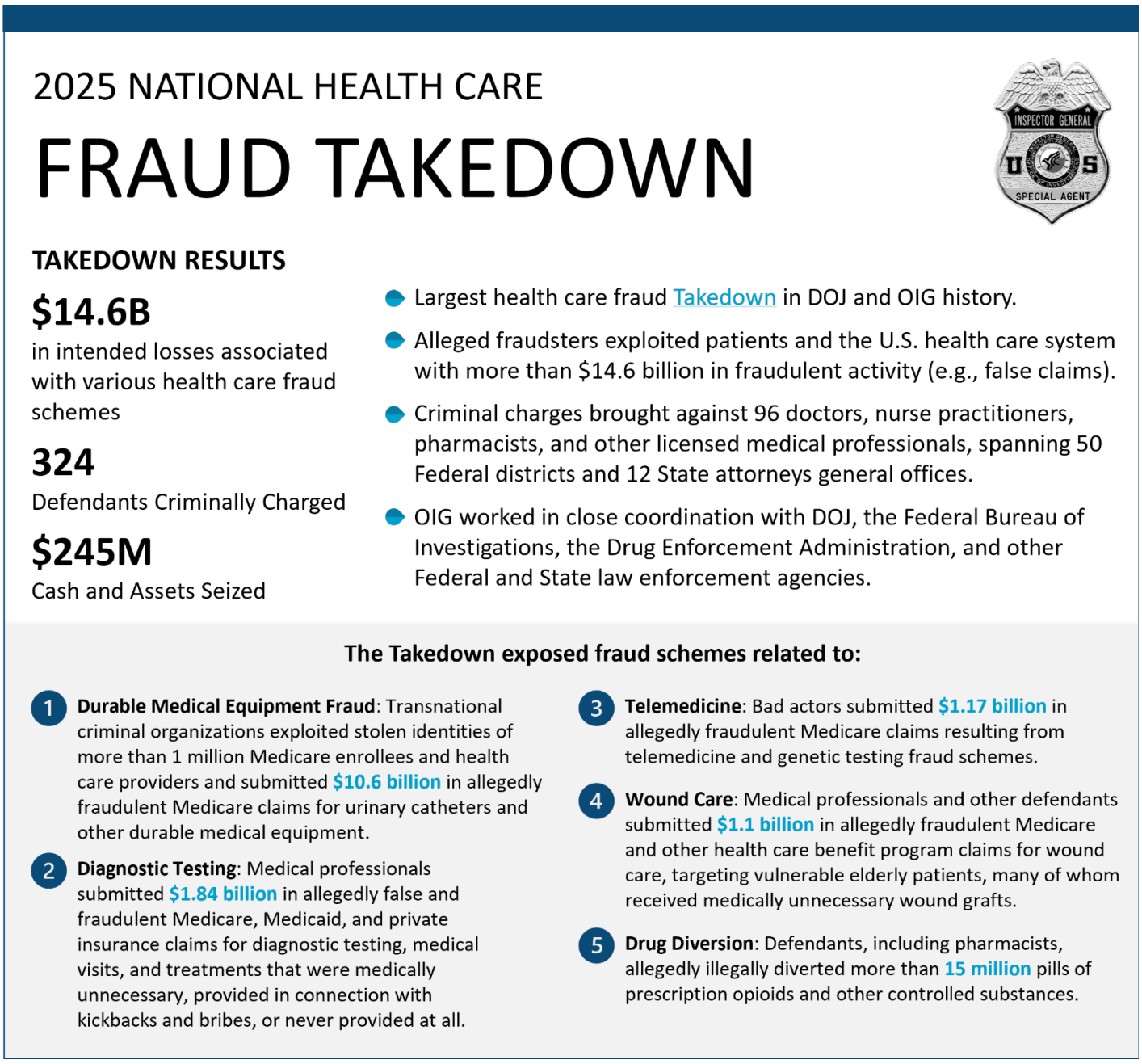

### Remote Patient Monitoring

OIG found that the use of remote patient monitoring (RPM) for Medicare enrollees grew substantially in 2024. For example, payments for RPM totaled $536 million in 2024, which was a 31 percent increase from 2023. OIG developed several measures to monitor billing for RPM, such as billing for a high proportion of enrollees who have no prior history with the medical practice and billing for multiple monitoring devices a month for a single enrollee. These measures, if adopted, can help the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage organizations, and other entities ensure that enrollees receive the benefit of RPM while minimizing program integrity risks (OEI-02-23-00261).

## Enforcement Actions To Address Fraud

OIG exercises its enforcement tools and authorities to ensure that bad actors are held accountable and that misspent and defrauded funds are recovered. OIG's investigations of health care fraud and abuse during this reporting period led to **352 criminal actions,** including convictions. OIG investigations of violations of the civil

False Claims Act led to **481 civil actions,** including civil settlements and judgments. Selected examples are below.




***Marketing Company Operators:*** Two operators of the New Jersey marketing company Empire Pain Center Holdings LLC were sentenced to prison for their roles in conspiracies to commit health care fraud and to pay and receive illegal kickbacks. The pair participated in a scheme with durable medical equipment (DME) companies, telemedicine companies, and doctors to submit false claims to Federal health care programs, including Medicare, based on a circular scheme of kickbacks and bribes. In total, the operators caused the submission of false and fraudulent DME claims to Federal health care programs totaling just more than $127 million.

**CASE OUTCOMES**

- 131 months in prison
- $127.6M in restitution
- $68.5M in forfeitures

***Pharmaceutical Company:*** Gilead Sciences, Inc., a large pharmaceutical manufacturer, entered into a $202 million civil settlement to resolve claims that it offered and paid kickbacks in the form of honoraria payments, meals, and travel expenses to health care practitioners who spoke at or attended Gilead speaker events to induce them to prescribe Gilead HIV Drugs in violation of the anti-kickback statute. This caused false claims for the Gilead HIV Drugs to be submitted to and paid by Federal health care programs in violation of the False Claims Act.

## Program Exclusions

OIG excluded **1,336** individuals and entities from participation in Federal health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded cannot receive payment from Federal health care programs for any items or services they furnish, order, or prescribe. A selected example is below.


***Ordering Provider:*** OIG excluded an individual for a minimum of 38 years based on his role in a health care fraud and kickback scheme involving the sale of fraudulent prescriptions for DME and other medical supplies. This individual and his co-conspirators sold fraudulent prescriptions that were generated using call centers to DME suppliers, pharmacies, and laboratories. The court sentenced the individual to serve 14 months in prison and pay more than $48 million in restitution.

## Medicaid Fraud Control Units

Medicaid Fraud Control Units (MFCUs) are key partners with OIG in the fight against fraud, waste, and abuse in State Medicaid programs. MFCUs investigate and prosecute Medicaid provider fraud, as well as abuse or neglect of residents in health care facilities and board and care facilities and of Medicaid enrollees in noninstitutional or other settings. In fiscal year (FY) 2025, OIG and MFCUs worked together on 1,115 joint investigations. Additionally, our joint work resulted in 168 civil settlements or Civil Monetary Penalty Law outcomes and 245 criminal actions. For information about MFCU accomplishments, including their return on investment of $3.46 for every $1 spent, see our most recent MFCU Annual Report.

## OIG Hotline

OIG investigates tips received through its hotline, which accepts reports from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. During the reporting period, OIG evaluated and processed 32,804 tips leading to 17,609 referrals to entities such as OIG's investigative and legal branches, HHS Operating Divisions, and other Federal agencies. Additionally, during the reporting period, investigations previously initiated through hotline tips resulted in 41 criminal and civil actions associated with expected recoveries of more than $86 million. See Appendix C for additional information on OIG's hotline activity during this reporting period.

# 2 | Strengthening Financial Integrity

## Preventing and Detecting Improper Payments

In FY 2024, CMS reported a range of program-specific improper payment rates from 3.7 percent to 7.6 percent, resulting in an estimated $86.6 billion in payments that either failed to meet legal requirements or were issued in incorrect amounts. OIG's oversight plays a critical role in preventing and detecting improper payments, which can jeopardize the integrity of CMS programs. Selected examples are below.

**Effects of Improper Payments**

Improper payments duplicate other payments, fund ineligible services, enrich ineligible providers, serve ineligible recipients, or violate other program rules.

### Autism Services Payments

Wisconsin's fee-for-service Medicaid payments for applied behavioral analysis increased from $39.9 million in 2018 to $53.7 million in 2022. OIG found that payments for these services provided to children diagnosed with autism did not fully comply with Federal and State requirements, resulting in at least an estimated $18.5 million ($12.2 million Federal share) in improper payments in 2021 and 2022. Wisconsin also made an estimated $94.3 million ($62.3 million Federal share) in potentially improper applied behavior analysis payments during the same period. In addition, session notes that were cloned or otherwise unreliable are an indication that children with autism may not have received the services needed (A-06-23-01002).

**IMPROPER PAYMENTS**

OIG recommended that Wisconsin refund the

**$12.2M**

Federal share of the improper payments

### Provider Relief Fund Payments

OIG found that 11 of 30 reviewed hospitals and 10 of 30 reviewed nursing facilities did not comply or may not have complied with Federal requirements when using Provider Relief Fund (PRF) payments. These funds could have been used to offset allowable lost revenues or to support other activities related to the COVID-19 public health emergency (A-02-22-01003, A-05-22-00012). Overall, OIG found $711.2 million in unallowable expenditures or inaccurately calculated lost revenues reimbursed with PRF payments:

- Ten of thirty reviewed hospitals claimed a total of $63 million in unallowable PRF expenditures.
- Two of thirty reviewed hospitals inaccurately reported $645.6 million in lost revenues.
- Eight of thirty reviewed nursing facilities used $2.3 million in PRF payments for unallowable expenditures or inaccurately calculated lost revenues.
- Three nursing facilities used $333,000 in PRF payments for expenditures that may not have been allowable.

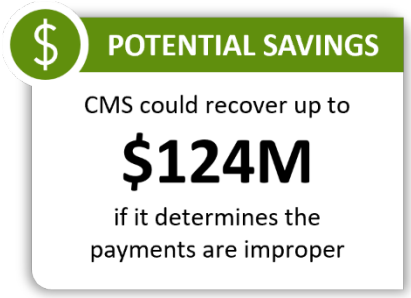
# Fostering Cost-Effectiveness

OIG's audits and evaluations promote efficiency, effectiveness, and accountability across HHS programs, often identifying opportunities for significant savings when its recommendations are implemented. During this reporting period, OIG identified **$147.4 million in potential savings** and issued **195 recommendations** aimed at strengthening program performance and integrity. Selected examples are below.

### Trauma Team Activation Claims and Charges

OIG estimated that approximately 77 percent of all claims submitted to Medicare with trauma team activations from January 2020 through June 2022 did not comply with Federal requirements. OIG also estimated that hospitals billed approximately $2.4 billion in unallowable charges for trauma team activations that did not meet Medicare requirements for the same period. Hospitals followed internal policies that were too broad, resulting in trauma team activation in circumstances when activation was not reasonable and necessary. These unallowable charges may have caused incorrect outlier payments and could potentially result in higher future payments (A-01-23-00500).

### Evaluation and Management Services Payments




OIG found that Medicare payments to providers for evaluation and management services provided on the same day as eye injections were at risk for noncompliance with Medicare requirements. Medicare allows these two services to be billed on the same day in limited circumstances only. For 42 percent of eye injections provided from June 2022 through May 2023, providers also billed for evaluation and management services using a modifier that allowed the claims to bypass system edits designed to prevent improper payments. Medicare paid $124 million nationwide for these services, and enrollees were held responsible for approximately $31 million in coinsurance associated with these services (A-09-23-03014).

# Protecting the Fiscal Integrity of Managed Care

In 2024, Medicare Advantage, Medicare's managed care program, served 32.8 million enrollees and accounted for $462 billion in Medicare spending. Similarly, nearly 72 million Medicaid enrollees received care through managed care organizations (MCOs), with combined Federal and State payments totaling approximately $518 billion. Given the scale of enrollment and expenditures, OIG has prioritized oversight of managed care. This includes conducting comprehensive financial reviews, detecting and preventing fraud within managed care plans, and ensuring payment accuracy. Selected examples are below.

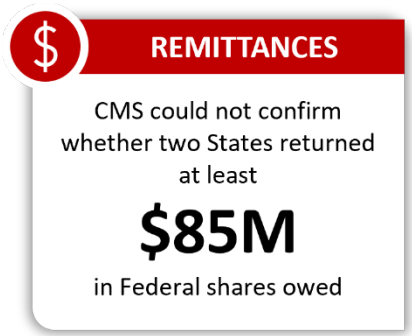
## Medicare Managed Care

### High-Risk Diagnosis Codes

OIG found that most of Coventry Health and Life Insurance Company's submissions of certain high-risk diagnosis codes for use in the Medicare Advantage risk adjustment program did not comply with Federal requirements. Coventry received at least an estimated $6.9 million in overpayments for 2018 and 2019 for certain diagnosis codes with a higher risk of miscoding. This audit was part of a multiyear series of audits reviewing the accuracy of specific diagnosis codes that Medicare Advantage organizations submitted to CMS (A-02-22-01020).

## Medicaid Managed Care

### Medical Loss Ratio Remittances




OIG found that CMS cannot readily determine whether States are returning the Federal shares of Medicaid Loss Ratio (MLR) remittances. States can require managed care plans that do not meet MLR requirements to refund money, at least half of which States must remit to the Federal Government. These remitted amounts can total hundreds of millions of dollars. CMS needs to improve its financial reporting system and its internal communication between staff to ensure that States are appropriately remitting funds owed to the Federal Government (OEI-03-23-00041).

### MCO Payments for Personal Care Assistant Services

OIG found that New Jersey did not ensure that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing personal care assistant services to selected participants of New Jersey's Medicaid Personal Preference Program (PPP), which allows Medicaid participants to remain in their home and active in their community without requiring the use of a home health care agency. Overall, OIG estimated that MCOs paid caregivers $197 million on behalf of PPP participants whose services were not provided in accordance with Federal and State requirements. As a result, the program was vulnerable to misuse of Federal funds, and the health and safety of PPP participants may have been placed at risk (A-02-22-01024).

### MCO Fraud, Waste, and Abuse Referrals

OIG found that 10 percent of Medicaid managed care plans reported that they did not make any referrals of potential provider fraud, waste, or abuse to the State or MFCU in 2022. Of those plans that reported making provider referrals, more than half made 2 or fewer referrals per 10,000 enrollees. As the primary entities responsible for contracting with and paying providers to deliver health care services to enrollees, Medicaid managed care plans are best positioned to identify provider fraud (OEI-03-22-00410).

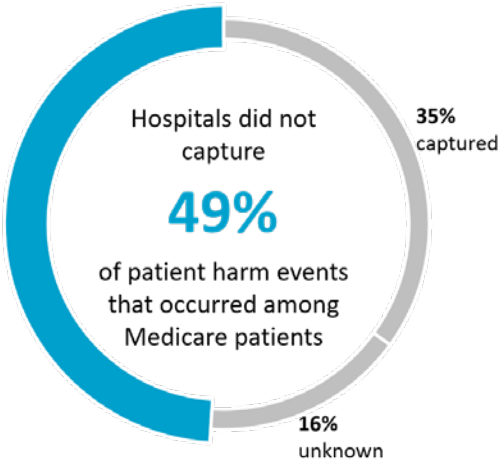
# 3 | Protecting Patients From Harm

Each year, millions of Americans rely on hospitals, nursing homes, and other care facilities for essential health care services. HHS programs play an important role in protecting the health and safety of those Americans, including protecting against patient harm events and hazards in health care facilities. OIG is committed to providing oversight that helps HHS improve its programs and ensure that people receive health care services free from harm, abuse, or neglect. Selected examples are below.

## Fostering Patient Safety

### Hospital Identification of Patient Harm Events

OIG found that hospitals do not identify, investigate, or report many patient harm events, limiting hospital transparency and accountability for harm that occurred in their facilities. For example, hospitals did not capture half (49 percent) of patient harm events that occurred among hospitalized Medicare patients. Our findings illustrate the need for further action to improve hospital identification and response to patient harm (OEI-06-18-00401, OEI-06-18-00402).




### Patient Safety Organization Program

OIG found that after 20 years, the promise of the Patient Safety Organization program, a key provision of the Patient Safety and Quality Improvement Act of 2005, remains unfulfilled. OIG identified key challenges, such as uncertainties around legal protections, that prevent the program from achieving its goal of facilitating patient safety learning and improvement on a national scale (OEI-01-24-00150).

### Safety in Intermediate Care Facilities

OIG found deficiencies that put the health and safety of residents and staff in intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) at an increased risk of injury or death during emergencies such as fires, natural disasters, or infectious disease outbreaks. Previous OIG audits of similar issues at nursing homes identified multiple issues that put residents at risk. In the most recent audits, OIG identified ICF/IIDs that did not have policies and procedures for safe evacuations and staff and client tracking during an emergency, as well as other emergency preparedness deficiencies in Maine, Oklahoma, and North Carolina (A-01-24-00004, A-06-24-09002, and A-04-24-02504).

### Rates at Which Medicare Enrollees Leave Hospitals Against Medical Advice

OIG found that the rates at which Medicare enrollees leave acute-care hospitals against medical advice have steadily increased since 2006, with higher rates of enrollees leaving against medical advice at hospitals with lower quality-of-care ratings. Enrollees with decision-making capacity are empowered to discharge themselves and leave against medical advice; however, the data show that they are more likely to have poor health outcomes, which raises Medicare costs in the future (A-04-24-03003).

# Advancing Nursing Home Resident Safety

In FY 2024, approximately 1.2 million individuals lived in more than 15,000 certified nursing homes. Building on decades of oversight, OIG continues to uncover systemic challenges in nursing home care. When warranted, OIG investigates misconduct that endangers residents' health and safety and pursues enforcement actions against individuals and entities responsible for abuse or neglect. Selected examples are below.

## Enforcement Actions To Address Grossly Substandard Care in Nursing Homes

***Nursing Home Chain:*** A nursing home chain entered into a $4.5 million civil settlement to resolve allegations that some of the nursing homes: (1) violated the False Claims Act by systematically failing to provide services to nursing home residents and/or providing materially and grossly substandard services to nursing home residents; (2) failed to have a sufficient number of appropriately trained staff possessing satisfactory skill levels to adequately care for the residents; (3) failed to take adequate measures to prevent, control, and provide care related to infections; and (4) failed to take adequate measures to prevent and follow appropriate protocols related to resident falls. The nursing home chain entered a 5-year quality-of-care corporate integrity agreement with OIG.

**CASE OUTCOMES**

- 42 months in prison
- 3 years of supervised release
- $8,000 in restitution
- $5,000 in fees

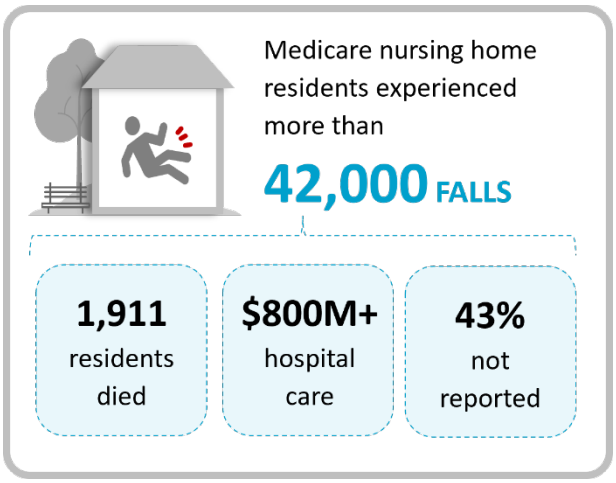
***Nursing Home Nurse:*** A former Iowa nurse was convicted and sentenced to more than 3 years in prison after she pled guilty to one count of acquiring and attempting to acquire a controlled substance by misrepresentation, fraud, deception, or subterfuge. The nurse admitted to burglarizing private residences to steal narcotic pain medications, stealing narcotics from elderly and hospice patients in nursing homes, replacing hydrocodone with Tylenol, and falsifying medical records.

***Senior Living Facility Employee:*** An employee of a senior living facility was excluded from Federal health care programs for a minimum period of 7 years based on her conviction for abuse of a dependent adult. The employee admitted to regularly giving the patient a higher dose of medication (almost 6 times the amount prescribed to the patient) to keep the patient sedated to make the employee's job easier.

## Ensuring Nursing Home Quality of Care

### Preventing Falls Among Nursing Home Residents

OIG found that Medicare-enrolled nursing home residents experienced more than 42,000 falls with major injury and hospitalization over a 1-year period. These falls reduced residents' quality of life and were costly for the Medicare program and enrollees who together paid more than $800 million for the resulting hospital care (OEI-05-24-00181). OIG also found that falls are significantly under-reported, so CMS's Care Compare website does not provide reliable information for residents, their families, CMS, or nursing homes. For example, OIG found that nursing homes failed to report 43 percent of falls with major injury and hospitalization among Medicare-enrolled residents (OEI-05-24-00180).



### Compliance With Staff Background Check Requirements

As part of a series of nationwide audits, OIG found that Alabama and Hawaii did not ensure that selected nursing homes complied with Federal and State requirements that prohibit employment of individuals with disqualifying backgrounds. Effective State oversight of compliance with background check requirements is critical to ensuring the safety of nursing home residents. When nursing homes do not complete background checks as required, there is an increased risk that residents at these nursing homes are vulnerable to employees with a history of disqualifying offenses (A-04-24-08104, A-09-23-02003).

## Enforcement Actions Against Abusive Providers

***Doctor:*** A doctor was excluded for a minimum period of 90 years based on his convictions related to tampering with consumer products and adulteration of drugs in the surgical center where he worked. The doctor injected IV bags of saline with various drugs and waited for the bags to be used in others' surgeries, ultimately leading to one death. The doctor was sentenced to serve 190 years in prison and had his medical license revoked by the Texas Medical Board.


***Rheumatologist:*** A Texas rheumatologist was convicted for perpetrating a health care fraud scheme involving more than $118 million in false claims and payments totaling more than $28 million by insurers as a result of him falsely diagnosing patients with chronic, incurable illnesses to bill for tests and ongoing treatments that the patients did not need. These unnecessary tests and treatments included a variety of injections, infusions, x-rays, MRIs, and other procedures—all with potentially harmful and even deadly side effects. To receive payment for these expensive services, he fabricated medical records and lied about the patients' condition to insurers.


***OB/GYN:*** A suburban Chicago OB/GYN pled guilty to charges related to billing Medicaid and private insurers for nonexistent and unnecessary services. The OB/GYN submitted and caused her employees to submit fraudulent claims to Medicaid and numerous other insurers for procedures and services that were not medically necessary. Some of the procedures were performed without patient consent. The OB/GYN also fraudulently overstated the length and complexity of in-office and telemedicine visits and submitted claims using billing codes for which the visits did not qualify in order to seek higher reimbursement rates. She also prepared false patient medical records to support the fraudulent reimbursement claims.

# 4 | Addressing Public Health Crises

## Combating the Substance Use Disorder Crisis

The overdose crisis remains a pressing national challenge, with nearly 81,000 overdose deaths in 2024 alone. To combat this crisis, OIG works to ensure that the care and treatment that individuals receive is safe and of the highest quality. OIG also ensures accountability for those who commit fraud or engage in harmful conduct such as the unlawful distribution of controlled substances. Selected examples are below.

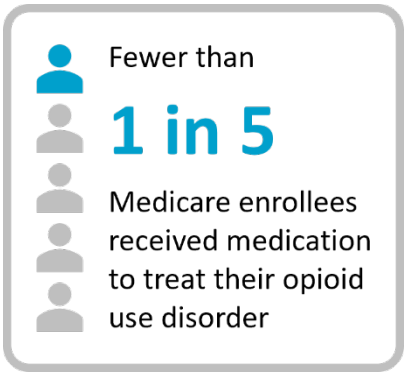
### Substance Use Disorder Treatment Access

#### Gaps in Health Center Services

OIG found that gaps in specific substance abuse treatment services may impede access to comprehensive care at health centers. While most health centers provide some behavioral health services to patients with substance use disorder, only 56 percent offered comprehensive treatment (i.e., mental health treatment, drug counseling, and medications to treat opioid use disorder). For many communities, health centers serve as the primary access point for their health care needs and thus play an important role in national efforts to address substance use disorder (OEI-BL-22-00520).

#### Medication To Treat Opioid Use Disorder

OIG found that Medicare enrollees face challenges accessing essential treatment and medication for their opioid use disorder. For example, in 2023, fewer than one in five Medicare enrollees received medication to treat their opioid use disorder. OIG also found that opioid overdoses among Medicare enrollees slightly increased in 2023, despite a record high number of enrollees receiving opioid overdose-reversal drugs (OEI-02-24-00430).




### Enforcement Actions To Address Illegal Prescribing and Distribution

OIG takes civil, criminal, and administrative actions against individuals and entities that defraud HHS programs by illegally prescribing or distributing opioids and other controlled substances.

***Pharmacy:*** Walgreens entered into a $350 million civil settlement to resolve allegations that the national pharmacy chain illegally filled millions of invalid prescriptions for opioids and other controlled substances in violation of the Controlled Substances Act and then sought payment for many of those invalid prescriptions from Medicare and other Federal health care programs in violation of the False Claims Act. Walgreens entered a 5-year corporate integrity agreement with OIG.


***Clinic Owner:*** The owner of a clinic was excluded for a minimum of 25 years based on a conviction for several counts, including conspiracy to distribute, distribution of controlled substances, and money laundering. The clinic owner and several co-conspirators fraudulently misused a physician identity validation tool to issue false

prescriptions for controlled substances. After issuing the false prescriptions, the owner had the prescriptions filled and then sold the controlled substances to drug traffickers. The court sentenced the owner to serve 180 months in prison.

**CASE OUTCOMES**

- 6 years in prison
- 3 years of supervised release
- Nearly $562K in forfeitures
- $1,100 special assessment

***Physician:*** A Michigan physician who operated a cash-for-prescription opioid scheme through a sham clinic was convicted of conspiracy to unlawfully distribute controlled substances and 10 counts of illegal distribution of opioids, including oxycodone and oxymorphone. This physician issued more than 3,000 prescriptions for more than 200,000 pills to individuals who had no legitimate medical need, earning more than $500,000 in cash during the scheme. The clinic also created fraudulent medical records to support the illegal prescriptions.

# Addressing the Behavioral Health Crisis

The Nation continues to face a behavioral health crisis. In 2024, nearly one in four adults experienced a mental illness, and more than 10 percent of adolescents ages 12–17 reported having serious thoughts of suicide. In response, OIG's oversight promotes access to safe, high-quality care for individuals in need. OIG also takes enforcement action against those who seek to exploit this crisis through fraud schemes that target patients seeking behavioral health care. Selected examples are below.

## Access to Behavioral Health Services

### Behavioral Health Provider Availability

OIG found that Medicare and Medicaid enrollee access to needed behavioral health care is hampered not only by a lack of providers actively serving Medicare and Medicaid enrollees but also by the inability of active providers to treat new patients. For example, OIG found that 45 percent of surveyed behavioral health providers reported that they were not available to treat new patients enrolled in traditional Medicare, Medicare Advantage, and Medicaid managed care. Among the providers who were available to treat a new patient, 24 percent reported appointment wait times of more than 30 calendar days. Timely access to behavioral health services is critical for the well-being of people enrolled in Medicare and Medicaid (OEI-09-21-00410).

### Suicide-Related Followup Care for Children

OIG found most children enrolled in Medicaid did not receive timely suicide-related followup care. For example, in half of the cases of hospitalizations or emergency department visits for suicidal thoughts or behaviors OIG reviewed, children did not receive a followup visit in the week after their discharge—a critical time for intervention. To reduce suicide rates among children, States must implement accessible and effective prevention efforts, including timely followup care for children who exhibit suicidal thoughts or behaviors (OEI-07-23-00510).

## Enforcement Actions Against Behavioral Health Providers

***Intensive Outpatient Treatment Center:*** NUWAY Alliance and related entities entered into an $18.5 million civil settlement to resolve allegations that they compensated Medicaid patients for seeking intensive outpatient treatment in violation of the Federal anti-kickback statute and resulting in false claims. NUWAY also allegedly submitted false claims to Medicaid for intensive outpatient services it had not provided by double billing for the same periods of time. NUWAY entered a 5-year corporate integrity agreement with OIG.


***Rehabilitative Service Providers:*** Two Miami-based individuals were convicted for using a behavioral health clinic to fraudulently bill more than $20 million to Medicare, Medicaid, and private insurers for services—including psychosocial rehabilitation—that were medically unnecessary or never provided. The clinic used fabricated progress notes, often filled with repeated stock phrases and typos, and paid illegal kickbacks to patients to generate claims. Fraud proceeds were used to purchase luxury vehicles, real estate, and investment assets.

# 5 | Advancing Excellence in Health and Human Service Programs

HHS operates more than 100 programs that are designed to enhance and protect the health and well-being of every American. OIG conducts oversight to help ensure that HHS programs perform well by fostering better outcomes and lowering costs. Selected examples are below.

### Grants Payment System Controls

After bad actors fraudulently diverted $7.8 million in grant funds from HHS's Program Support Center (PSC) grant payment system from March 2023 through January 2024, OIG found that PSC did not have effective internal controls to communicate fraudulent activity to PSC leadership, grant awarding agencies, and grant recipients at the time of the fraud. Further, PSC's approach to risk management was siloed and did not address the risk of bad actors gaining access to the payment system (A-18-24-03700).

### Contract Awarding, Monitoring, and Closeout

OIG found that the Administration for Children and Families (ACF) did not comply with Federal requirements when awarding, monitoring, and closing out five contracts awarded in 2021 for the provision of shelter and services for unaccompanied alien children at emergency intake sites. These five contracts, totaling more than $2.8 billion, were awarded on a sole source basis with no competitive bidding. Because of the noncompliance, ACF had $12.6 million in obligated contract funds unavailable for other needs. Further, ACF could have paid prices that were not fair and reasonable and could be liable for future payments to the contractors (A-06-22-07000).

### Sanitation Facilities Construction Program Projects

OIG found that the Indian Health Service (IHS) did not implement controls for identifying which Sanitation Facilities Construction Program projects to fund and did not properly record some projects in the Sanitation Deficiency System with the required documentation. As a result, IHS potentially funded projects that may not be ready for construction for several years, increasing the risk that funds may be lost or misused (A-05-22-00021).

### Domestic Food Facility Inspections

OIG found gaps in the Food and Drug Administration's (FDA's) domestic food facility inspections that are intended to help ensure the safety of the Nation's food supply. For example, OIG found FDA did not inspect many facilities within the required timeframes and is not inspecting enough facilities to meet the timeframes in the future. Without increasing efforts to inspect food facilities and meet required timeframes, FDA cannot identify harmful conditions and prevent facilities from producing and distributing unsafe food (OEI-02-23-00300).

# 6 | Strengthening Cybersecurity

HHS faces persistent cybersecurity threats that exacerbate challenges related to how the Department uses data and technology essential to accomplishing its mission. OIG provides critical oversight of the Department's cybersecurity, focusing on protections for information systems and technology that store or use sensitive and mission-critical data. Selected examples are below.

## Cybersecurity Risks to Genomic Data

OIG found that the National Institutes of Health (NIH) did not communicate the national security concerns and increased risks associated with maintaining genomic data to the award recipient that manages the Data and Research Center, which houses the All of Us Research Program participant data. OIG identified issues that increased the risk of bad actors gaining unauthorized access to the information systems and being able to download and misuse the genomic data of All of Us participants (A-18-24-06111).

***Transnational Criminals**:* Two defendants were found guilty and each sentenced to 40 years in Federal prison for conspiring to commit wire fraud and money laundering. The defendants were part of a transnational organized crime syndicate that defrauded vulnerable individuals, companies, and Government entities, including HHS and its programs, out of approximately $17 million by employing various fraud schemes, social engineering cyberattacks, and other internet scams. They then laundered the money through a network of various bank accounts and sent money to bank accounts, co-conspirators, and businesses located in Africa and Asia.

## Oversight of Contractor Cybersecurity

OIG found that, for 14 reviewed HHS information and communications technology service contracts, 4 contractors reported 10 cybersecurity incidents, but 2 of the 4 did not report an identified cybersecurity incident to HHS within the required timeframe. In addition, 8 of the 14 reviewed contracts did not include required language regarding reporting of all suspected or confirmed cybersecurity incidents and breaches. As a result, HHS may not have been aware of cybersecurity incidents or breaches of a contractor's system and may not have been provided an early opportunity to take action to mitigate potential risk to HHS (A-18-22-06100).

# OIG Impact From Recommendations

## April 1, 2025–September 30, 2025

In keeping with the mandates of the Inspector General Act and to drive positive change, OIG provides HHS with data-driven findings and actionable recommendations. OIG-issued recommendations, when implemented, result in both monetary and nonmonetary benefits. The recommendations issued during this reporting period identified $836.5 million in questioned costs (including $93.4 million in unsupported costs) and $147.4 million in funds put to better use.

### RECOMMENDATIONS ISSUED

| | |
|---|---|
| 94 | Preventing, detecting, and deterring fraud, waste, and abuse |
| 23 | Fostering sound financial stewardship and reducing improper payments |
| 6 | Holding wrongdoers accountable and recovering misspent public funds |
| 21 | Fostering quality, safety, and value of HHS-funded services |
| 34 | Promoting public health and safety |
| 17 | Supporting high-performing health and human services programs |

**OIG issued**

**195**

**recommendations that identified**

**$983.9M**

**in questioned costs and funds put to better use**

### RECOMMENDATIONS IMPLEMENTED

| | |
|---|---|
| 98 | Preventing, detecting, and deterring fraud, waste, and abuse |
| 18 | Fostering sound financial stewardship and reducing improper payments |
| 6 | Holding wrongdoers accountable and recovering misspent public funds |
| 6 | Fostering quality, safety, and value of HHS-funded services |
| 15 | Promoting public health and safety |
| 22 | Supporting high-performing health and human services programs |

**HHS and non-HHS entities implemented**

**165**

**recommendations that saved**

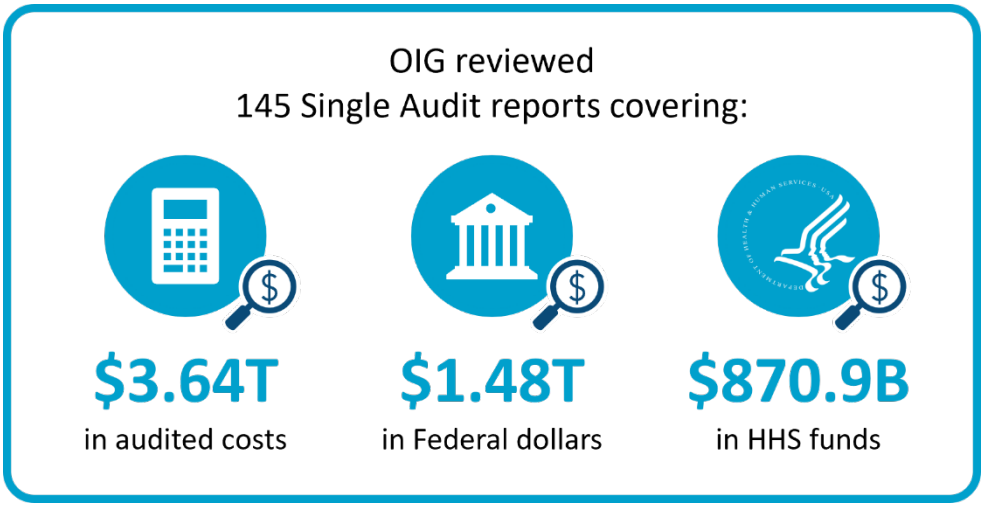
**$9.5M**

# Additional OIG Activities

## Single Audits

OIG conducts oversight of Single Audits—organizationwide audits of non-Federal entities' financial statements and expenditures of Federal awards—to monitor how recipients are using Federal funds for HHS programs. By working to improve the quality of Single Audits, OIG provides assurance to the public that taxpayer dollars are being safeguarded and spent for their intended purposes, resulting in millions of Americans receiving improved health care and human services. See below for the number of Single Audits OIG reviewed during the reporting period, as well as the amounts those Single Audits covered. Read more on OIG's Single Audits website.

**Single Audits (April 1, 2025–September 30, 2025)**




## Whistleblower Retaliation

OIG substantiated one complaint from a whistleblower who reported wrongdoing associated with HHS-funded programs and services and was retaliated against because of it. Read more about this complaint here and more about OIG's Whistleblower Protection Coordinator role here.

# Appendix A: Audits and Evaluations

The following table summarizes OIG's audit and evaluation reports issued during the reporting period, including, if applicable, the associated questioned costs, funds put to better use, unsupported costs, and whether a management decision was made during the reporting period.[1] During the reporting period, OIG identified **$836.5 million in questioned costs**, **$147.4 million in funds put to better use**, and **$93.4 million in unsupported costs**. See Appendix B for more detail about reports with questioned costs and funds put to better use. Note that OIG has not yet received management decisions for most reports listed below because those decisions are not due to OIG until 6 months following the issuance of a report.

**Table 1: Audit and Evaluation Reports Issued (April 1, 2025–September 30, 2025)**

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| **Administration for Children and Families (ACF)** | | | | |
| *Minnesota Could Better Ensure That Childcare Assistance Providers Comply With Attendance Requirements* (A-05-24-00001), May 2025 | - | - | - | - |
| *Michigan Did Not Effectively Monitor Home Heating Benefits Provided Under the Low-Income Home Energy Assistance Program* (A-01-22-02502), June 2025 | $27,027 | - | $264 | - |
| *ACF Did Not Monitor States' Compliance With All American Rescue Plan Child Care Stabilization Grant Provisions* (A-02-23-02007), August 2025 | - | - | - | - |
| *ACF Did Not Award, Monitor, and Close Selected Contracts for the Unaccompanied Alien Children Program in Accordance With Federal Requirements* (A-06-22-07000), September 2025* | - | - | - | - |
| *West Virginia Did Not Comply With Intake, Screening, Assessment, and Investigation Requirements for Responding to Reports of Child Abuse and Neglect* (OAS-25-01-011), September 2025 | - | - | - | - |
| **Administration for Community Living (ACL)** | | | | |
| *Risk Assessment of the Administration for Community Living's Purchase Card Program for Fiscal Year 2022* (A-04-24-02042), April 2025 | - | - | - | - |
| *Risk Assessment of the Administration for Community Living's Travel Card Program for Fiscal Year 2022* (A-04-24-02043), April 2025 | - | - | - | - |
| *2024 Performance Data for the Senior Medicare Patrol Projects* (OEI-02-25-00160), June 2025 | - | - | - | - |

[1] OIG issued two nonpublic audit reports during the reporting period.

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| **Administration for Strategic Preparedness and Response (ASPR)** | | | | |
| *ASPR Established Adequate Controls for Maintaining Physical Security and Inventory Records at Stockpile Site D* (OAS-25-04-001), April 2025 | - | - | - | - |
| *ASPR Established Adequate Controls for Maintaining Physical Security and Inventory Records at Stockpile Site E* (OAS-25-04-062), July 2025 | - | - | - | - |
| *During Hurricanes Fiona and Ian, HHS Helped Minimize Disruptions to Medical Services at Select Health Care Facilities* (OEI-04-23-00420), August 2025[2] | - | - | - | - |
| **Agency for Healthcare Research and Quality (AHRQ)** | | | | |
| *The Patient Safety Organization Program: Key Barriers Impeding Nationwide Progress Toward Reducing Patient Harm in Hospitals* (OEI-01-24-00150), September 2025 | - | - | - | - |
| **Centers for Disease Control and Prevention (CDC)** | | | | |
| *Kentucky Did Not Meet All of the Requirements for the COVID-19 Screening Testing Program at K-12 Schools* (A-05-23-00018), July 2025 | $4,569,390 | - | $4,569,390 | - |
| **Centers for Medicare & Medicaid Services (CMS)** | | | | |
| *Ohio Did Not Comply With Federal Waiver and State Requirements at 18 of the 19 Adult Day Health Care Facilities Audited* (A-05-23-00006), April 2025 | - | - | - | Yes |
| *Fewer Than One in Five Medicare Enrollees Received Medication To Treat Their Opioid Use Disorder* (OEI-02-24-00430), April 2025 | - | - | - | - |
| *Maryland Did Not Comply With Federal Waiver and State Requirements at 20 Adult Day Care Facilities Audited* (A-03-24-00201), May 2025 | - | - | - | Yes |
| *Medicare Payments for Evaluation and Management Services Provided on the Same Day as Eye Injections Were at Risk for Noncompliance With Medicare Requirements* (A-09-23-03014), May 2025 | - | $123,955,176 | - | Yes |
| *Most Medicare Part D Plans' Formularies Included Humira Biosimilars for 2025* (OEI-05-23-00520), May 2025 | - | - | - | - |
| *Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the Fourth Quarter of 2024* (OEI-03-25-00030), May 2025 | - | - | - | - |
| *CMS Is Not Systematically Tracking Whether States Return Federal Shares of Medicaid Managed Care Remittances* (OEI-03-23-00041), May 2025 | $85,117,346 | - | $85,117,346 | Yes |
| *California Medicaid Fraud Control Unit: 2023 Inspection* (OEI-06-23-00450), May 2025 | $37,207 | - | $37,207 | - |
| *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health and Life Insurance Company (Contract H1608) Submitted to CMS* (A-02-22-01020), June 2025 | $6,995,522 | - | - | Yes |
| *Maine Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control* (A-01-24-00004), June 2025 | - | - | - | - |

[2] The scope of this evaluation also includes the Office of the Secretary and CMS.

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries* (A-05-20-00021), June 2025 | - | $5,723,292 | - | - |
| *Medicare Home Health Agency Provider Compliance Audit: HRS Home Health* (A-05-22-00017), June 2025 | $100,696 | - | - | - |
| *Part D Plans Generally Include Drugs Commonly Used by Dual-Eligible Enrollees: 2025* (OEI-05-25-00120), June 2025 | - | - | - | - |
| *Availability of Surveyed Behavioral Health Providers To Treat New Patients Enrolled in Medicare and Medicaid* (OEI-09-21-00410), June 2025 | - | - | - | - |
| *CMS Use of Staffing Data To Inform State Oversight of Nursing Homes* (OEI-04-22-00550), June 2025 | - | - | - | Yes |
| *A Large Northeastern Hospital Could Improve Certain Security Controls for Preventing and Detecting Cyberattacks* (A-18-22-08019), July 2025 | - | - | - | - |
| *Medicare Home Health Agency Provider Compliance Audit: Sunflower Home Health* (A-05-23-00002), July 2025 | - | - | - | - |
| *Wisconsin Made at Least $18.5 Million in Improper Fee-For-Service Medicaid Payments for Applied Behavioral Analysis Provided to Children Diagnosed With Autism* (A-06-23-01002), July 2025 | $12,287,252 | - | - | Yes |
| *Oklahoma Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety, Emergency Preparedness, and Infection Control* (A-06-24-09002), July 2025 | - | - | - | - |
| *Wisconsin Physicians Service Government Health Administrators Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers* (A-06-24-04001), July 2025 | - | - | - | - |
| *Pennsylvania Made More Than $8.7 Million in Unallowable Capitation Payments for Enrollees With Multiple Medicaid Identification Numbers* (A-04-24-07110), July 2025 | $4,596,390 | - | - | - |
| *North Carolina Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Infection Control* (A-04-24-02504), July 2025 | - | - | - | - |
| *CMS Should Take Additional Actions To Help Hospitals Prepare for a Future Emerging Infectious Disease Outbreak* (A-02-22-01019), July 2025 | - | - | - | Yes |
| *Medicare Could Have Saved an Estimated $17.7 Million if CMS's Oversight Had Prevented At-Risk Payments for Anesthesia Administered During Spinal Pain Management Procedures* (A-09-23-03013), July 2025 | - | $17,688,110 | - | Yes |
| *Analysis of Selected Nursing Facilities' Use of Medicaid Reimbursement for Direct Care Compensation* (A-07-23-04134), July 2025 | - | - | - | - |
| *Hospitals Did Not Capture Half of Patient Harm Events, Limiting Information Needed To Make Care Safer* (OEI-06-18-00401), July 2025[3] | - | - | - | Yes |

[3] The scope of this evaluation also includes AHRQ.

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| *Hospitals Reported Few Captured Patient Harm Events to CMS and States* (OEI-06-18-00402), July 2025 | - | - | - | - |
| *Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2023 Average Sales Prices* (OEI-03-25-00050), August 2025 | - | - | - | - |
| *Alabama Did Not Always Verify Selected Nursing Homes' Compliance With Background Check Requirements* (A-04-24-08104), August 2025 | - | - | - | - |
| *CGS Administrators, LLC, Claimed Some Unallowable Medicare Supplemental Executive Retirement Plan III Costs Through Its Incurred Cost Proposals* (OAS-25-07-049), August 2025 | $1,913 | - | - | - |
| *CGS Administrators, LLC, Did Not Claim Some Allowable Medicare Pension Costs Through Its Incurred Cost Proposals* (OAS-25-07-051), August 2025 | - | - | - | - |
| *CGS Administrators, LLC, Did Not Claim Some Allowable Medicare Excess Plan Costs Through Its Incurred Cost Proposals* (OAS-25-07-052), August 2025 | - | - | - | - |
| *Palmetto Government Benefits Administrator, LLC, Overstated Its Medicare Segment Pension Assets as of January 1, 2022* (A-07-23-00638), August 2025 | - | - | - | - |
| *Blue Cross Blue Shield of South Carolina Overstated Its Supplemental Executive Retirement Plan III Medicare Allowable Segment Pension Assets as of January 1, 2022* (A-07-24-00647), August 2025 | $13,431 | - | $13,431 | - |
| *Palmetto Government Benefits Administrator, LLC, Did Not Claim Some Allowable Medicare Pension Costs Through Its Incurred Cost Proposals* (OAS-25-07-020), August 2025 | - | - | - | - |
| *Blue Cross Blue Shield of South Carolina Overstated Its Excess Plan Partial Medicare Segment Pension Assets as of January 1, 2022* (OAS-25-07-026), August 2025 | - | - | - | - |
| *Palmetto Government Benefits Administrator, LLC, Claimed Some Unallowable Medicare Postretirement Benefit Costs Through Its Incurred Cost Proposal* (A-07-24-00640), August 2025 | $9,169 | - | - | - |
| *Palmetto Government Benefits Administrator, LLC, Understated Its Excess Plan Medicare Segment Pension Assets as of January 1, 2022* (OAS-25-07-028), August 2025 | $169,446 | - | - | - |
| *Palmetto Government Benefits Administrator, LLC, Did Not Claim Some Allowable Medicare Excess Plan Costs Through Its Incurred Cost Proposals* (OAS-25-07-046), August 2025 | - | - | - | - |
| *Palmetto Government Benefits Administrator, LLC, Claimed Some Unallowable Medicare Supplemental Executive Retirement Plan III Costs Through Its Incurred Cost Proposals* (OAS-25-07-048), August 2025 | $4,082 | - | - | - |
| *Companion Data Services, LLC, Did Not Claim Some Allowable Medicare Pension Costs Through Its Incurred Cost Proposals* (OAS-25-07-022), August 2025 | - | - | - | - |
| *Companion Data Services, LLC, Understated Its Medicare Segment Pension Assets as of January 1, 2022* (OAS-25-07-023), August 2025 | $269,643 | - | - | - |
| *Companion Data Services, LLC, Overstated Its Excess Plan Medicare Segment Pension Assets as of January 1, 2022* (OAS-25-07-027), August 2025 | - | - | - | - |
| *Medicare Enrollees Left Acute-Care Hospitals Against Medical Advice at Increasing Rates* (A-04-24-03003), August 2025 | - | - | - | - |
| *Companion Data Services, LLC, Claimed Some Unallowable Medicare Postretirement Benefit Costs Through Its Incurred Cost Proposals* (A-07-24-00641), August 2025 | $880 | - | - | - |

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| *Companion Data Services, LLC, Claimed Some Unallowable Medicare Supplemental Executive Retirement Plan III Costs Through Its Incurred Cost Proposals* (A-07-24-00644), August 2025 | $299 | - | - | - |
| *Companion Data Services, LLC, Did Not Claim Some Allowable Medicare Excess Plan Costs Through Its Incurred Cost Proposals* (OAS-25-07-047), August 2025 | - | - | - | - |
| *CMS Should Confirm It Is Receiving Medicare Postoperative Visit Data on Global Surgeries When Reporting Is Required* (A-05-20-00027), August 2025 | - | - | - | - |
| *Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers* (A-06-24-05003), August 2025 | - | - | - | - |
| *National Government Services, Inc., Reopened and Corrected Cost Report Final Settlements for Desk Reviews Only With Obvious Errors To Correct Payments Made to Medicare Providers* (A-06-24-05004), August 2025 | - | - | - | - |
| *Comparison of Average Sales Prices and Average Manufacturer Prices: Results for the First Quarter of 2025* (OEI-03-25-00040), August 2025 | - | - | - | - |
| *Billing for Remote Patient Monitoring in Medicare* (OEI-02-23-00261), August 2025 | - | - | - | - |
| *By Requiring Emergency Preparedness Plans for Independent Labs, CMS Could Better Ensure That Medicare Enrollees Have Access to Infectious-Disease Diagnostic Testing During a Public Health Emergency* (A-09-23-03003), September 2025 | - | - | - | - |
| *Hawaii Did Not Ensure That Selected Nursing Facilities Complied With Federal and State Background Check Requirements* (A-09-23-02003), September 2025 | - | - | - | - |
| *Mississippi Did Not Report and Return All Medicaid Overpayments for the State's Medicaid Fraud Control Unit Cases* (A-06-24-04002), September 2025 | $3,615,578 | - | $3,615,578 | - |
| *New Jersey Did Not Ensure That Some Medicaid Personal Care Assistant Services Provided Under the Personal Preference Program Met Federal and State Requirements* (A-02-22-01024), September 2025 | - | - | - | - |
| *Texas Did Not Calculate or Collect Hospice Cap Overpayments Totaling $10.5 Million* (A-06-24-09001), September 2025 | $6,916,454 | - | - | - |
| *Hospitals Charged CMS for Trauma Team Activations That Did Not Comply With Federal Requirements* (A-01-23-00500), September 2025 | - | - | - | - |
| *Most Children Enrolled in Medicaid Did Not Receive Timely Suicide-Related Followup Care* (OEI-07-23-00510), September 2025 | - | - | - | - |
| *Medicare Part B Payment Trends for Skin Substitutes Raise Major Concerns About Fraud, Waste, and Abuse* (OEI-BL-24-00420), September 2025 | - | - | - | - |
| *Nursing Homes Failed To Report 43 Percent of Falls With Major Injury and Hospitalization Among Their Medicare-Enrolled Residents* (OEI-05-24-00180), September 2025 | - | - | - | - |
| *Serious Falls Resulting in Hospitalization Among Medicare-Enrolled Nursing Home Residents, July 2022–June 2023* (OEI-05-24-00181), September 2025 | - | - | - | - |
| *Puerto Rico Medicaid Fraud Control Unit: 2024 Onsite Review* (OEI-06-24-00300), September 2025 | - | - | - | - |
| *Some Medicaid Managed Care Plans Made Few or No Referrals of Potential Provider Fraud* (OEI-03-22-00410), September 2025 | - | - | - | - |

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| **Food and Drug Administration (FDA)** | | | | |
| *FDA Food Safety Inspections of Domestic Food Facilities* (OEI-02-23-00300), June 2025 | - | - | - | - |
| **Health Resources and Services Administration (HRSA)** | | | | |
| *Ten of Thirty Selected Nursing Facilities Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments* (A-05-22-00012), June 2025 | $2,589,066 | - | - | - |
| *Eleven of Thirty Selected Hospitals Did Not Comply With Terms and Conditions and Federal Requirements for Expending Provider Relief Fund Payments* (A-02-22-01003), June 2025 | $708,590,817 | - | - | - |
| *Most Health Centers Provide Some Behavioral Health Services to Patients With Substance Use Disorder, Despite Facing Challenges That Limit Comprehensive Treatment* (OEI-BL-22-00520), August 2025 | - | - | - | - |
| *Seventeen of Twenty-Five Selected Hospitals Did Not Comply or May Not Have Complied With the Provider Relief Fund Balance Billing Requirement* (A-02-22-01018), September 2025 | $637,035 | - | - | - |
| *HRSA Rural Communities Opioid Response Program Award Recipients Generally Met All Core Activities and Benchmarks* (A-06-23-07000), September 2025 | - | - | - | - |
| **Indian Health Service (IHS)** | | | | |
| *Indian Health Service's Controls Over Sanitation Facilities Construction Program Projects Funded Under the Infrastructure Investment and Jobs Act Could Be Improved* (A-05-22-00021), May 2025 | - | - | - | - |
| **National Institutes of Health (NIH)** | | | | |
| *NIH Recipients Conducting Biospecimen Research: Gaps in Emergency Planning and Reporting* (OEI-04-23-00280), June 2025 | - | - | - | - |
| *The National Institutes of Health Needs To Improve the Cybersecurity of the All of Us Research Program to Protect Participant Data* (A-18-24-06111), September 2025 | - | - | - | - |
| **Office of the Secretary (OS)** | | | | |
| *Department of Health and Human Services Met Many Requirements, but Did Not Fully Comply With the Payment Integrity Information Act of 2019 and Applicable Improper Payment Guidance for Fiscal Year 2024* (OAS-25-17-042), May 2025 | - | - | - | - |
| *HHS's Grant Payment System Lacked Effective Internal Controls To Prevent $7.8 Million in Fraud, and HHS Has Begun Taking Corrective Actions To Reduce Fraud Risk* (A-18-24-03700), June 2025 | - | - | - | - |
| *Department of Health and Human Services' Hybrid Work Environment as of May 2024* (A-05-24-00008), June 2025 | - | - | - | - |
| *Deficiencies With Incorporating Required Cybersecurity Language in HHS Contracts and Timeliness of Contractor Incident Reporting* (A-18-22-06100), September 2025 | - | - | - | - |

| Report | Questioned Costs | Funds Put to Better Use | Unsupported Costs | Management Decision Made |
|---|---|---|---|---|
| **Substance Abuse and Mental Health Services Administration (SAMHSA)** | | | | |
| *Florida Did Not Fully Comply With Federal Reporting and Oversight Requirements for Its Opioid Response Grant* (A-04-24-08106), August 2025 | - | - | - | - |
| *California Met Some Requirements of the Projects for Assistance in Transition From Homelessness Program but Did Not Accurately Report Program Activities for Selected Providers* (A-09-23-01002), September 2025 | - | - | - | - |
| **Total Reports: 92** | **$836,548,643** | **$147,366,578** | **$93,353,216** | **10[4]** |

***Contract audit per the National Defense Authorization Act (NDAA) for Fiscal Year 2008, section 845.

[4] This table represents management decisions on reports issued during the reporting period only. OIG has not yet received management decisions for most reports listed above because those decisions are not due to OIG until 6 months following the issuance of a report. For additional information on reports for which a management decision was made during the reporting period, including reports that were issued prior to the reporting period, see Appendix B.

# Appendix B: Report Details

## Audit and Evaluation Reports With Questioned Costs

OIG identified **$836.5 million in questioned costs** during the reporting period. The table below summarizes audit and evaluation reports with questioned costs and HHS program officials' decisions to take action on these and other outstanding audit recommendations.

**Table 2: Audit and Evaluation Reports With Questioned Costs (April 1, 2025–September 30, 2025)**

| | | Number of Reports | Dollar Value Questioned | Dollar Value Unsupported |
|---|---|---|---|---|
| A. | Reports for which no management decision has been made by the commencement of the reporting period | 13 | $158,744,000 | $19,594,000 |
| B. | Reports issued during the reporting period | 21 | $836,549,000 | $93,353,000 |
| | **Subtotal (A + B)** | **34** | **$995,293,000** | **$112,947,000** |
| **Less:** | | | | |
| C. | Reports for which a management decision was made during the reporting period | | | |
| | i. Disallowed costs | 8 | **$82,207,000*** | $12,272,000 |
| | ii. Costs not disallowed | 5 | $73,317,000 | $7,322,000 |
| | **Subtotal (i + ii)** | **13** | **$155,524,000** | **$19,594,000** |
| D. | Reports for which no management decision has been made by the end of the reporting period [(A + B) – Subtotal C] | **21** | **$839,769,000** | **$93,353,000** |
| E. | Reports for which no management decision was made within 6 months of issuance | **2** | **$22,503,000** | - |

* Audit and evaluation receivables (expected recoveries).

# Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use

OIG identified **$147.4 million in funds put to better use** during the reporting period. The table below summarizes audit and evaluation reports with recommendations that funds be put to better use and HHS program officials' decisions to take action on these and other outstanding audit and evaluation recommendations.

**Table 3: Audit and Evaluation Reports With Recommendations That Funds Be Put to Better Use (April 1, 2025–September 30, 2025)**

| | Number of Reports | Dollar Value |
|---|---|---|
| A. Reports for which no management decision has been made by the commencement of the reporting period | 6 | $12,179,712,000 |
| B. Reports issued during the reporting period | 3 | $147,367,000 |
| **Subtotal (A + B)** | **9** | **$12,327,079,000** |
| **Less:** | | |
| C. Reports for which a management decision was made during the reporting period | | |
| i. Value of recommendations agreed to by management | | |
| a. Based on proposed management action | 1 | $5,210,000 |
| b. Based on proposed legislative action | 0 | - |
| ii. Value of recommendations not agreed to by management | 4 | $8,054,868,000 |
| **Subtotal (i + ii)** | **5** | **$8,060,078,000** |
| D. Reports for which no management decision had been made by the end of the reporting period [(A + B) – Subtotal C] | **4** | **$4,267,001,000** |

# Appendix C: Investigative Actions

During the reporting period, OIG's investigative work led to **$2.2 billion in investigative receivables** and **352 criminal actions**. OIG also **took civil actions, such as assessing monetary penalties, against 481 individuals and entities**, and **excluded 1,337 individuals and entities from Federal health care programs**. The following table summarizes OIG's investigative activities and results during the reporting period.[5]

**Table 4: Investigative Activity and Results (April 1, 2025–September 30, 2025)**

| | | |
|---|---|---|
| **Investigative Receivables** | | |
| Amount due to HHS | | $1,247,197,953 |
| Amount due to non-HHS entities | | $952,247,999 |
| | **Total Investigative Receivables** | **$2,199,455,952** |
| **Investigative Results** | | |
| Criminal actions resulting from investigations | | 352 |
| Civil actions | | 481 |
| Judgments/settlements | | 348 |
| Civil monetary penalties | | 133 |
| | **Total Criminal and Civil Actions** | **833** |
| Investigations closed | | 909 |
| **Criminal Referrals** | | |
| Referrals to DOJ | | 1,317 |
| Indictments and criminal informations resulting from referrals made prior to and during the reporting period | | 341 |
| Referrals to State and local authorities | | 134 |
| Indictments and criminal informations resulting from referrals made prior to and during the reporting period | | 99 |
| | **Total Criminal Referrals** | **1,451** |
| **Exclusions** | | |
| Individuals | | 1,307 |
| Entities | | 29 |
| | **Total Exclusions** | **1,336** |
| **OIG Hotline Activity** | | |
| Total Contacts Received Via Hotline and Web Portal | | 86,747 |
| Evaluated for Potential Investigation | | 32,804 |
| Referred Internally or to Appropriate Agency for Action | | 17,609 |
| Closed (e.g., no HHS violation) | | 15,195 |
| Other Contacts[6] | | 53,943 |
| **Related to Trafficking in Persons (FY 2025)** | | |
| Suspected violations reported | | 22 |
| Investigations conducted | | 17 |
| Criminal actions resulting from investigations | | 2 |
| Recommendations | | 0 |

[5] OIG issued no investigative reports. See Appendix F for OIG's definition of an investigative report.

[6] Includes those contacts that are reporting fraud, waste, and abuse at other Federal or State agencies, confirming potential scams, requesting contact information for HHS programs or State and local agencies, asking questions about how to submit a complaint, and requesting Freedom of Information Act information.

OIG conducted three investigations of senior Government employees (as defined in the IG Act) during the reporting period. Of these investigations, no allegations of misconduct were substantiated. Descriptions of investigations involving senior Government employees that were closed and not disclosed to the public in which allegations of misconduct were investigated and not substantiated follow.

**Table 5: Investigations of Senior Government Employees (April 1, 2025–September 30, 2025)**

| Description of Investigation |
|---|
| OIG investigated a senior Government employee (SES) for allegations of fraud. The fraud was alleged to be in relation to the misuse of campaign funds. OIG closed this investigation with no findings made. |
| OIG investigated an SES for an alleged conflict of interest. The alleged conflict arose when a grant was awarded to a company where the SES was a co-founder. OIG did not find any evidence to support the allegations and the investigation was closed. |
| OIG investigated an SES (GS-15 or equivalent) at the FDA for allegations related to the possession of child sexual abuse material. The case was initiated when the employee connected an external hard drive to his FDA computer, which FDA cybersecurity tools showed a large number of explicit file names. Prosecution of the employee was declined by DOJ, and the employee subsequently retired from the FDA. |

# Appendix D: Safe Harbor Proposals

OIG annually solicits proposals for developing new and modifying existing safe harbors to the Federal anti-kickback statute, section 1128B(b) of the Social Security Act, and for developing special fraud alerts. In November 2024, OIG published its annual solicitation in the *Federal Register*. Below we summarize the nine proposals OIG received and OIG's response.

| Proposal | OIG Response |
|---|---|
| Modifications to, and guidance regarding, the group purchasing organization (GPO) safe harbor, 42 C.F.R. § 1001.952(j), to distinguish between different types of purchasing agents (e.g., GPOs, pharmacy benefit managers (PBMs), or other intermediaries) and to implement different standards for the different types of entities. | OIG is not adopting these suggestions. We may consider this topic in future rulemaking or in future guidance. We note that OIG has published a response in the frequently asked questions section of our website explaining the potential application of the GPO safe harbor to remuneration paid by pharmaceutical manufacturers to PBMs.[7] Finally, OIG highlights that there is a statutory exception addressing GPOs at section 1128B(b)(3)(C) of the Social Security Act. |
| New safe harbor to protect a clinical trial sponsor's subsidization of cost-sharing obligations as well as other items and services that remove obstacles to enrolling and participating in clinical trials. | OIG is not adopting this suggestion. Although OIG appreciates the goal of facilitating participation in clinical trials, we have longstanding concerns regarding the routine waiver or subsidy of cost-sharing obligations and the provision of other incentives to Federal health care program enrollees. We may consider this topic in future rulemaking. |
| New safe harbor to protect remuneration from a clinical trial sponsor to a patient to subsidize indirect costs such as travel, lodging, child care expenses, and lost wages. | OIG is not adopting this suggestion but may consider the topic in future rulemaking. |
| Modifications to the safe harbors for value-based arrangements, including the safe harbors for value-based arrangements with substantial financial risk and full financial risk, 42 C.F.R. §§ 1001.952(ff) and (gg), to protect the exchange of remuneration by entities that currently cannot use one or more of these safe harbors (e.g., pharmaceutical manufacturers, manufacturers of a device or medical supply, and suppliers of durable medical equipment, prosthetics, orthotics, or supplies). | OIG is not adopting this suggestion. OIG continues to evaluate the ways in which these entities may be able to contribute to the coordination of care and the overall delivery of high-value care; however, OIG continues to have concerns, based on our historical law enforcement experience, that such entities could misuse the flexibilities afforded by the value-based safe harbors to offer kickbacks under the guise of care coordination activities or to tether a clinician to a particular product. Further, we believe there is a risk that certain such arrangements could result in providers selecting products that may not be clinically appropriate for, or in the best interest of, a patient. We may consider this topic in future rulemaking. |
| Safe harbor or guidance to facilitate access to multifunction devices (e.g., a smartphone or e-tablet) for managing a patient's health care, including the social determinants (e.g., finances, scheduling, and transportation) that affect a patient's health. | OIG is not adopting this suggestion. First, we believe that the existing value-based safe harbors provide sufficient regulatory flexibility for multifunction devices in value-based arrangements. As explained in the 2020 OIG rulemaking, Medicare and State Health Care Programs: Fraud and Abuse, Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements (known as the 2020 OIG Rulemaking), there are several factors that would dictate whether in-kind remuneration in the form of a multifunction device would meet safe harbor requirements, such as whether the remuneration is predominantly used to engage in value-based activities that are directly connected to the coordination and management of |

[7] See OIG, Frequently Asked Questions, General Questions Regarding Certain Fraud and Abuse Authorities, Question #11, https://oig.hhs.gov/faqs/general-questions-regarding-certain-fraud-and-abuse-authorities/.

| | |
|---|---|
| | care for the target patient population.[8] In addition, the OIG advisory opinion process remains available to stakeholders seeking prospective immunity from administrative enforcement sanctions in connection with specific arrangements that would not receive protection under those safe harbors. |
| New safe harbor to address value-based pricing arrangements with medical technology manufacturers to both protect price adjustments and provide a mechanism under which services would be bundled with product(s) being sold, leased, or rented, subject to appropriate safeguards, where the arrangement is dependent upon the achievement of a measurable clinical and/or cost outcome. | OIG is not adopting this suggestion at this time. We may consider this topic in future rulemaking. |
| New safe harbor to protect remuneration from kidney transplant programs to reimburse living donors for out-of-pocket costs incurred when preparing for and serving as a living kidney donor. | OIG is not adopting this suggestion at this time. We may consider this topic in future rulemaking. |
| New safe harbor for Indian Health Care Providers (IHCPs) similar to the safe harbor for federally qualified health centers at 42 C.F.R. § 1001.952(w). | OIG is not adopting this suggestion. We may consider this topic in future rulemaking. Although not specific to IHCPs, OIG believes existing regulations, and in particular, the safe harbors that were finalized in the 2020 OIG Rulemaking, may offer sufficient regulatory flexibility and can facilitate innovative value-based and care coordination arrangements for IHCPs. |
| Safe harbor to protect cost-sharing waivers for connected health technologies used for care management and remote patient monitoring, particularly where the costs of collection exceed the amount to be collected, with reasonable and objective conditions to prevent fraud and abuse. | OIG is not adopting this suggestion. We have longstanding concerns regarding the routine waiver or subsidy of cost-sharing obligations and the provision of other incentives to Federal health care program enrollees. |

[8] OIG, "Medicare and State Health Care Programs: Fraud and Abuse, Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements," 85 Fed. Reg. 77, 684 at 77,709 (Dec. 2, 2020).

# Appendix E: Peer Reviews

Peer reviews are conducted by member organizations of the Council of the Inspectors General on Integrity and Efficiency (CIGIE). The CIGIE peer review program provides OIGs and their stakeholders with an assessment of the OIG's compliance with relevant quality standards and its quality control systems (e.g., policies and procedures).

## Office of Audit Services

During the reporting period, OIG's Office of Audit Services (OAS) did not receive a peer review. The most recent peer review OAS received was conducted by the Department of Housing and Urban Development (HUD) OIG, the final report of which was issued in March 2024. In that review, OAS received a "pass" rating, and HUD-OIG issued no recommendations. OAS has no outstanding peer review recommendations. OAS did not conduct a peer review during the reporting period. The most recent peer review OAS conducted was of the Department of Defense OIG, the final report of which was issued in September 2024.

## Office of Evaluation and Inspections

During the reporting period, OIG's Office of Evaluation and Inspections (OEI) did not receive a peer review. The most recent peer review OEI received was conducted by the Department of Energy (DOE) OIG, the final report of which was issued in February 2023. In that review, DOE-OIG determined that OEI's policies and procedures and the four reports reviewed generally were consistent and complied with CIGIE Blue Book standards. OEI has no outstanding peer review recommendations. OEI did not conduct a peer review during the reporting period. The most recent peer review OEI conducted was of the Special Inspector General for Afghanistan Reconstruction OIG, the final report of which was issued in March 2023.

## Office of Investigations

During the reporting period, OIG's Office of Investigations (OI) did not receive a peer review. The most recent peer review OI received was conducted by the United States Postal Service (USPS), the final report of which was issued in November 2024. In that review, USPS-OIG determined that OI's system of internal safeguards and management procedures for the investigative function was in full compliance with the quality standards established by CIGIE and the Attorney General's guidelines. OI has no outstanding peer review recommendations. OI did not conduct a peer review during the reporting period. The most recent peer review OI conducted was of the U.S. Department of Agriculture OIG, the final report of which was issued in June 2025.

# Appendix F: Glossary

See At a Glance: OIG Accomplishments for corresponding statistics.

**Audit and Evaluation Receivables**
Monies identified through OIG audits that the audited entity has sustained or formally agreed should not be charged to the Government. It does not reflect actual collections.

**Civil Actions**
Actions, including civil settlements and civil judgments, including actions resulting from the use of OIG's Civil Monetary Penalties Law authority.

**Criminal Actions**
Actions, such as convictions, that occur once an individual or entity's guilt is determined and a sentence is imposed, or when a defendant enters a pretrial diversion program before or after indictment.

**Criminal Informations and Indictments**
Instances in which a formal accusation of a crime is made against an individual or entity by a grand jury or prosecuting attorney.

**Excluded Individuals and Entities**
Untrustworthy individuals and entities OIG has excluded, pursuant to section 1128 of the Social Security Act, from federally funded health care programs for a variety of reasons, including a conviction for Medicare or Medicaid fraud. Those that are excluded can receive no payment from Federal health care programs for any items or services they furnish, order, or prescribe.

**Final Management Decision**
A final decision by management concerning its response to the findings and recommendations included in an audit report, including actions concluded to be necessary.

**Funds Put to Better Use**
Funds that could be used more efficiently if management took actions to implement and complete an OIG recommendation, through reductions in outlays, deobligation of funds, and/or avoidance of unnecessary expenditures. Also referred to as "recommendations that funds be put to better use."

**Investigations Completed**
Completed OIG criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations.

**Investigative Receivables**
Monies ordered or agreed upon to be returned or paid to HHS or other Federal and State entities or private individuals because of OIG investigative activity that led to criminal actions, civil and administrative settlements, civil judgments, or administrative actions. It does not reflect actual collections.

**Investigative Report**
A report that identifies or brings renewed attention to systemic weaknesses or vulnerabilities within HHS programs and recommends administrative, procedural, policy, regulatory, or legislative change to correct or minimize the problem during the reporting period.

**Potential Cost Savings**
Funds put to better use or funds that HHS could use more efficiently if it took action to implement OIG recommendations.

**Questioned Cost**
A cost that is questioned by OIG because of: (1) an alleged violation of a provision of a law, regulation, contract, grant, cooperative agreement, or other agreement or document governing the expenditure of funds; (2) a finding that, at the time of the audit, the cost is not supported by adequate documentation; or (3) a finding that the expenditure of funds for the intended purpose is unnecessary or unreasonable. Subcategories of questioned costs include:

> **Disallowed Costs**
> A subset of questioned costs; these are costs that HHS program officials have, in a management decision, sustained or agreed should not be charged to the Government.
>
> **Unsupported Costs**
> A subset of questioned costs; these are costs that OIG found that, at the time of the audit, are not supported by adequate documentation.

**Recommendations Implemented**
Recommendations implemented by HHS and others can result in substantial savings and can also result in improvements to HHS programs.

**Recommendations Issued**
Actionable recommendations, based on data-driven findings, that OIG provided to HHS and that if implemented can result in both monetary and nonmonetary benefits.

**Referrals**
Presentations of OIG subjects to Federal, State, or local prosecuting jurisdictions for criminal prosecutorial consideration.

**Reports Issued**
OIG published reports, including audit reports, evaluation reports, and reports of findings in response to Office of Special Counsel whistleblower disclosures.

**Return on Investment**
OIG uses 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.

**Total Monetary Impact**
Total amount of potential savings from investigative receivables, audit and evaluation receivables, and recommendations that funds be put to better use.

# Appendix G: Reporting Requirements

The National Defense Authorization Act (NDAA) of Fiscal Year 2023, section 5273, amended the Inspector General Act of 1978 and the Inspector General Empowerment Act of 2016 to streamline semiannual reporting requirements for offices of inspectors general, which now appear in the note of 5 U.S.C. § 405. The following table presents the new NDAA requirements and other remaining requirements, along with the location of the information in this report.

| Section | Requirement | Location |
|---|---|---|
| **U.S.C. § 405 (note)** | | |
| 5(a)(1) | Significant problems, abuses, and deficiencies | Throughout this report |
| 5(a)(2) | Recommendations for which corrective action has not been completed | OIG Impact From Recommendations and OIG's Recommendations Tracker |
| 5(a)(3) | Significant investigations closed during the reporting period | Throughout this report |
| 5(a)(4) | Convictions during the reporting period | Appendix C: Investigative Actions |
| 5(a)(5) | Information regarding reports issued during the reporting period | Appendix A: Audits and Evaluations |
| 5(a)(6) | Information regarding any management decision made during the reporting period with respect to any report issued during a previous reporting period | At a Glance: OIG Accomplishments, OIG Impact From Recommendations, and OIG's Recommendations Tracker |
| 5(a)(7) | Information required by the Federal Financial Management Improvement Act of 1996 | None this reporting period |
| 5(a)(8) | Results of peer reviews of HHS-OIG conducted by other OIGs | Appendix E: Peer Reviews |
| 5(a)(9) | Outstanding recommendations from peer reviews of HHS-OIG conducted by other OIGs | Appendix E: Peer Reviews |
| 5(a)(10) | Peer reviews of other OIGs conducted by HHS-OIG | Appendix E: Peer Reviews |
| 5(a)(11) | Investigative statistical tables | Appendix C: Investigative Actions |
| 5(a)(12) | Metrics description for investigative statistical tables | Appendix C: Investigative Actions |
| 5(a)(13) | Investigations of senior Government employees | Appendix C: Investigative Actions |
| 5(a)(14) | Description of whistleblower retaliation instances | Additional OIG Activities |
| 5(a)(15) | Description of attempts to interfere with OIG independence | None this reporting period |
| 5(a)(16) | Descriptions of investigations of senior Government employees | Appendix C: Investigative Actions |
| 5(a)(16) | Descriptions of nonpublic reports | Appendix A: Audits and Evaluations |
| **Other Requirements** | | |
| NDAA 2008, § 845 | Significant contract audits | Appendix A: Audits and Evaluations |
| Social Security Act § 1128D Health Insurance Portability and Accountability Act | Public proposals for new and modified safe harbors | Appendix D: Safe Harbor Proposals |
| Trafficking Victims Prevention and Protection Reauthorization Act of 2022 | Investigations relating to trafficking in persons | Appendix C: Investigative Actions |

# Stay in Touch

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# Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

Scan to Report at
**TIPS.HHS.GOV**

**Phone: 1-800-447-8477**

**TTY: 1-800-377-4950**

## Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

## How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

## Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.