Testimony of

JESSICA TILLIPMAN

ASSOCIATE DEAN FOR GOVERNMENT PROCUREMENT LAW STUDIES AND GOVERNMENT CONTRACTS ADVISORY COUNCIL DISTINGUISHED PROFESSORIAL LECTURER IN LAW

THE GEORGE WASHINGTON UNIVERSITY LAW SCHOOL

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Protecting Patients and Taxpayers: Combating Healthcare Fraud and Leakage to Strengthen Program Integrity

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Chairman Schweikert, Ranking Member Hassan, and Members of the Committee, thank you for the opportunity to testify.

My name is Jessica Tillipman, and I am the Associate Dean for Government Procurement Law Studies at the George Washington University Law School, where I have taught government procurement, anti-corruption, and compliance courses for over twenty years. My research examines integrity challenges across public-spending systems. The weaknesses that expose health care programs to loss are not unique to health care. They recur across the government's spending systems, whether the government is paying Medicare or Medicaid claims, delivering SNAP benefits, administering pandemic relief, or purchasing goods or services.

Let me begin where there should be no disagreement. Fraud is real. It is serious. And it is not going away, no matter how strong the controls. The question before this Committee is not whether fraud exists. It is whether our response fits the problem. For an economic committee, that is a budgeting question, because the wrong label and the wrong tool both misallocate time, money, and staff.

Our government's mismatched response to this challenge is driven primarily by two pathologies. The first is the allure of the shiny new thing: a new slogan, a new task force, a new technology, or a dramatic crackdown. That is where the money and attention go. The second is quieter and more harmful. The critical work that prevents loss has been quiet for so long that its value has become invisible, and invisible work is the easiest to cut. It can even look like waste, so that the very thing that fights waste is cut in the name of eliminating it. My argument is this: we already know what works. It is not new, and it will not dominate a news cycle. It is the boring, foundational work we have been told to do for years, yet we have neither prioritized it nor funded it the way these problems require.

I. Words Matter

Start with the words, because under this Committee, they have budgetary ramifications. In fiscal year 2025, the Centers for Medicare & Medicaid Services (CMS) reported an estimated $96 billion in improper payments across its major health programs.[1] In Medicaid, more than three-quarters of improper payments were attributable to insufficient documentation, which CMS itself states is generally not indicative of fraud or abuse.[2] That does not make those payments presumptively proper; it means they call for verification and, where warranted, targeted review, rather than treatment as established fraud. When we treat these improper payments as if they were stolen, we make a category error with fiscal consequences: we point the fraud apparatus at paperwork while underfunding the controls that prevent loss.

Fraud is a legal conclusion. It generally involves a knowing or willful misrepresentation, and, as the Government Accountability Office (GAO) explains, whether the conduct is fraudulent is determined by the judicial or other adjudicative system.[3] An improper payment is a distinct, broader payment-integrity category: it includes payments that should not have been made or were made in an incorrect amount, as well as payments whose propriety cannot be determined because the required documentation is missing or insufficient.[4] Notably, "while all fraudulent payments are considered improper, not all improper payments are due to fraud."[5] "Leakage" is a useful umbrella term for preventable loss, but it is not itself a legal or measurement category, nor does it identify the underlying problem.

The distinction is not academic. Administrative error, documentation failure, and fraud call for different responses, with different predicates and consequences. Criminal fraud warrants prosecution. Civil False Claims Act (FCA) violations warrant treble damages and civil penalties. Improper payments require corrective action and improved controls. Abuse warrants corrective action. Waste and mismanagement require management reform. When oversight findings conflate these categories, such as labeling documentation gaps as "fraud" or treating all improper payments as criminal conduct, the result distorts reality, misallocates enforcement resources, unfairly stigmatizes program participants, and hinders the actual reforms needed to improve program integrity.

II. What Works, and Where the System Breaks Down

The United States has built a robust institutional architecture to prevent, detect, and punish healthcare fraud. The system recognizes fraud risk as a persistent feature of large healthcare

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[1] *See* Ctrs. for Medicare & Medicaid Servs., *Fiscal Year 2025 Improper Payments Fact Sheet*, CMS.gov (Jan. 15, 2026), https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2025-improper-payments-fact-sheet ($28.83 billion in Medicare Fee-for-Service; $23.67 billion in Medicare Part C; $4.23 billion in Medicare Part D; $37.39 billion in Medicaid; $1.37 billion in Children's health Insurance Program).
[2] *Id.*
[3] U.S. Gov't Accountability Off., *Improper Payments and Fraud: How They Are Related but Different*, GAO-24-106608 (December 7, 2023), https://www.gao.gov/assets/d24106608.pdf.
[4] *Id.*
[5] *Id.*

programs and addresses it through oversight and enforcement mechanisms tailored to different categories of misconduct: criminal prosecution for intentional fraud; civil liability for recklessness; and administrative remedies for noncompliance.

- CMS, through its Medicare enrollment system, and state Medicaid agencies screen providers at enrollment and obtain ownership-and-control disclosures;
- The Department of Health and Human Services Office of Inspector General (HHS-OIG) audits, investigates, and oversees the Medicare and Medicaid programs;
- GAO audits and evaluates healthcare programs for Congress;
- Medicaid Fraud Control Units (MFCUs) investigate and prosecute Medicaid provider fraud and patient abuse or neglect;
- The Department of Justice (DOJ) prosecutes criminal health care fraud and brings civil FCA cases involving federal health care programs; and
- The FCA's qui tam provisions allow private relators to file FCA cases in the government's name and, if successful, may receive fifteen to thirty percent of the proceeds.

This architecture relies on multiple overlapping institutions—an intentional redundancy designed to avoid a single point of failure. The system's credibility depends on institutions with distinct authorities, independent oversight functions, and public reporting requirements. Independence and stable resourcing are design features that make oversight credible and durable across administrations. Oversight capacity depends on institutional stability: continuity of leadership, adequate resourcing, and public access to findings. When these conditions are disrupted, fraud detection may suffer, and public confidence in oversight findings erodes.

The work that prevents loss rarely makes headlines. It is the quiet work of screening before payment, sharing information when risk is identified, maintaining independent oversight, and following through on known weaknesses. None of it is novel, and none of it lends itself to a dramatic announcement. But it is the work that makes the rest of the system function. That infrastructure is not self-executing. It depends on people, stable leadership, usable information, and institutions with the capacity to act on what they find. Those conditions have been weakened in identifiable ways, and in many instances, GAO or HHS-OIG has already identified a remedy that remains unimplemented.

First, this system assumes that there is someone left to do the investigating, and that assumption is becoming increasingly difficult to sustain. HHS-OIG projects its lowest staffing level in two decades, even as health care fraud schemes become more complex and technologically sophisticated.[6] It estimates that additional resources would allow it to address 400 to 450 viable fraud cases and more than 5,000 hotline complaints each year, and that without those resources, at least 1,200 viable fraud cases will go unpursued over the next three years.[7] The budgetary pressure is not limited to HHS-OIG. The House Appropriations Committee's fiscal year 2027 Legislative Branch bill would cut GAO's appropriation by $200 million, roughly 25 percent

[6] *See* Office of Inspector Gen., U.S. Dep't of Health & Hum. Servs., Fiscal Year 2027 Congressional Budget Justification (2026), https://oig.hhs.gov/about-oig/oig-budget/.
[7] *Id.*

below its current level.[8] The same report describes GAO's recommendations as having the potential to "save billions of dollars and greatly improve government operations," and states:

> *Eliminating Waste, Fraud, and Abuse*.—The Committee continues to support GAO's efforts to identify and report on inefficiencies in federal programs. To strengthen this work, the Committee encourages GAO to enhance interagency data-sharing, promote government-wide coordination, and expand the implementation of GAO's recommendations. The Committee believes such partnerships can further reduce redundancy, improve program outcomes, and maximize the efficient use of taxpayer funds.[9]

Second, the systems designed to detect fraud and improper payments do not always share information with one another. Until December 2025, CMS generally did not notify supplemental payers, including state Medicaid agencies, when Medicare providers were under payment suspension for suspected fraud. As a result, some payers continued making beneficiary cost-sharing payments on claims that CMS had already flagged as potentially fraudulent.[10]

In one catheter-billing scheme GAO reviewed, state Medicaid agencies paid at least $196,000 in combined state and federal cost-sharing funds in 2023 and 2024 to providers that CMS had already suspended.[11] The dollars in that case were small, but the gap is structural: suspected fraud identified in Medicare did not reach state systems in time to stop the next payment. A payment suspension for suspected fraud should trigger systematic information-sharing as a matter of course, not ad hoc coordination after the fact. CMS has begun sharing that information, but the reporting must become routine and timely enough to be useful.

Third, the government has moved beyond reliance on pure pay-and-chase but has not yet built a prevention-first payment architecture. CMS has made progress on the front end, using targeted pre-payment edits, prior authorization, provider screening, and analytics.[12] Treasury's Do Not Pay program is the clearest example of the preventive approach, combining eligibility checks, identity verification, and pre-disbursement review.[13] What the system still lacks is consistent cross-program verification at the points where the government decides who may enroll, who may bill, and who gets paid.[14]

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[8] H.R. Rep. No. 119-666, at 27 (2026).
[9] *Id.*
[10] *See* U.S. Gov't Accountability Off., GAO-26-107799, *Medicare:* CMS's Use of Data Analytics to Identify and Prevent Fraud (April 21, 2026), https://www.gao.gov/products/gao-26-107799.
[11] *Id.*
[12] U.S. Gov't Accountability Off., GAO-16-394, *Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data* (April 13, 2016), available at https://www.gao.gov/products/gao-16-394.
[13] "Do Not Pay | Bureau of the Fiscal Service," Treasury.gov (April 8, 2026), https://fiscal.treasury.gov/payment-integrity/do-not-pay-dnp; Cong. Research Serv., *Improper Payments: Ongoing Challenges and Recent Legislative Proposals* (June 2, 2026), https://www.everycrsreport.com/files/2026-06-02_R48296.pdf.
[14] *Id.*

Two qualifications to this payment structure remain critical. First, verification must include privacy and due-process safeguards and remain risk-based, so that legitimate claims are not unnecessarily delayed and the government does not spend a disproportionate share of its resources on low-risk transactions. Second, some payments and enrollments cannot be fully verified before action is taken. When continuity of care makes lighter front-end verification appropriate, the government must route those transactions into targeted review afterward, precisely because they did not receive the front-end check. The alternative is to accept the residual risk.

Fourth, bad actors can still conceal who ultimately owns and controls the entities that bill public programs.[15] At formation, a company can be created in this country without disclosing who ultimately owns or controls it, so the name on the paperwork can be a nominee while the real owners remain hidden.[16] As DOJ alleged in Operation Gold Rush, which DOJ has described as the largest health care fraud case by loss amount it has ever charged, a bad actor can even buy a company that already holds Medicare billing privileges and operate through the same arrangement.[17] Medicare and Medicaid rely on enrollment disclosures, but ownership verification is fragmented, and misrepresentation may not be detected until after payment has been made. Back-end enforcement can address it later, but it cannot undo ownership opacity at the point of entry. This is not only a health-care problem: GAO has found that federal programs face heightened fraud risk when beneficial ownership is opaque, with harm that can extend to national security and public safety.[18]

Technology is often touted as the ultimate panacea for what ails Medicare and Medicaid. It is a force multiplier, and advanced analytics reveal what no person can: patterns across millions of claims, networks of shell entities, and relationships that surface only in the aggregate. Operation Gold Rush demonstrates both the promise and limitations of technology. Proactive data analytics uncovered a scheme that DOJ alleges involved more than $10.6 billion in false claims built on stolen identities.[19] CMS and HHS-OIG prevented the organization from receiving all but approximately $41 million of the roughly $4.45 billion scheduled to be paid by Medicare. The

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[15] *See* U.S. Gov't Accountability Off., GAO-25-107143*, Fraud in Federal Programs: FinCEN Should Take Steps to Improve the Ability of Inspectors General to Determine Beneficial Owners of Companies* (April 8, 2025), https://www.gao.gov/assets/gao-25-107143.pdf ("With this information and such relationships hidden, bad actors may target federal programs—and by extension, taxpayer dollars—to improperly receive federal contracts or fraudulently access federal benefits").

[16] U.S. Gov't Accountability Off., GAO-26-107967, *Corporate Transparency: Treasury Should Address Gaps in Ownership Information Resulting from Expanded Exemptions* (May 29, 2026), https://www.gao.gov/products/gao-26-107967.

[17] *See* Press Release, U.S. Att'y's Office, E.D.N.Y., *11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice* (June 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

[18] *See* U.S. Gov't Accountability Off., GAO-25-107143*, Fraud in Federal Programs: FinCEN Should Take Steps to Improve the Ability of Inspectors General to Determine Beneficial Owners of Companies* (April 8, 2025), https://www.gao.gov/assets/gao-25-107143.pdf.

[19] *See* Press Release, U.S. Att'y's Office, E.D.N.Y., *11 Defendants Indicted in Multi-Billion Health Care Fraud Scheme, the Largest Case by Loss Amount Ever Charged by the Department of Justice* (June 30, 2025), https://www.justice.gov/usao-edny/pr/11-defendants-indicted-multi-billion-health-care-fraud-scheme-largest-case-loss-amount.

scheme nonetheless resulted in approximately $900 million in payments from Medicare supplemental insurers.

Analytics are only as good as the system beneath them. Drop the technology onto thin documentation, missing policies, and weak oversight, and it will launder the same failures faster because the tool amplifies whatever governance it inherits. That is why technology is a bronze bullet, not a silver one, powerful but never enough on its own. It also must run alongside human review, real oversight, and due process, because a detector that flags suspected fraud and withholds payment or benefits before asking questions punishes the honest and erodes trust in the system it was meant to defend.

III. The Wrong Approach

For many of the challenges affecting Medicare and Medicaid, GAO and HHS-OIG have already recommended solutions, yet we keep reaching past them. The problem is not that the government lacks tools. It is that it too often substitutes the most visible response for the one supported by the evidence.

The first is overstatement, and it takes two forms. One is treating improper payment estimates as fraud estimates, which I have already addressed. The other is treating enforcement recoveries as a budget-balancing strategy. Recoveries are real and valuable. They return funds, impose accountability, and can deter future misconduct. But recovery begins after a payment has gone out. It cannot, by itself, close a structural fiscal gap.[20] The work that changes the fiscal trajectory begins earlier: verification before payment, timely information sharing, independent oversight, and implementation of open recommendations.

The second is the blunt instrument: an across-the-board enrollment moratorium that does not distinguish between a compliant operator and a high-risk one within the same provider category, and thus can block both.[21] Moratoria may be lawful and sometimes warranted where there is a significant risk of fraud, but they are the sledgehammer of fraud control: they restrict entry across a category rather than verify ownership, billing legitimacy, or medical necessity on a provider-by-provider basis. Used too readily, they shift the cost of program-integrity failure onto legitimate providers and beneficiaries. Moratoria should therefore remain temporary emergency measures, not routine program-integrity tools: time-limited, evidence-based, access-monitored,

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[20] See Cong. Budget Off., *Monthly Budget Review: Summary for Fiscal Year 2025*, at 1 (Nov. 10, 2025), https://www.cbo.gov/publication/61307 (reporting a fiscal year 2025 federal budget deficit of $1.8 trillion); Press Release, U.S. Dep't of Just., *False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025* (Jan. 16, 2026), https://www.justice.gov/opa/pr/false-claims-act-settlements-and-judgments-exceed-68b-fiscal-year-2025 (reporting more than $6.8 billion in fiscal year 2025 FCA settlements and judgments).

[21] *See* Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Home Health Agencies (HHAs), 91 Fed. Reg. 27,954 (May 15, 2026); Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratorium on Enrollment of Hospices, 91 Fed. Reg. 27,946 (May 15, 2026); Medicare, Medicaid, and Children's Health Insurance Programs: Announcement of Nationwide Temporary Moratoria on Enrollment of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Supplier Medical Supply Companies, 91 Fed. Reg. 9,855 (Feb. 27, 2026).

and subject to meaningful exceptions where beneficiary access would otherwise be impaired. The better control is already in the government's toolkit: targeted, risk-based screening at enrollment and before payment.

The third is the impulse to build something new and call it progress. The core tools for protecting the integrity of health care programs are not new. The False Claims Act dates back to 1863. The inspector general system, MFCUs, and the qui tam mechanism all predate today's initiatives. Their effectiveness depends on stable resourcing and coordination. A new enforcement structure can help, but only if it adds capacity, preserves expertise, and improves coordination with HHS-OIG, MFCUs, and state agencies. Even then, it does not replace the functions the system already depends on. A new division on the org chart does not carry out the outstanding GAO and HHS-OIG recommendations already on the record.

One principle ties these failures together. Precision cuts both ways. It means being tough on fraud when the applicable predicates are met and restrained when they are not. Due process is not an obstacle to enforcement. It's what makes enforcement credible.

IV. Fund the BORING

Nothing I have said is an argument against enforcement, which is essential. Fiscal year 2025 produced record FCA recoveries and DOJ's National Health Care Fraud Takedown, which charged 324 defendants in cases involving more than $14.6 billion in alleged intended loss.[22] Those results are significant, and the teams responsible for them truly deserve recognition. But a takedown is the last mile, not the first. The case that makes the headline is the culmination of a long chain: the career investigators and data analysts who identify the pattern, the inspectors general who audit the program, the MFCUs and the state program-integrity staff who work the files, and the whistleblowers who come forward. Enforcement is only as strong as that chain. You cannot prosecute the cases that the quiet work never identified or developed.

Enforcement is also only half of the system. Recovery runs at the back end: the government pays, then claws back the money through the FCA, audits, and settlements. Prevention runs at the front end, screening eligibility and stopping the payment before it ever leaves—the same discipline I described earlier as verification before payment. The infrastructure does much of that prevention work, and prevention often does not show up in recovery totals, which is exactly why its return is so easy to miss. Recovery is essential, but it cannot substitute for preventing improper payments before they are made.

Even within that recovery channel, the government depends on people it does not employ. Of the $6.8 billion in FCA settlements and judgments in fiscal year 2025, more than $5.3 billion came from qui tam matters involving private relators who shared information with the government

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

about potential violations.[23] That is the largest source of FCA recoveries in a record year, and it is not guaranteed. An Article II challenge to the qui tam mechanism is before the Eleventh Circuit. If that constitutional theory is ultimately upheld, it could substantially weaken a channel responsible for most of the FCA's recoveries.[24] Protecting the infrastructure means protecting that channel too.

The dependency itself is simple. We do not get to keep the last mile while starving the road that leads to it. The takedowns we celebrate, the recoveries we report, the cases that make the news—all of it relies on the quiet work that came before. Cut that work, and the enforcement it feeds goes with it, more slowly and less visibly, but it still disappears.

You cannot task-force your way out of a fraud problem. The actual solution is, by comparison, boring. It is the methodical, foundational work that does not photograph well and does not show its return within a single fiscal year. The solution spells, almost too neatly, the word itself:

> **B: Beneficial ownership.** Close the ownership-opacity gap that lets the same concealed owners bill across multiple programs.
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> **O: Open recommendations.** Implement the recommendations GAO and HHS-OIG have already made and not yet implemented.
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> **R: Risk-based review.** Screen before payment so suspicious claims are caught, while legitimate claims still move quickly.
>
> **I: Interoperability.** Enable the systems to share timely information so investigators can see the whole scheme rather than isolated pieces.
>
> **N: New technology.** Analytics and machine learning deployed as infrastructure: a multiplier on a sound governance foundation, never a substitute for one.
>
> **G: Governance.** Build the data governance, privacy safeguards, and accountability that determine whether any of the above works.

None of this is new, and none of it works without the people who run it: the investigators and auditors whose capacity is being reduced even as viable cases go unpursued and recommendations go unimplemented. Capacity is the precondition for the entire agenda. It is also the easiest thing to cut.

V. We Already Know What to Do

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

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

Administering these programs well is hard work. The numbers are staggering. The money moves quickly. Health care involves an extraordinary number of people and institutions, including providers, payers, administrators, regulators, and beneficiaries, who work within systems that do not always connect. The people responsible for administering those systems are capable and working under significant constraints. That complexity explains why the work is hard. It does not explain why we keep falling short.

The shortfall is in execution, and it is documented. In May 2025, GAO identified 35 priority recommendations for HHS, a category GAO designates as warranting priority attention from Department leadership.[25] Over the following year, HHS implemented four of them. In May 2026, GAO added seven more, leaving 38 priority recommendations open. GAO highlighted two areas for timely, focused attention: strengthening the integrity and oversight of the Medicare and Medicaid programs and improving oversight and coordination of public health programs. Separately, as of May 2026, GAO reported 436 open HHS recommendations, including work on Medicare and Medicaid program integrity and oversight.[26] HHS-OIG's public tracker, last updated May 15, 2026, listed 1,085 unimplemented recommendations across the Department.[27] Those are different counts from different bodies, but they point to the same conclusion. Congress does not have an idea deficit. It has an implementation deficit. We know what to do. The question is why we still have not done it.

That deficit is not a sign that the work is simple or merely neglected. Carrying out these recommendations is slow, costly, sustained work, and the time, money, and expertise it requires keep being pulled toward whatever moves the news cycle. The incentives favor the visible over the durable, so the quiet work thins while the visible work keeps getting fed.

Underlying those reasons is one more, the simplest. The successes of this work are largely invisible, while its failures are public. When the system fails, fraud becomes the news, often stripped of its qualifiers, and the takedown that follows is what everyone sees. When prevention works, the payment is stopped before it is made, leaving nothing for the public to see. Of course, none of it is hidden. It is published and searchable on GAO's website and on Oversight.gov for anyone who wants it. But it simply never draws the same audience as a takedown, so the quiet success earns no applause. This work that protects the public is often the work the public never registers, leaving it with the fewest defenders and making it the easiest to cut. This committee sees both the headline and the record behind it, so while the public will judge by what it is shown, you can judge by the record.

We do not need a new idea. We need to finish the known work and protect the people who do it. Fund the BORING: the quiet work that makes the headlines possible.

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[25] U.S. Gov't Accountability Off., GAO-26-108997, *Priority Open Recommendations: Department of Health and Human Services* (June 3, 2026), https://www.gao.gov/products/gao-26-108997.
[26] *Id.*
[27] Office of Inspector Gen., U.S. Dep't of Health & Hum. Servs., Recommendations Tracker, https://oig.hhs.gov/reports/recommendations/tracker/?view-mode=report-grouped&hhs-agency=all (last visited June 22, 2026).