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Five Things Every Health Care Provider Should Know About HHS OIG's 2025 Semiannual Report

On June 2, 2025, the Department of Health and Human Services (HHS), Office of Inspector General (OIG) published its Semiannual Report to Congress. This report covers the period from October 1, 2024, through March 31, 2025, and highlights the OIG's key findings and recommendations for the reporting period.

Below are the five critical insights every health care provider should be aware of from the report.

1. Monetary Impact: OIG reported \$16.61 billion in total for their work's monetary impact, including \$3.51 billion of the total from investigative receivables, which is money ordered or agreed to be returned to HHS or other governmental entities based on OIG investigations. The findings are evidence of OIG's active enforcement during the reporting period.

2. Enforcement Actions and Exclusions: The OIG initiated a total of 744 enforcement actions, with a nearly equal distribution between criminal (349) and civil (395) actions. Additionally, over 1,500 individuals were added to the OIG exclusion list, rendering them ineligible to participate in federally funded health care programs. These findings highlight the OIG's commitment to pursuing criminal and civil resolution of health care matters as well as health care program exclusions.

3. Medicare Advantage Program Oversight: The OIG identified significant issues within the Medicare Advantage risk adjustment program, including \$13.6 million in net overpayments to three Medicare Advantage plans due to incorrect diagnosis coding. The evaluation revealed that in-home health risk assessments (HRAs) linked chart reviews generated \$4.2 billion of the \$7.5 billion in risk-adjustment payments. Consequently, the OIG recommended that the Centers for Medicare & Medicaid Services (CMS) impose additional restrictions on the use of diagnoses reported solely in in-home HRAs, indicating this area will likely be a focus of future OIG compliance monitoring.

4. Improper Payments: OIG found that CMS "made millions of dollars" in improper drug payments, resulting in unnecessary costs to the federal government and taxpayers. According to its report, this included \$465 million for drugs covered under Medicare Part A

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but paid under Part D, \$454 million for COVID-19 tests exceeding the monthly limit, and \$190 million for outpatient services that were already covered. Given the impact of these payments, claims submitted for these services will likely face higher scrutiny from OIG and CMS in the future.

5. Fraud, Waste and Abuse: OIG evaluated and processed almost 31,000 tips that led to 17,000 referrals including to the Department of Justice and other agencies. During the review period, hotline complaints resulted in expected recoveries totaling \$121 million according to the report.

The report demonstrates the OIG's prioritization of effort to investigate fraud, waste and abuse allegations, and its willingness to seek both civil and criminal resolutions as well as federal health care program exclusion when appropriate. Importantly, the report provides insight into the OIG's priorities and potential areas for future enforcement.

Polsinelli's government investigations attorneys have extensive experience with OIG investigations, including the False Claims Act and Anti-kickback Statute, and are prepared to assist with compliance or any potential enforcement action.