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

HHS OIG Data Brief • A-04-24-03003

Medicare Enrollees Left Acute-Care Hospitals Against Medical Advice at Increasing Rates

Key Takeaways:

- The rates at which enrollees leave acute-care hospitals against medical advice (AMA) have steadily increased since 2006 across most demographics we analyzed and spiked during the COVID-19 public health emergency.
- Enrollees who left AMA were more likely to have poor health outcomes than enrollees discharged to their homes.
- The rates at which enrollees have left AMA appear inversely correlated to the quality-of-care ratings of the associated hospitals—the lower the rating, the higher the rates.
- Enrollees eligible for both Medicare and Medicaid (dual enrollees) and enrollees with a mental health diagnosis were more likely to leave AMA than Medicare-only enrollees and enrollees without a mental health diagnosis, respectively.
- This data brief may be beneficial in the development of future guidance to address this growth, which could improve enrollee health outcomes and save taxpayer dollars.

Purpose of This Data Brief

After being admitted as acute-care hospital inpatients, Medicare enrollees with decision-making capacity, or their surrogates, can discharge themselves and leave against medical advice (AMA).[1] Acute-care hospitals record an enrollee's discharge status using a code on the claim. For example, they use a specific code if they discharge an enrollee to their home (01) and another if they transfer the enrollee to a different acute-care hospital (02). Hospitals designate that an enrollee left AMA using code 07.

Our objectives were to 1) analyze rates and outcomes for Medicare enrollees at acute-care hospitals who leave AMA and 2) provide the Centers for Medicare & Medicaid Services (CMS) and other stakeholders with information that can be used to improve enrollee outcomes.

[1] Leaving AMA is not limited to Medicare enrollees who are admitted as an inpatient. Enrollees who have not been admitted but are receiving hospital outpatient services may also leave AMA.

BACKGROUND

The Medicare Program

Medicare provides health insurance for people aged 65 and older, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge. CMS administers the Medicare program and contracts with Medicare Administrative Contractors to, among other things, process and pay claims submitted by health care providers.

Acute-Care Hospitals

The Social Security Act (the Act) established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare Part A enrollees (the Act §§ 1886(d) and (g)).[2] Payments under IPPS are typically higher than payments for outpatient care. An acute-care hospital stay is generally payable under IPPS if it meets the two-midnight benchmark. This benchmark is met when the admitting practitioner expects the enrollee to require hospital care that crosses two consecutive midnights and such reasonable expectation is supported by the medical record documentation. If a stay does not cross two consecutive midnights because of unforeseen circumstances, such as the enrollee dying, transferring, or leaving AMA, the inpatient stay is still payable.[3]

IPPS payment rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which an enrollee's stay is assigned.[4] The MS-DRG payment is, with certain exceptions, intended to be payment in full to the acute-care hospital for all inpatient costs associated with the enrollee's stay. However, Medicare sometimes pays hospitals a lower per diem rate when they transfer an enrollee to another acute or post-acute-care setting.[5] Regardless of the length of stay, when enrollees leave AMA and do not transfer to another hospital or post-acute care facility, Medicare pays the hospital the full MS-DRG payment.

---

[2] The analysis in this data brief only included inpatient claims from acute-care hospitals paid under IPPS. For example, we excluded all Critical Access Hospitals (CAHs) and all acute-care hospitals in Maryland, as both were paid under different payment systems. However, when analyzing readmission rates, we included all hospital claims paid by Medicare Part A, not just claims of acute-care hospitals paid under the IPPS.

[3] CMS and its contractors presume stays meet compliance with the two-midnight benchmark when an enrollee leaves AMA and do not review these stays to determine if they met the two-midnight benchmark.

[4] There are over 760 different MS-DRGs. These MS-DRGs can be categorized into 26 different medical diagnostic categories (MDCs).

[5] The intent of this policy is to avoid providing an incentive for a hospital to transfer an enrollee to another setting before treatment of the enrollee's acute condition is stabilized.

Conditions of Participation

Hospitals that participate in the Medicare and Medicaid programs must comply with CMS's health and safety standards, known as the Conditions of Participation (CoPs). As part of CMS's CoPs, a hospital's discharge planning process must ensure an effective transition of the enrollee from hospital to post-discharge care and reduce the factors leading to preventable hospital readmissions. The hospital must start the discharge planning process early in the hospital stay. The hospital must also include the patient and the patient's caregiver as "active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences . . ." (42 CFR § 482.43).

However, CMS has no guidance on how to reconcile this requirement when a hospital designates that a patient decided to leave AMA. Such a designation could indicate a breakdown in the active partnership between the hospital and the patient. During our discussions with CMS, officials could not offer any clinical, regulatory, or professional standards to guide hospitals on when to designate that a patient is leaving AMA other than citing the use of clinical judgment. In addition, CMS has no guidance on what discharge-planning and follow-up steps are expected when a patient leaves AMA.

In 2019, CMS stated in the Federal Register that "[w]e understand that situations may arise where patients may prefer not to participate in the discharge planning process. For patients who decline to participate in the discharge planning process or leave the hospital or CAHs against medical advice, we expect hospitals to document in the medical record the patient's refusal to participate in the discharge planning process, and that such attempts to include the patient and/or the patient's caregiver in the discharge planning process were made by hospital staff" (84 Fed. Reg. 51836, 51855 (Sept. 30, 2019)). However, CMS has no guidance further addressing this expectation. Hospitals typically ask patients to sign a form indicating that they acknowledge they are leaving AMA, that they understand the risks associated with leaving AMA, and that they release the hospital and its employees from liability.[6]

CMS relies on State survey agencies and accreditation organizations (AOs) to survey and certify compliance with the CoPs. Four AOs survey roughly 90 percent of acute-care hospitals. During our audit, we discussed with CMS and the AOs their oversight procedures for assessing compliance with the CoPs but could not identify any additional guidance or survey steps that they use that specifically pertain to patients leaving AMA.

[6] The wording of these liability waivers varies from hospital to hospital and may not alleviate all liability for the hospital or its employees.

Data Used To Develop This Data Brief

The claims used in developing this data brief came from CMS's Integrated Data Repository (IDR).[7] We analyzed paid claims for acute-care hospital inpatient stays for which the claim was paid under the IPPS.[8, 9]

The audit period in this data brief is January 1, 2019, through December 31, 2023. However, we also looked at data prior to our audit period to analyze trends over time.[10]

All enrollees in our analysis received Medicare Part A benefits. If an enrollee also received Medicaid benefits, we refer to them as "dual enrollees." We identified enrollees covered by Medicaid at the time of discharge. If an enrollee did not receive Medicaid benefits, we refer to them as "Medicare-only." Although being a dual enrollee is not an exact measure of income, due in part to the variability of Medicaid eligibility rules within each State, an enrollee's Medicaid status can be used as a proxy for an enrollee's income level.[11] Dual enrollees generally have lower incomes than Medicare-only enrollees.

The diagnosis codes used in our analysis are defined by the International Classification of Diseases (ICD), Clinical Modification (CM), Official Guidelines for Coding and Reporting (ICD Coding Guidelines).[12]

---

[7] The IDR is a high-volume data warehouse integrating Medicare claims, enrollee and provider data sources, and ancillary data such as contract information and risk scores.

[8] This analysis excludes claims from hospitals not paid under IPPS, e.g., all CAHs and all acute-care hospitals in Maryland, as both were paid under different payment systems. However, when analyzing readmission rates, we included all hospital claims paid by Medicare Part A, not just claims of acute-care hospitals paid under the IPPS.

[9] We excluded enrollees who died during a hospital stay.

[10] Within the IDR, claims data from 2006 are the first full year's worth of available data. We grouped the claims based on the year of the discharge, starting with claims with discharges in 2006 and ending with claims with discharges in 2023. See the Appendix for more details about our audit period.

[11] To participate in Medicaid, Federal law requires States to cover certain groups of individuals. Low-income families, qualified pregnant women, children, and individuals receiving Supplemental Security Income are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community-based services. The extent of Medicaid coverage can also vary based on eligibility rules. We classified Medicare enrollees as dual enrollees if the IDR showed they were enrolled for any type of Medicaid coverage. If the value of the Medicaid enrollment field in the IDR was missing, we excluded the stay from our enrollment analysis.

[12] Physicians and other health care providers use the ICD as a coding system to classify and code all diagnoses, symptoms, and procedures. Effective October 1, 2015, CMS transitioned from the 9th revision of the ICD Coding Guidelines (ICD-9-CM) to the 10th revision (ICD-10-CM).

We calculated relative risk measures to determine how much more or less likely it is for an enrollee to leave an acute care hospital AMA, die, or be readmitted in one scenario compared to another.[13]

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The Appendix describes our audit scope and methodology.

RESULTS OF ANALYSIS

The rates at which enrollees have left acute-care hospitals AMA have steadily increased since 2006 and spiked during the COVID-19 public health emergency (PHE).[14] This increase could have a negative effect on patient health outcomes and a financial impact on the Medicare program. Information in this data brief may be beneficial to CMS and other stakeholders when developing future guidance to help address this growth, which could improve patient outcomes and save taxpayer dollars.

Growth in Rates of Enrollees Leaving AMA

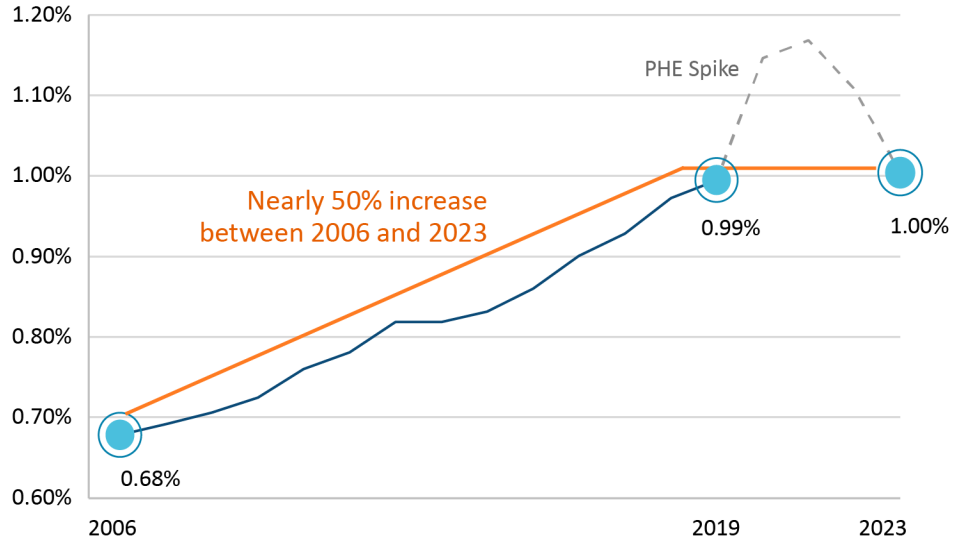
Between 2006 and 2023, the rate of enrollees who left AMA has increased by almost 50 percent. The rate increased from approximately 0.68 percent of discharges in 2006, to 0.99 percent of discharges in 2019. In 2006, enrollees left AMA 72,529 times out of 10,699,861 discharges. In 2019, enrollees left AMA 84,123 times out of 8,456,947 discharges.[15] During the PHE, the rates increased to as much as 1.17 percent before dropping down to 1 percent in 2023, a rate still slightly higher than the pre-PHE level (see Figure 1).

[13] The relative risk of two events is the ratio of the chance of Event A to the chance of Event B. We present relative risk results in this data brief using statements like, "Event A was X times as likely than Event B." When we analyzed the relative risk values, we used a value of 1 to mean no difference between the scenarios existed. The further the relative risk was from 1, the more likely the scenario was to occur compared to the other.

[14] The COVID-19 PHE started on Mar. 1, 2020, and ended on May 11, 2023.

[15] Although the rate of enrollees leaving AMA has been increasing, the total number of stays for which enrollees left AMA has not had the same growth because of the decline in the total number of Part A acute-care hospital inpatient discharges.

Figure 1: Rates of Enrollees Leaving Acute-Care Hospitals AMA Over Time



The growth in the rates of enrollees who left AMA appears consistent across most of the demographics that we analyzed, including enrollee type, hospital size, population density, and medical condition.[16]

Enrollee Health Outcomes After Leaving AMA

During our audit period, when enrollees left AMA, they were more than twice as likely to be readmitted or die within 30 days of discharge (see Figures 2 and 3) than enrollees discharged home. Enrollees who leave AMA were more likely to have poor health outcomes, which raises Medicare costs in the future.

[16] The growth in the rates of enrollees who left AMA varies across some medical diagnostic categories (MDCs), which classify hospital stays into related groups; however, there is consistent growth across most MDCs. Notably, from 2006 to 2019, the rates of enrollees who left AMA for the MDCs for the Endocrine, Nutritional, and Metabolic System and Infection and Parasitic Diseases and Disorders increased by 114 percent and 108 percent, respectively. The rates of enrollees who left AMA for the MDCs for the Male Reproductive System and the Female Reproductive System increased by 204 percent and 156 percent, respectively. A few MDCs did not show consistent growth despite traditionally having some of the highest rates of enrollees leaving AMA. For example, the rates for the MDC of Alcohol/Drug Use or Induced Mental Disorders remained stable and the rates for the MDC of Mental Disease Disorders decreased slightly.

Figure 2: 30-Day All-Cause Readmission Rates of Enrollees Who Left AMA Versus Enrollees Discharged Home

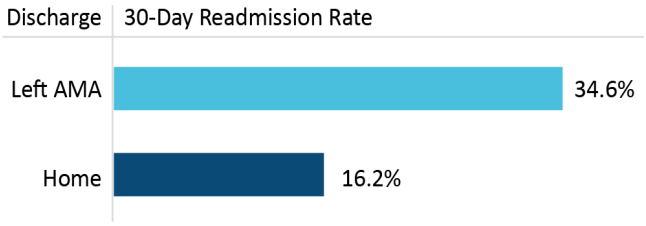
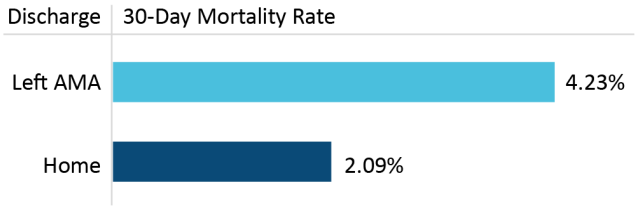


Figure 3: 30-Day All-Cause Mortality Rates of Enrollees Who Left AMA Versus Enrollees Discharged Home



The increased risk of readmission and mortality can vary within the medical diagnostic categories (MDCs). For example, enrollees who left AMA during a stay for an MDC of Diseases and Disorders of the Musculoskeletal System and Connective Tissue (MDC 08) were more than four times as likely to be readmitted than an enrollee who was discharged at a time doctors deemed appropriate. However, enrollees who left AMA during a stay for an MDC of Myeloproliferative Diseases and Disorders or Poorly Differentiated Neoplasms (MDC 17) were only marginally more at risk of being readmitted.

Health Outcomes of Enrollees Leaving AMA Over Time

The health outcomes for enrollees who leave AMA has remained fairly constant, except for a spike in mortality during the PHE. Dual enrollees have consistently higher readmission rates when they leave AMA than Medicare-only enrollees who leave AMA and all enrollees discharged to home. However, Medicare-only enrollees have consistently higher mortality rates when they leave AMA than dual enrollees and all enrollees discharged home (see Figures 4 and 5).

Figure 4: 30-Day All-Cause Readmission Rates Over Time by Enrollment Type

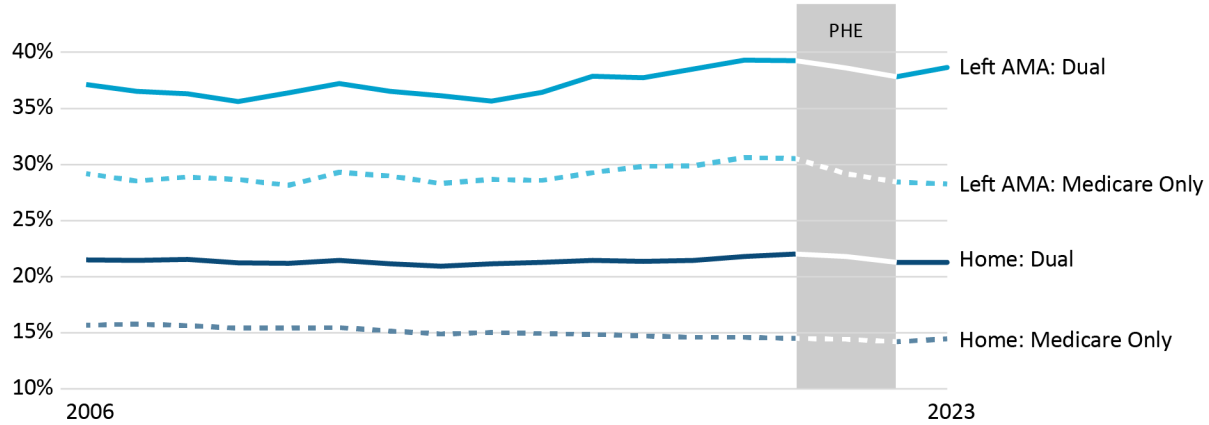
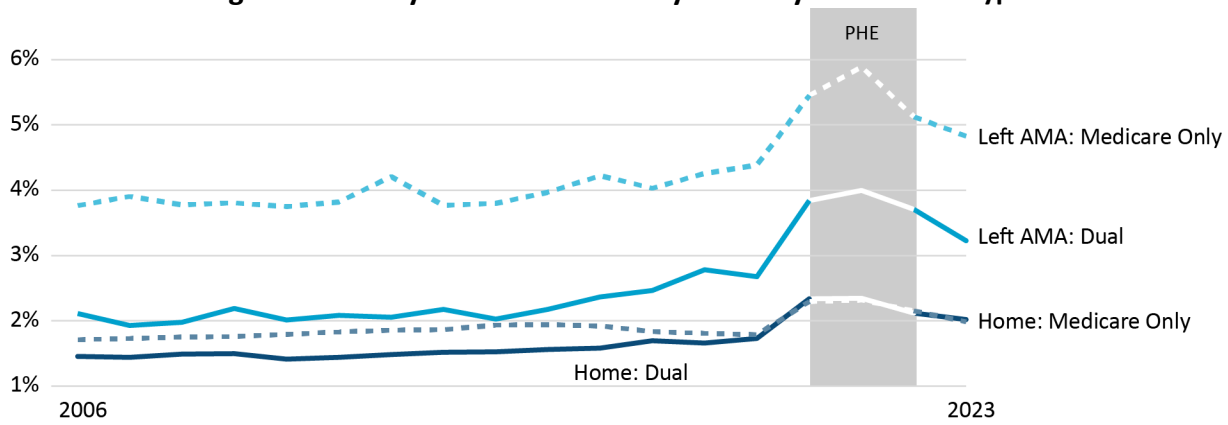


Figure 5: 30-Day All-Cause Mortality Rates by Enrollment Type



Analysis of Rates of Enrollees Who Left AMA and Hospital Quality of Care

CMS uses the Overall Hospital Quality Star Rating (Star Rating) to summarize a variety of measures across five categories.[17] Not every hospital has a Star Rating due to minimum reporting thresholds.[18] Once reporting thresholds are met, a hospital's Star Rating is calculated using only those measures for which data are available. The Star Rating compares hospitals within peer groups. For example, larger hospitals with a more diverse patient population, such as urban teaching hospitals, which have a greater number of measures, are placed into a different peer group than smaller hospitals with a less diverse population of patients.

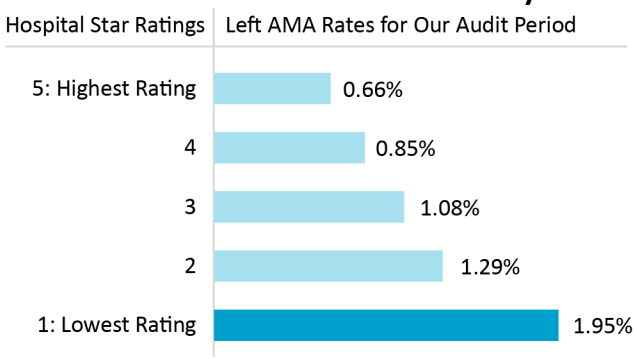
The readmission and mortality measures that CMS uses to calculate Star Ratings exclude stays for which the enrollee left AMA, which could inflate a hospital's quality care measures.[19] Despite this, the rates that enrollees have left AMA appear inversely correlated to the overall quality-of-care ratings of the hospitals during our audit period. The lower the Star Rating a hospital has, the more likely its enrollees were to leave AMA. Hospitals with the lowest Star Rating were almost three times more likely to have an enrollee leave AMA than hospitals with the highest Star Rating (see Figure 6).

[17] CMS releases the Star Ratings annually, but the timeframes used for each update can vary and are not always the same for each measure. For the 2024 Star Ratings, the multiple collection periods span Apr. 1, 2019, through Mar. 31, 2023. The five categories are mortality, safety of care, readmission, patient experience, and timely and effective care. CMS calculates a standardized score for each category that it then uses to calculate the overall Star Rating. Some of the measures used to calculate the Star Rating are based only on data from Medicare enrollees; others are based on data from hospitals' general patient population, regardless of payer. For example, mortality and readmissions measures include data from Medicare enrollees only. The patient experience, safety of care, and timely and effective care measures include data from any adult patient treated at hospitals.

[18] To receive a Star Rating, a hospital must have at least three measures in at least three categories, one of which must be either the safety of care or mortality category.

[19] A hospital's Star Rating could be lower with the inclusion of the enrollees from these stays because they typically have higher readmission and mortality rates. CMS states that it excludes these enrollees because hospitals do not often have the opportunity to deliver full care and prepare the enrollees for discharge.

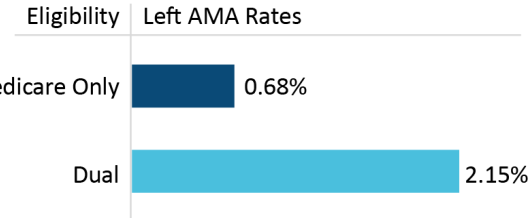
Figure 6: Rates of Enrollees Who Left AMA by Star Ratings



Dual Enrollees Leave AMA at Higher Rates

During our audit period, dual enrollees were more than three times as likely to leave AMA than Medicare-only enrollees (see Figure 7).

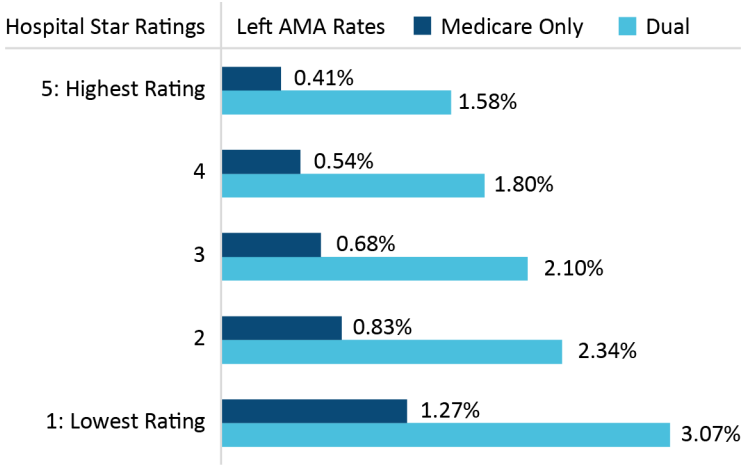
Figure 7: Rates of Enrollees Who Left AMA by Enrollment Type



Dual Enrollment and Hospital Star Ratings

During our audit period, a dual enrollee was more likely to leave AMA than a Medicare-only enrollee regardless of the Hospital Star rating. In addition, a dual enrollee at a lowest-rated hospital was almost 7.5 times more likely to leave AMA than a Medicare-only enrollee at a highest-rated hospital (see Figure 8).

Figure 8: Rates of Enrollees Who Left AMA by Star Ratings and Enrollment Type



Analysis of Enrollees for Whom the Hospital Coded That a Procedure or Treatment Was Not Carried Out

Hospitals can include an ICD-10-CM diagnosis code on a claim indicating that treatment was not carried out for a variety of reasons (Z53 diagnosis codes), such as the enrollee's religious beliefs (see Table 1 for a full list of the Z53 diagnosis codes). Hospitals can include these codes when a patient leaves AMA or when the hospital discharges the patient home or elsewhere.[20]

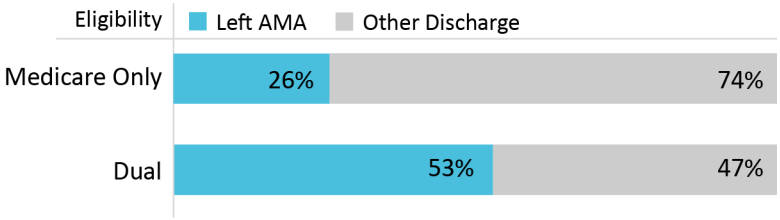
Table 1: Diagnosis Codes Indicating a Procedure or Treatment Was Not Carried Out

Diagnosis Code	Reason Procedure or Treatment Not Carried Out
Z53.01	Patient smoking
Z53.09	Other contraindication
Z53.1	Patient's decision for reasons of belief and group pressure
Z53.20	Patient's decision for unspecified reasons
Z53.21	Patient leaving prior to being seen by health care provider
Z53.29	Patient's decision for other reasons
Z53.8	Other reasons
Z53.9	Unspecified reason

During our audit period, when a Z53 diagnosis code was applied, the hospital was twice as likely to indicate that it was a dual enrollee who left AMA rather than a Medicare-only enrollee (see Figure 9). As mentioned previously, CMS could not offer any clinical, regulatory, or professional standards to guide hospitals on when to designate that a patient is leaving AMA, other than citing the use of clinical judgment.

[20] During our audit period, the hospitals used a Z53 code roughly 23 percent of the time when an enrollee left AMA and approximately 1 percent of the time when the enrollee was otherwise discharged.

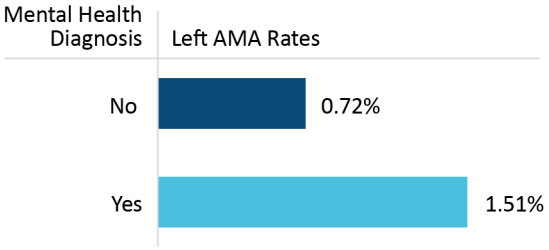
Figure 9: Rates of Enrollees Who Left AMA by Enrollment Type Where the Hospital Coded That a Procedure or Treatment Was Not Carried Out



Enrollees with a Mental Health Diagnosis Leave AMA at Higher Rates

During our audit period, an enrollee diagnosed as having a mental, behavioral, or neurodevelopmental disorder (mental health diagnosis) was more than twice as likely to leave AMA than an enrollee without this type of diagnosis (see Figure 10).[21]

Figure 10: Rates of Enrollees Who Left AMA and Had a Mental Health Diagnosis Versus Those Who Did Not



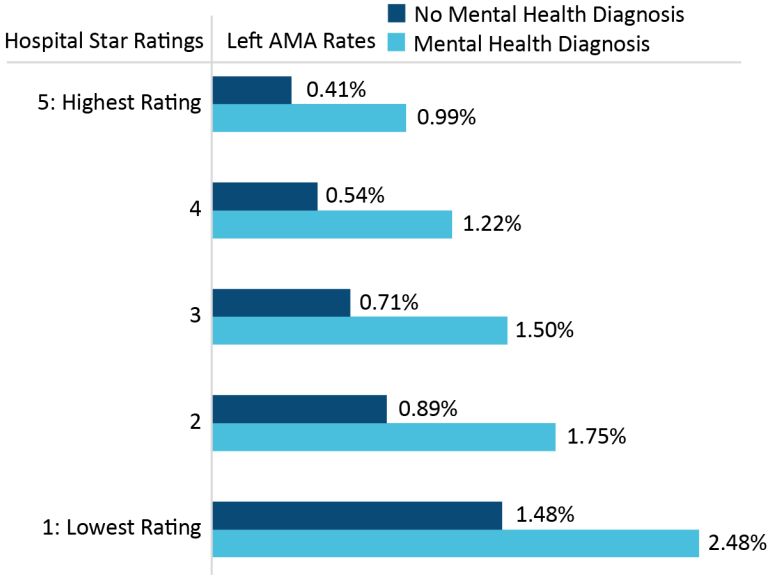
Even when excluding stays with an MDC for Alcohol/Drug Use or Induced Mental Disorders (MDC 20) and Mental Diseases and Disorders (MDC 19) from our analysis, enrollees with a mental health diagnosis were still almost twice as likely to leave AMA as enrollees without this type of diagnosis.

Enrollees with a Mental Health Diagnosis and Hospital Star Ratings

During our audit period, an enrollee with a mental health diagnosis was more likely to leave AMA than an enrollee without a mental health diagnosis, regardless of the hospital's Hospital Star rating. In addition, an enrollee with a mental health diagnosis at a lowest-rated hospital was more than six times as likely to leave AMA than an enrollee without a mental health diagnosis at a highest-rated hospital (see Figure 11).

[21] Within the ICD-10-CM, the code for mental, behavioral, or neurodevelopmental disorders starts with an "F." There is no diagnosis code or other field to indicate when a patient has been deemed incapacitated or incompetent to make decisions about their health care treatment and the decision to leave AMA.

Figure 11: Rates of Enrollees Who Left AMA by Star Ratings and Mental Health Diagnosis



CONCLUSION

This data brief highlights the potential consequences and increasing frequency of Medicare enrollees leaving AMA. Enrollees with decision-making capacity are empowered to discharge themselves and leave AMA; however, the data show that they are more likely to have poor health outcomes, which raises Medicare costs in the future.

The rates at which enrollees have been leaving AMA have been steadily increasing since at least 2006, spiked during the PHE, and returned to a rate after the PHE that remained slightly higher than the pre-PHE rate. In addition, the growth rates of enrollees who left AMA appear consistent across many demographics and are not isolated to one hospital type, enrollee group, or medical condition.

The results of our analysis also identify areas where stakeholders might focus when developing guidance related to patients leaving AMA. Specificially, the rates that enrollees leave AMA appear inversely correlated to the overall quality-of-care ratings of the hospitals. In addition, dual enrollees and enrollees with mental health diagnoses have been leaving AMA at disproportionate rates.

The information in this data brief presents trends in rates that enrollees leave acute-care hospitals AMA and is provided for informational purposes only; therefore, the data brief does not contain any specific recommendations. However, information in this data brief may be helpful to CMS and other stakeholders when conducting further research and developing guidance and best practices that can be used to address this growth and improve enrollee outcomes. Finding ways to reduce the rate of enrollees who leave AMA or the poor outcomes these enrollees suffer when they do leave AMA will likely improve the health of the Medicare

enrollees and save Medicare costs.

We issued a draft of this data brief to CMS. CMS furnished technical comments, which we addressed as appropriate.

APPENDIX: AUDIT SCOPE AND METHODOLOGY

The Medicare claims used in this data brief come from the IDR. We analyzed paid claims for acute-care hospital inpatient stays where the claim was paid under the IPPS. Specifically, we analyzed the rates of enrollees leaving AMA across a variety of demographic variables.

The audit period in this data brief is January 1, 2019, through December 31, 2023. This covers the years included in the collection of the data used to calculate the most recent Star Rating.[22] However, we also looked at trends that started before our audit period.

Our objective did not require an overall assessment of CMS's internal control structure. Rather, we interviewed CMS officials and AOs to gain an understanding of any relevant requirements within the CoPs and corresponding survey procedures.

We calculated relative risk measures to determine how much more or less likely it is for an enrollee to leave an acute care hospital AMA, die, or be readmitted in one scenario compared to another.[23]

We conducted our audit from May 2024 through July 2025, which included discussing the results of the audit with CMS officials.

We issued a draft of this data brief to CMS. CMS furnished technical comments, which we addressed as appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[22] For the most recent Star Ratings, the collection periods vary per measure, but span Apr. 1, 2019, through Mar. 31, 2023.

[23] The relative risk of two events is the ratio of the chance of Event A to the chance of Event B. We will present relative risk results in this data brief using statements like, "Event A was X times as likely as Event B." When we analyzed the relative risk values, we used a value of 1 to mean no difference between the scenarios existed. The further the relative risk was from 1, the more likely the scenario was to occur compared to the other.

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.

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.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov