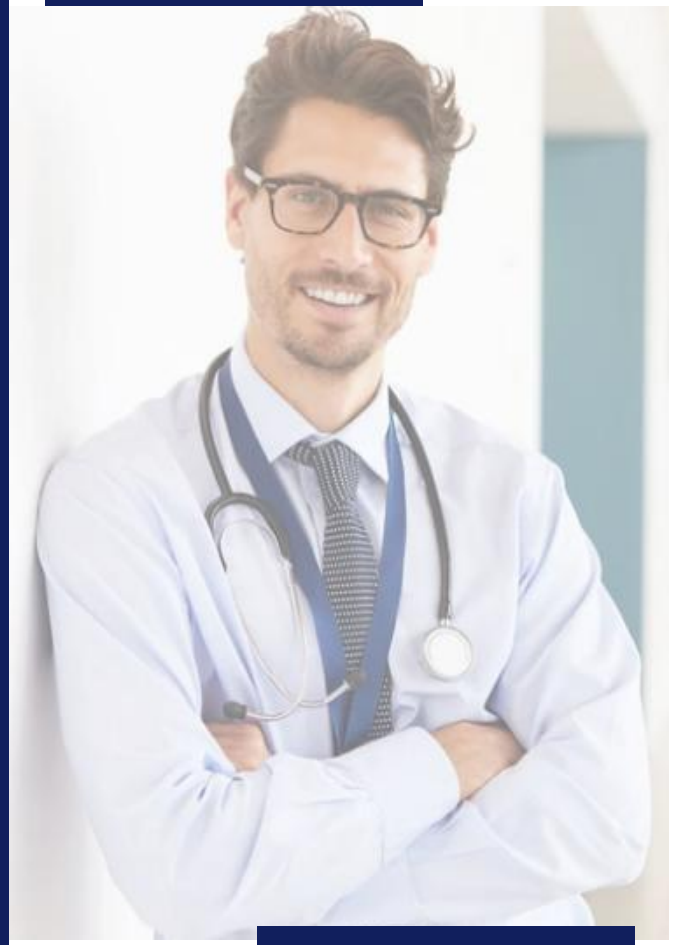
PBACO

Fraud & Abuse

David Klebonis
President & COO

About PBACO



96% AVERAGE QUALITY SCORE
SINCE PY2023

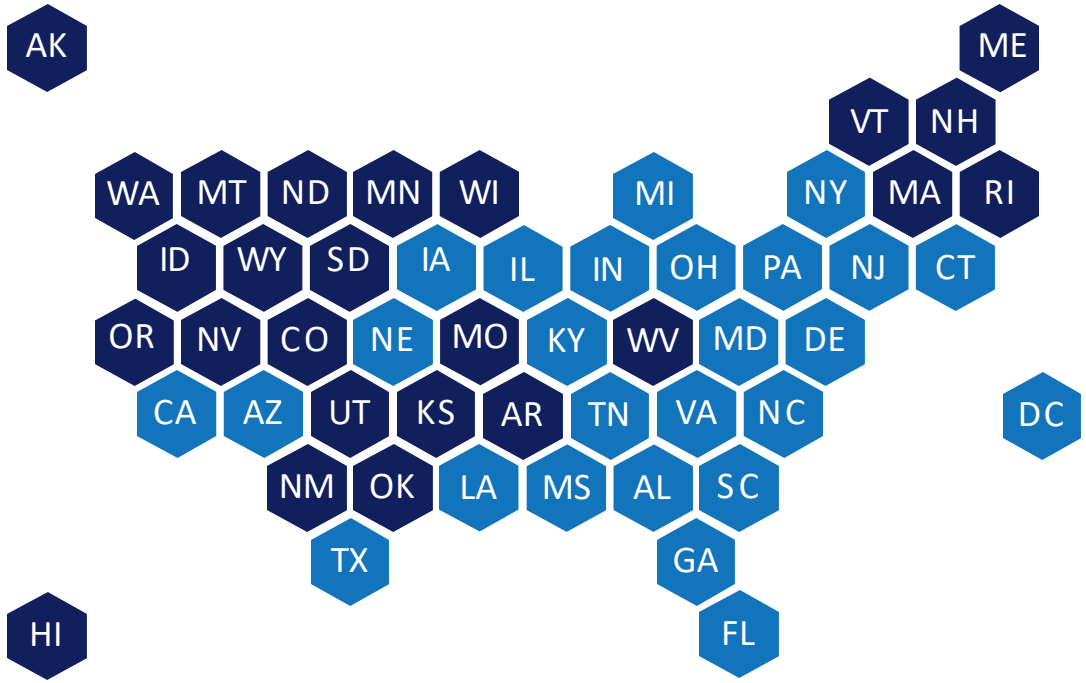
100% Quality Score PY2020 & 2021

OVER $467.3M IN DISTRIBUTIONS
TO PHYSICIANS

TOP 5 RANK NATIONALLY
SINCE INCEPTION

#1 in Shared Savings PY2016, 2018, 2019, 2020 & 2021

EXPANDING OUR FOOTPRINT & NETWORK



$5B+
Medical Spend Under Management

490K+
PY25 Medicare, Commercial & ACO Reach LUM

26
PY25 States (including DC)

$800M
Medicare Trust Fund Savings

$571M+
MSSP Revenue to PBACO

15K+
Affiliated Providers PCPs, Specialists, PAs RNs

IDENTIFY AND PREVENT: HOW WE DO THIS

Identification

- Flag DME companies submitting suspicious or fraudulent claims
- Assess provider expenses (Total, Expense/Visit, Expense/Patient)

Scrutinize Ordering Practices

- Check if the ordering provider has a related E&M (Part A or B service)
    - Contact ordering providers directly by phone or mail
- Review online complaints (Better Business Breau, Google, Yelp)

Gather Supporting Evidence

- Verbal and written beneficiary attestations
- Claim trends (catheters, collagen dressings, etc.)

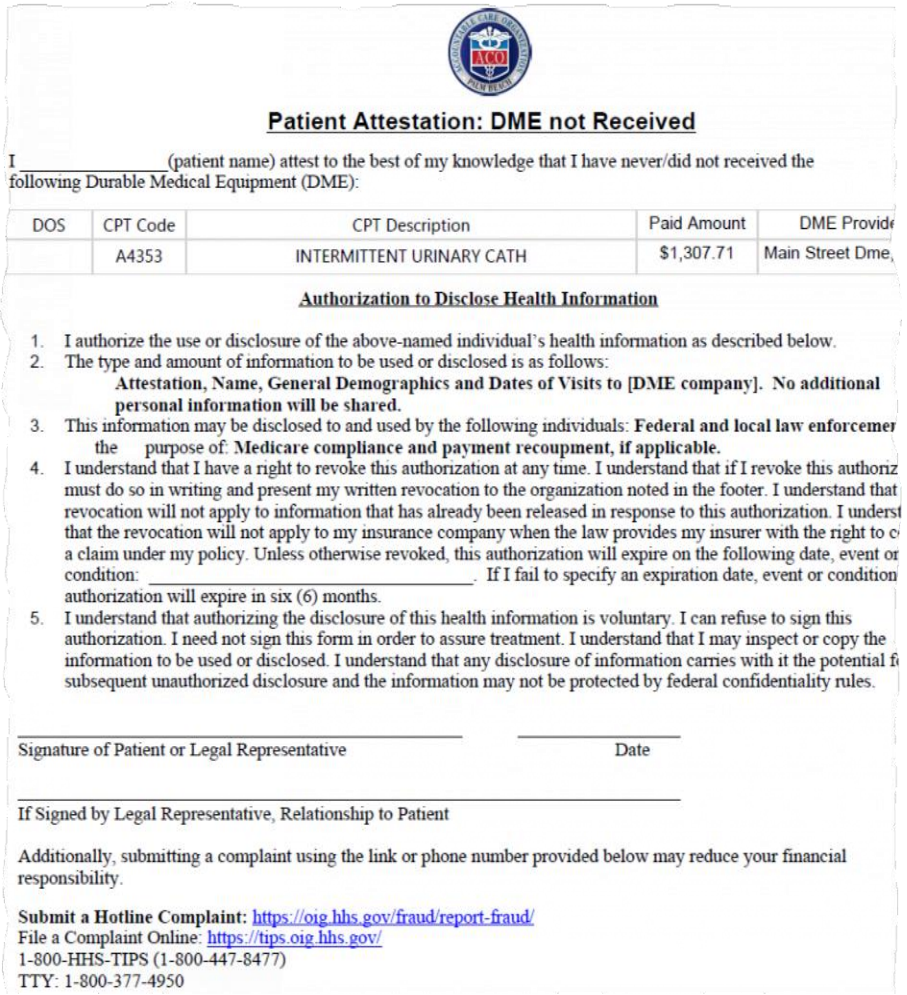
Escalate for Investigation

- Submit compiled evidence to HHS-OIG and Safeguard Services

End Result

- Prevent future fraud from flagged companies
- Medicare may adjust payments, though outcome is not guaranteed

BENEFICIARY ATTESTATION & SUBMISSION TRACKING



Patient Attestation: DME not Received

I _____(patient name) attest to the best of my knowledge that I have never/did not received the following Durable Medical Equipment (DME):

DOS	CPT Code	CPT Description	Paid Amount	DME Provide
	A4353	INTERMITTENT URINARY CATH	$1,307.71	Main Street Dme,

Authorization to Disclose Health Information

1. I authorize the use or disclosure of the above-named individual's health information as described below.
2. The type and amount of information to be used or disclosed is as follows:
   Attestation, Name, General Demographics and Dates of Visits to [DME company]. No additional personal information will be shared.
3. This information may be disclosed to and used by the following individuals: **Federal and local law enforcemer**
   the purpose of: **Medicare compliance and payment recoupment, if applicable.**
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authoriz must do so in writing and present my written revocation to the organization noted in the footer. I understand that revocation will not apply to information that has already been released in response to this authorization. I underst that the revocation will not apply to my insurance company when the law provides my insurer with the right to c a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition authorization will expire in six (6) months.
5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential f subsequent unauthorized disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Relationship to Patient

Additionally, submitting a complaint using the link or phone number provided below may reduce your financial responsibility.

Submit a Hotline Complaint: https://oig.hhs.gov/fraud/report-fraud/
File a Complaint Online: https://tips.oig.hhs.gov/
1-800-HHS-TIPS (1-800-447-8477)
TTY: 1-800-377-4950

Impact Snapshot (2021 – Present)

- **259 companies** reported to oversight agencies
- **2,609 verbal** and **1,705 written** attestations collected
- **$108M** identified in fraudulent claims
- **Just $19M** successfully recouped
- **Fewer than 10** indictments to date

FRAUDULENT PART B DME CLAIMS

Less than **5%** of fraudulent Part B DME claims are timely adjusted, or we receive a reopening payment.

In the event of a reopening payment, PBACO will ensure that any recovered funds are accurately reallocated to the appropriate entities.

ACO FRAUD PROCESS EXPLAINED

→ Claims reviewed monthly to identify new fraudulent claims/ companies

→ Practices are provided with a list of claims and asked to contact the patients for verbal attestations.

→ Findings are to be reported back to the ACO

→ Once 7 patients have confirmed that they did not receive the DME, the company can be reported to law enforcement.

→ Paper attestation forms are distributed to impacted practices for their patients to sign. The forms provide further assistance in fraud investigations.

HOW CAN YOU HELP?

Submit information about the fraudulent activity to Medicare

It is recommended that the patient as well as the provider report the fraud through one of the options below:

- FRAUD Hotline: 1-800-447-8477
- https://oig.hhs.gov/fraud/report-fraud/

It is also recommended that patients with multiple fraudulent claims request a new Medicare ID number:

- CMS handles all requests for changes in Medicare Numbers. Advise the patient to call Medicare 1-800-MEDICARE (1-800-633-4227) to request a new Medicare Number.

THANK YOU

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www.pbaco.org 561-429-2680

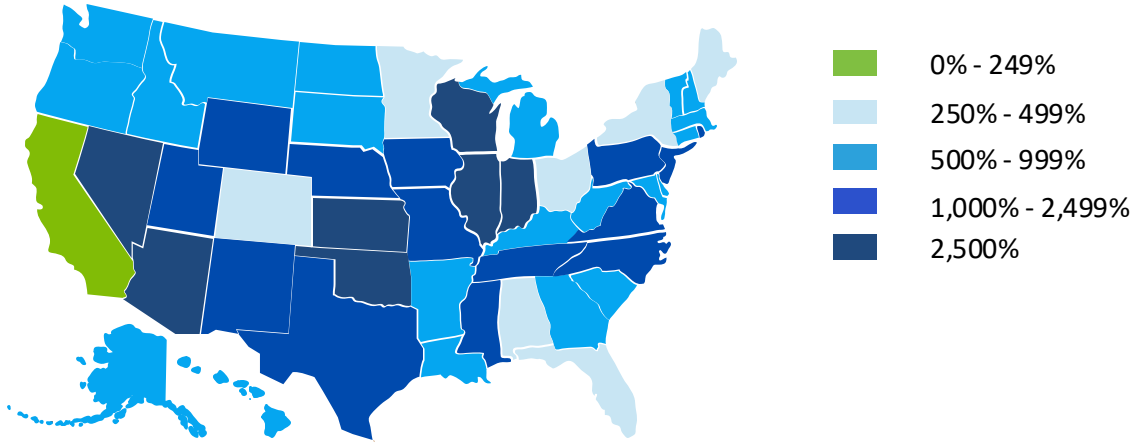
Hot Fraud Summer(s)!

ACOs are at the forefront of identifying fraud, waste, and abuse

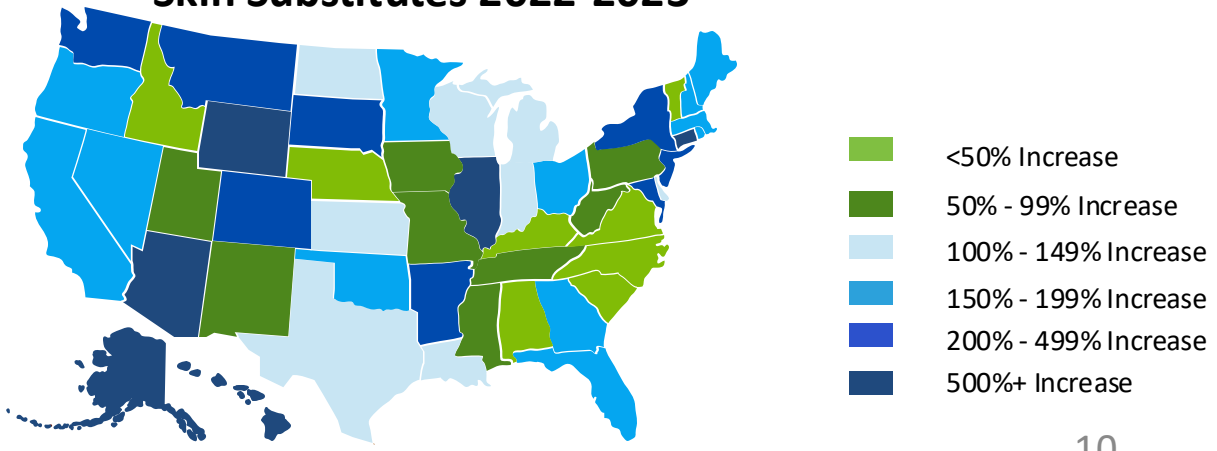
NAACOS:

- Support identification of trends– send what you're seeing to NAACOS connect and email advocacy@naacos.com
- Work with CMS to address fraud, waste, and abuse
  - Crushing Fraud, Waste, and Abuse- Chilli Cook Off
  - WISeR (Wasteful and Inappropriate Service Reduction) Model
  - Improvements to reporting process and feedback loops
- Ensure ACOs are not held accountable for fraudulent spending outside of their control

Catheter DME 2022-2023



Skin Substitutes 2022-2023



Serious Anomalous and Highly Suspect Billing (SAHS)

CMS will remove claims from benchmarks, expenditures, and trend adjustments

CURRENT POLICY

- CMS gives itself the sole discretion to identify SAHS billings that would warrant adjustments
- Criteria:
  - The billings have national or regional impact or significance;
  - Inaction would create an imbalance between ACO performance and historic benchmark expenditures;
  - Anomalous billings could result in significantly inaccurate and inequitable determinations that are outside of an ACOs' control; or
  - The claims may disproportionately represent Medicare providers or suppliers whose Medicare enrollment status has been revoked
- Additionally, CMS must consider the national or regional significance since any adjustment would be nationwide
  - The agency would be more likely to trigger an adjustment if the anomalous billing is outside of ACOs' control

RECOMMENDED MODIFICATIONS

- Application at ACO or county level, not just rare/extreme, national cases
- Criteria:
  - Significant increase in a particular billing code compared to historical;
  - Claims for which CMS payment is paid into escrow;
  - Claims submitted by a provider under indictment or investigation by a Federal agency;
  - Claims for DMEPOS that are not supported by a referral from a treating provider or by a corresponding office visit as evidenced from reliable sources such as CCLF6 (Part B DMEPOS File)
  - Claims from any DMEPOS provider for which CMS has reversed a threshold of the claims for a Performance Year;
  - Claims for billing codes previously deemed SAHS in prior years.
- A materiality threshold across all criteria:
  - Claims must represent a minimum percent of the ACO's benchmark for the applicable performance year
  - Claims must be for services not provided by an ACO participant

Other Recommendations

Download our fact sheet

Reopening Determination

- Allowing ACOs to reopen settlements from 2 to 3 years prior if criminal proceedings are initiated against potentially fraudulent providers
- Establishing a process for preliminary reconciliation when there is active fraud investigations for the ACO aligned beneficiaries.

Streamlined Reporting:

- Establish a streamlined process within HHS (including OIG) to report suspected fraudulent billing activity
- Include standardized checklist of required data elements for reports
- Include categorization to distinguish clear instances of fraud from potential waste or abuse

Feedback Loops:

- Acknowledge receipt of reporting within 30 days of receipt
- Mechanisms to inform ACOs reporting suspected fraud, including confirmation of report receipt within 30 days
- Sharing information on fraud trends to the extent applicable
- Flagging in beneficiary-level financial files any claims held in escrow due to fraud investigations to the extent applicable

Addressing Skin Substitutes

Download our fact sheet

Changing payment policy and coverage

- Close the loopholes that promote use of new/expensive products
  - ***Support paying skin substitutes as incident-to supplies*** (CY 2026 Physician Fee Schedule proposal)
  - ***Support development of single payment rate across all products regardless of new classification*** (CY 2026 Physician Fee Schedule proposal)
    - Skin Substitute Access and Payment Reform Act of 2025 is not preferred as sets limits higher than in the PFS proposal
- Create consistent coverage determination

Ensuring ACOs are held harmless

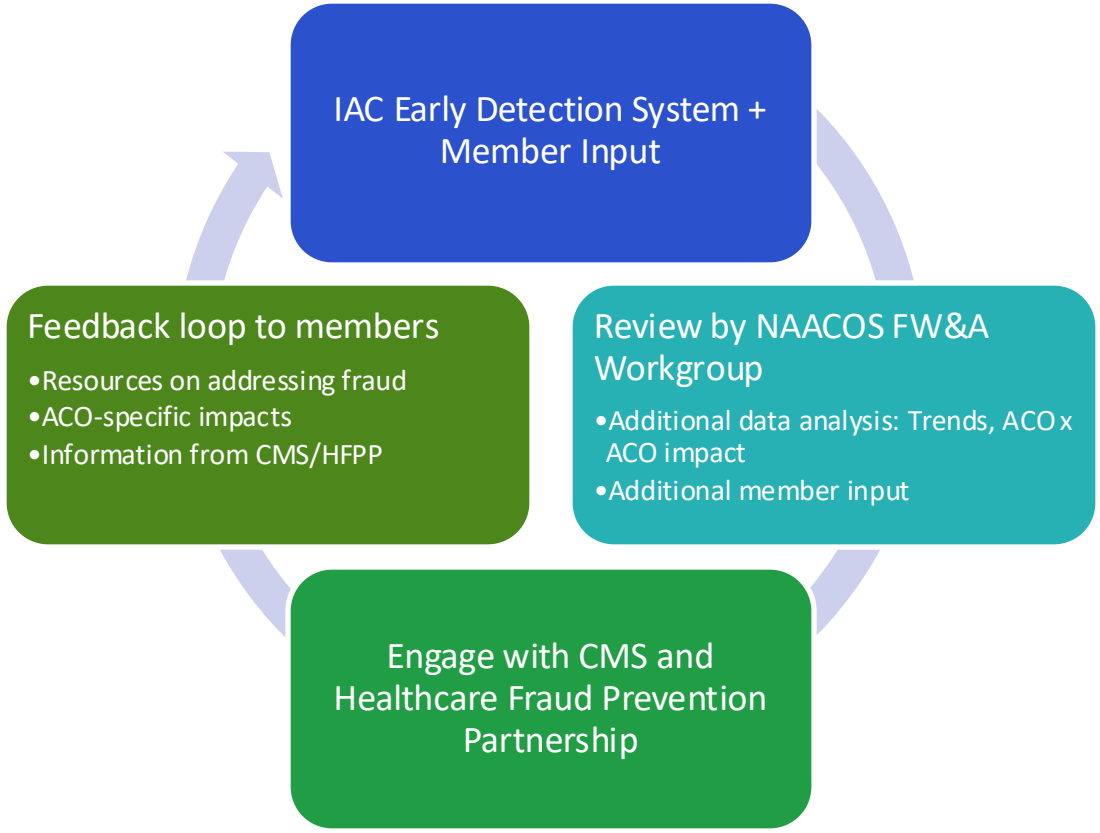
Trend factors protect most ACOs from the increase in skin substitute spending

ACOs outside of trend tend to be smaller and treat complex populations

Recommended policies:

- Set a truncation factor for skin substitute spending to bring ACOs higher than trend within trend.
- Allow ACOs to retrospectively opt-in to the CMS stop loss (REACH only).
- Remove skin substitute trend from RTA (if corridors are reached)

NAACOS Support



Send areas of suspected fraud, waste, and abuse to NAACOS Connect and advocacy@naacos.com

**Please exclude any PHI*