Accountable Care Detects and Helps Stop Fraud, Waste and Abuse

Providers in accountable care organizations (ACOs) are on the front lines of identifying and addressing fraud, waste, and abuse in health care. ACOs appreciate CMS' partnership in fighting fraud, waste, and abuse, improving reporting, and developing meaningful feedback loops. Stronger collaboration is needed to improve care, reduce fraud, and lower spending.

ACOs are key to understanding and controlling health costs.

In designing innovative care approaches, ACOs leverage claims and clinical data to identify opportunities for clincial interventions, as well as trends in cost and health care utilization. This approach allows ACOs to recognize unusual spending, guiding their own local investigations, and reports of suspected fraud to the federal government.

Identifies suspect trends	Investigates spending	Implements clinical interventions	Reports fraud to Feds	Scales best practices
Reviews data on ongoing basis; identifies outlier costs.	Taps providers, engages patients, and researches suppliers to understand spending.	Works with providers to mitigate spending through updates to clinical care.	Reports suspected fraud to federal partners at CMS, OIG, and others to investiate.	Works with NAACOS to identify regional and national trends; share mitigation strategies and resources.

ACOs Help Uncover Largest Medicare Fraud Scheme

In 2022, ACOs noticed significantly higher spending for two catheter codes, with spending increasing from $153 million in 2021 to $3.1 billion in 2023. Because of their close working relationships, many ACO directly connected with providers and patients to understand quickly that the unusual spending was likely fraud. Some ACOs went a step further, visiting bogus supplier business addresses. NAACOS worked with members to develop template resources to stem the fraud and help streamline communication with CMS. After more than 18 months, ACOs learned their work helped Medicare recover more than $9 billion in fraudulent claims as Operation Gold Rush.

Support ACOs as Stewards of the Medicare Program

Accountable care providers partner with CMS as good stewards of the Medicare program given their focus on promoting high-quality and efficient care. More must be done to protect ACOs from unsavory practices that have enormous consequences on spending.

Hold ACOs harmless for fraud, waste, and abuse

CMS must protect accountable care providers during the delayed timeline between identification and confirmation of fraud by:

- Allowing ACOs more time to reopen financial determinations to account for the delayed timeline between identification and confirmation of fraud;
- Establishing a process for preliminary reconciliation when there are active fraud investigations; and
- Modifying policies for serious, anomolous, and highly suspect claims to include regional instances and ongoing investigations of suspected fraud.

Leverage ACOs as partners and improve reporting and feedback processes

Currently, ACOs report each claim of suspected fraud to CMS and in a time consuming and cumbersome process that can leave ACOs without clear direction.

CMS can better engage ACOs by:

- Streamlining the reporting process within HHS and the Office of the Inspector General for suspected fraud;
- Including a standardized checklist of required data elements for reports;
- Outlining a classification framework to distinguish clear instances of fraud from potential waste or abuse;
- Acknowledging receipt of reporting within 30 days;
- Creating mechanisms to inform ACOs reporting suspected fraud and sharing information on fraud trends; and
- Flagging claims held in escrow due to fraud investigations in beneficiary-level financial files.

Contact at advocacy@naacos.com for more information.