

# Prepare to Swarm: Strategies to Combat Fraud, Waste & Abuse

Chair: Ken Schellhase, Ascension

# Prepare to Swarm: Strategies to Combat Fraud, Waste & Abuse

NAACOS Spring Conference

April 24, 2026



Ascension

*Ken Schellhase MD MPH  
Medical Director, Quality and Population Health  
Ascension Medical Group, Wisconsin*

# Ascension at a glance

## Size, scale and presence

Year ended 6/30/25

### ACUTE and POST-ACUTE CARE

**16,600**

Beds

**90**

Wholly Owned or  
Consolidated  
Hospitals  
\*updated 12/31/26

**22**

Post-Acute facilities  
\*updated 12/31/26

### CLINICAL ENTERPRISE

**23,400**

Affiliated  
Providers  
\*updated  
12/31/26

**5,100**

Employed  
Providers

**33,000**

Nurses

### AMBULATORY

**860**

Ascension Employed  
Clinician Network  
Locations

**194**

Imaging  
Locations

**267**

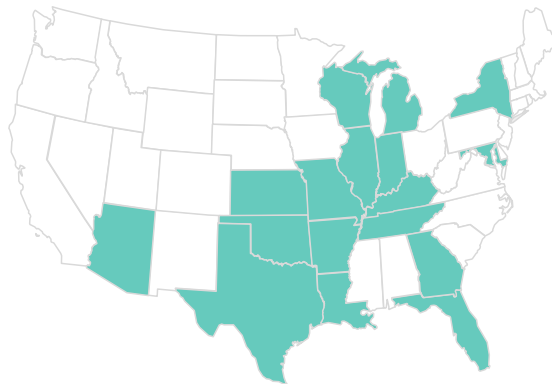
Physical Therapy  
Outpatient Clinics  
(Owned & Partnered)

**59**

Ambulatory Surgery  
Centers

Year ended 6/30/25

### Sites of care in 17 states and the District of Columbia



**\$25.3 billion**

Total Operating Revenue

**\$1.7 billion**

in care of persons living in poverty and other  
community benefit programs

**\$1.8 billion**

in unreimbursed Medicare costs

## Volumes

Year ended 6/30/25

**11.9 million**

physician office and clinic visits

**1.2 million**

equivalent discharges

**2.5 million**

emergency room visits

**467,000**

surgery visits

**414,000**

urgent care visits

**565,000**

discharges

**62,600**

births

**5.2 million**

Unique lives served

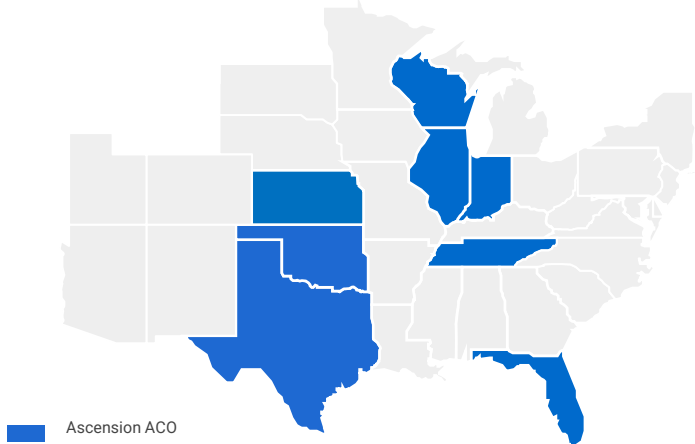
**206,390**

Observation days

# Ascension Medicare Shared Savings Program Accountable Care Organizations (MSSP ACOs)

March 2026

11 ACOs across 8 States\*



Long History of MSSP participation

Some ACOs began >10 years ago

>175,000 attributed Medicare Beneficiaries served by Ascension and its partners

**Wisconsin**

Basic A  
21k lives

**Evansville, IN**

Basic B  
8k lives

**Indianapolis, IN**

Enhanced  
20k lives

**Jacksonville, FL**

Enhanced  
10k lives

**Pensacola, FL**

Basic B  
16k lives

**Nashville, TN**

Enhanced  
25k lives

**Chicago, IL**

Basic E  
24k lives

**Tulsa, OK**

Enhanced  
13k lives

**TX (2 ACOs)**

Enhanced  
28k lives

**Wichita, KS**

Basic A  
11k lives



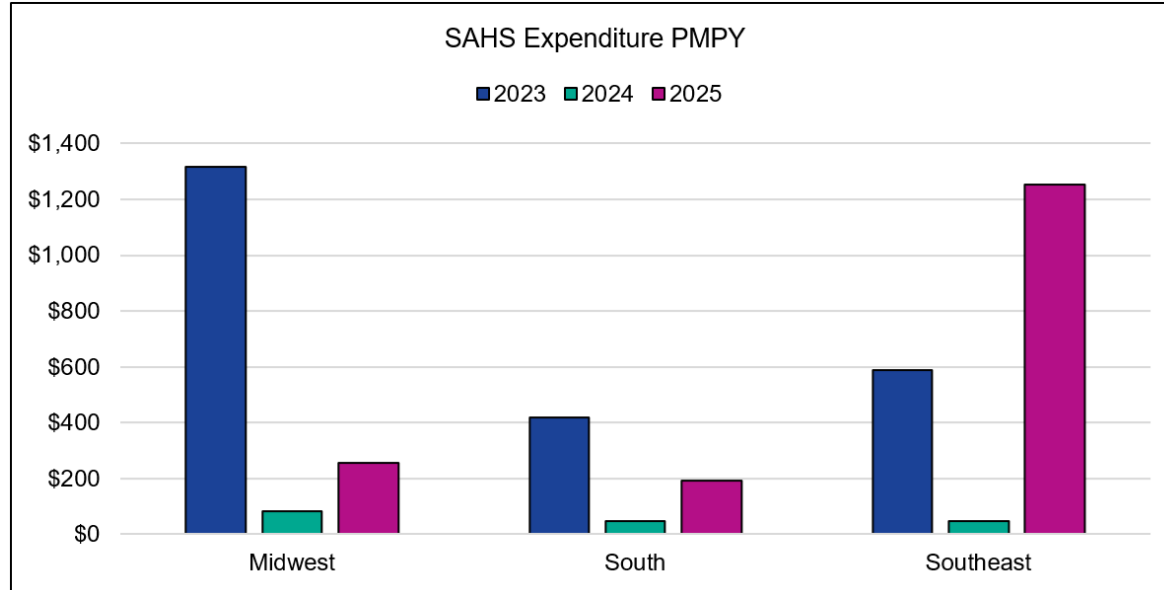
# SAHS Billing

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# SAHS Billing

Ascension has experienced **significant SAHS billing** and it has **varied between service areas** every year.

Without the SAHS policy, we estimate that our ACOs would have **lost millions in shared savings**.

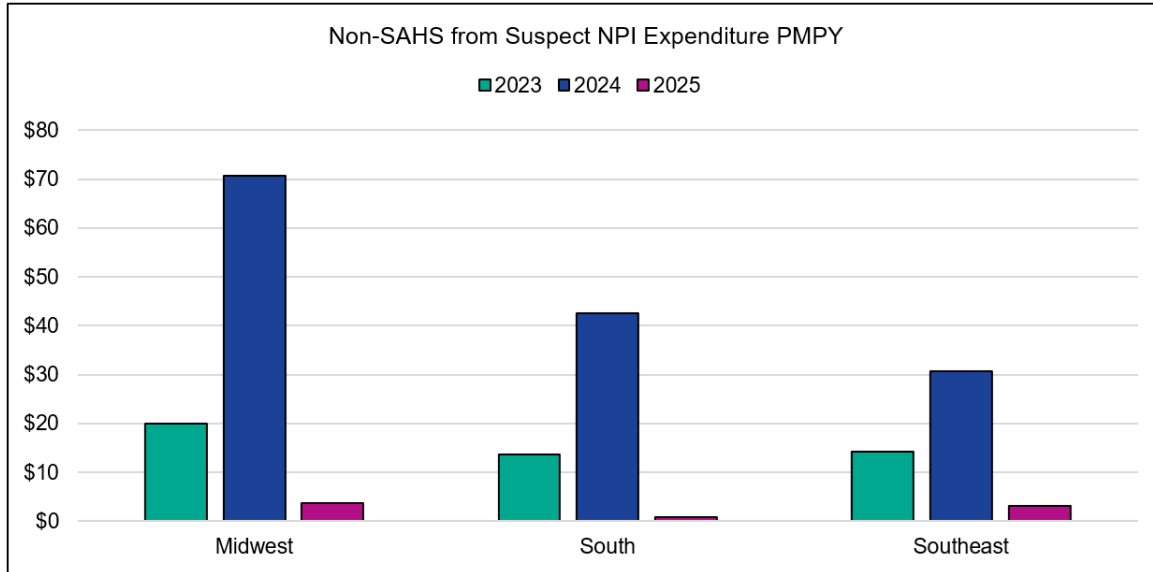


Midwest - IL, IN, WI; South - OK, TX; Southeast - FL, TN

# Suspect NPIs

# Suspect NPIs

Suspect NPIs have billed codes that are **not classified as SAHS**, which means that ACOs were held **accountable for spend that was likely fraudulent**.



## Suspect NPIs

In 2025, CMS classified **6 codes as SAHS**, compared to 2 codes in prior years.

This helped **migate the problem** of holding ACOs accountable for likely fraudulent spend.

Non-SAHS from Suspect NPIs % of Total Expenditures			
Region	2023	2024	2025
Midwest	0.2%	0.6%	0.0%
South	0.1%	0.4%	0.0%
Southeast	0.1%	0.2%	0.0%
Total	0.2%	0.4%	0.0%

2023 SAHS - A4352 and A4353

2024 SAHS - A4353 and A5057

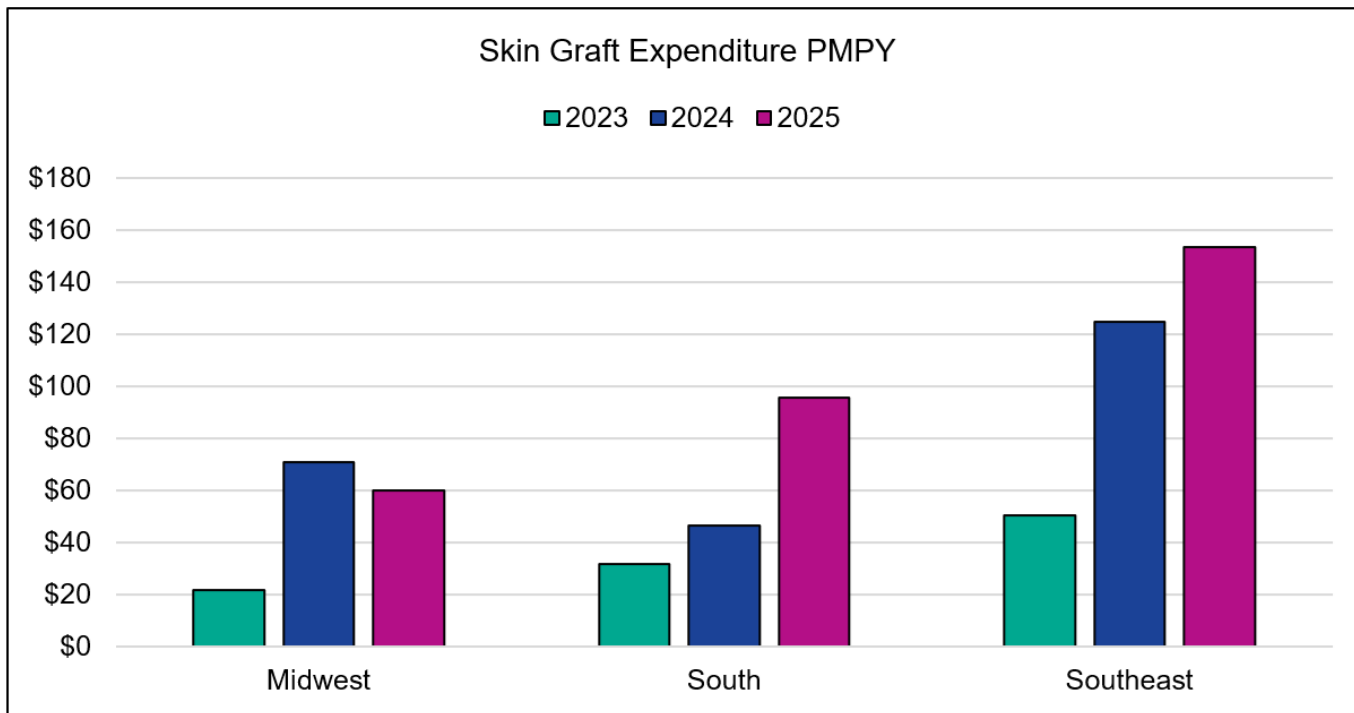
2025 SAHS - A4352, A4353, A6197, L0486, L1852, and L3916

# Skin Grafts

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# Skin Grafts

Truncated Skin Graft expenditures **increased by ~200%** from 2023 to 2025.



Values in chart consider truncation thresholds.

Midwest - IL, IN, WI; South - OK, TX; Southeast - FL, TN

## Skin Grafts

From 2023 - 2025, Skin Grafts have accounted for a **greater proportion** of Ascension's total expenditures.

Financial Impact of Skin Grafts		
Year	Truncated Skin Graft PMPY	% Total Expenditures
2023	\$35	0.3%
2024	\$84	0.7%
2025	\$102	0.8%

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## FWA Program and Policy Updates

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- Significant Anomalous and Highly Suspect (SAHS) Policy updates
- Skin Substitutes for REACH ACOs
- Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) RFI
- Wasteful and Innapropriate Service Reduction (WISeR)
- The Healthcare Fraud Prevention Partnership (HFPP)
- Six-month nation wide moratorium on certain DMEPOS companies
- Crushing Fraud Chili Cook-Off Competition
- Operation Gold Rush

# The Milliman Method: A Winning Chili-Cookoff Recipe

Explainable AI for FWA Detection

Adam Hearn, MS-DSPP

Data Scientist

APRIL 2026



# The CMS Crushing Fraud Chili Cook-Off Competition

On **December 15, 2025**, CMS announced results of the Crushing Fraud Chili Cook-Off: a market-based research challenge under CMS's "Crushing Fraud, Waste, & Abuse" initiative.

**259**

## Entries Submitted

Total competition submissions from across the industry<sup>1</sup>

**10**

## Finalists Selected

Demonstrated against the Medicare 5% Limited Data Set (LDS)<sup>2</sup>

**1**

## Competition Winner

Milliman selected as the winning entry<sup>3</sup>



CMS explicitly required **explainable AI** – models that produce transparent, decomposable evidence that can support enforcement action.

<sup>1</sup>[https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/witness\\_testimony\\_of\\_brandt\\_03.17.2026.pdf](https://democrats-energycommerce.house.gov/sites/evo-subsites/democrats-energycommerce.house.gov/files/evo-media-document/witness_testimony_of_brandt_03.17.2026.pdf)

<sup>2</sup> <https://www.cms.gov/priorities/crushing-fraud-waste-abuse/overview/crushing-fraud-chili-cook-competition>

<sup>3</sup> <https://www.businesswire.com/news/home/20251223398078/en/Milliman-Wins-CMS-Crushing-Fraud-Chili-Cook-Off-Competition>

# Chili Cookoff Evaluation Criteria – Three Signals for ACO Operators

The competition's evaluation criteria signal priorities that are directly relevant to ACOs evaluating FWA detection capability.



## Explainability

CMS required outputs an investigator can act on: evidence that can withstand legal scrutiny and regulatory review. The **CMS AI Playbook (Version 4)** mandates auditable data lineage and explainable outputs.<sup>1</sup>

A risk score that cannot be decomposed into its component drivers has limited enforcement utility.



## Novel Pattern Detection

CMS's existing Fraud Prevention System already screens all FFS claims using rule-based logic.

The competition sought approaches that surface patterns that current systems may miss: emerging and evolving schemes, not previously known fraud types.



## Practical Implementation at Medicare Scale

Can the model produce actionable leads in operational settings?

Can investigators use the output without specialized statistical training?

Model performance on a research dataset alone was insufficient.

<sup>1</sup><https://ai.cms.gov/CMS-AI-Playbook.pdf>

# Financial Mechanics of FWA Exposure in Accountable Care

ACOs are accountable for all Parts A and B spending on their attributed beneficiaries, regardless of which provider furnishes the services (**42 CFR §§ 425.600–610**). Fraudulent billing by non-participant providers counts against ACO expenditures at reconciliation, dollar for dollar.

## RECENT FWA EXPOSURE – ACO POPULATIONS



### Catheter Billing Spikes

Over **\$2 billion** in charges attributed to ACO beneficiaries in 2023, originating in non-ACO networks.<sup>1</sup> Similar spike in A4352 payments reported by Milliman in Q3 2025.<sup>2</sup>



### Skin Substitute Spending

Surged from **\$1.6B to \$9.9B** between 2022 and 2024. Directly affected ACO financial performance with no SAHS exclusion applied as of March 2026.<sup>3</sup>

## IMPACT BY RISK TRACK – \$10M FWA EXPOSURE SCENARIO

ACO Track	Sharing Rate	\$10M FWA Impact
One-sided ACO	40%	\$4.0M lost savings
ENHANCED two-sided	75%	\$7.5M lost savings



With an estimated 3–10% of healthcare spending lost to FWA, a mid-sized ACO with \$250M in total cost of care faces approximately **\$7.5–\$25M in potential FWA exposure**.<sup>4</sup>

<sup>1</sup> <https://www.fiercehealthcare.com/payers/giant-unknown-what-alleged-2b-medicare-catheter-fraud-scheme-means-acos>

<sup>2</sup> <https://www.milliman.com/en/insight/medicare-ifs-catheter-billing-anomalies-aco>

<sup>3</sup> <https://www.naacos.com/wp-content/uploads/2026/03/Data-Brief-Skin-Substitute-Costs-and-Spending.pdf>

<sup>4</sup> <https://www.nhcaa.org/tools-insights/about-health-care-fraud/the-challenge-of-health-care-fraud/>

# Methodology – Four Dimensions of FWA Detection

The most sophisticated schemes produce signals across financial, behavioral, network, and beneficiary-level dimensions.



## Financial – Billing Economics

**What it catches:** A DME supplier whose per-beneficiary catheter costs spike to multiples of peer norms. A laboratory billing at 5x the median PRPM for respiratory pathogen testing.

**Key metrics:** Paid PRPM, utilization per 1,000 members, units per recipient – normalized using risk-adjusted recipient months.



## Beneficiary – Spending Distribution

**What it catches:** Spending concentrated in a small number of patients (superutilizer waste/abuse). Rapid spending acceleration on individual beneficiaries (indicative of beneficiary exploitation)

**Key metrics:** Spending inequality (Gini coefficient), beneficiary spend velocity



## Behavioral – Billing Pattern Stability

**What it catches:** Billing concentrated almost exclusively in one procedure code. An abrupt shift in a provider's billing profile, potentially indicating a pivot to a new scheme.

**Key metrics:** Service concentration index, month-over-month billing profile similarity.



## Network – Referral and Sharing Patterns

**What it catches:** Two supposedly independent laboratories sharing 97% of their patients. A hub-and-spoke referral pattern centered on an entity with elevated financial risk.

**Key metrics:** Patient sharing intensity, provider hub score, network insularity

# Methodology – Network Analytics

Collusive behavior can be exposed through network analytics. Provider-by-provider review can miss it without proper shared relationship context.

## Network Modeling



Connects providers through shared beneficiaries to reveal multi-actor patterns that single-provider review would miss.

## Cluster and Hub Detection



Identifies hubs, tight clusters, and unusual member overlap to prioritize investigations alongside provider-level signals.

## Explainable Network Exhibits

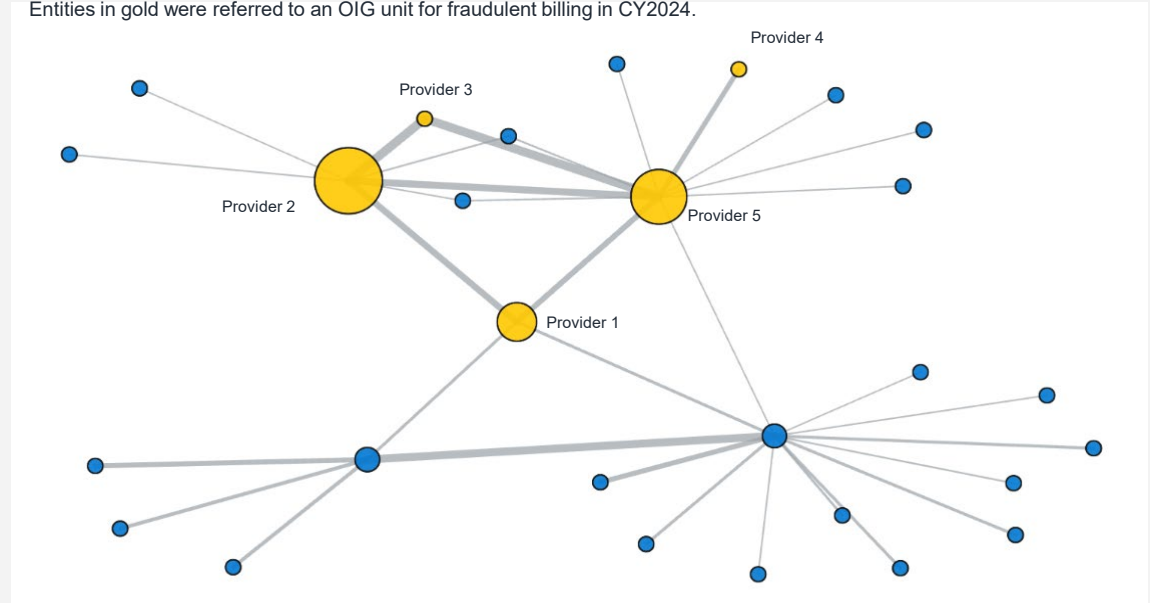


Supports audit-ready network visualizations for review and documentation.

## Graph-Based Network Signals

Note: Node size reflects Provider Hub Score (network centrality). Line thickness reflects shared-beneficiary overlap.

Entities in gold were referred to an OIG unit for fraudulent billing in CY2024.



# Prioritized Provider Listing for Compliance Workflows

AI outputs are only useful if they can be acted upon. The platform delivers ranked provider lists through an access-controlled dashboard: filterable by incurred month, provider type, HCPCS code, and risk score.

**Milliman**

Milliman Healthcare Anomaly Detection Platform  
**Demonstration**

Executive Summary **Provider Listing**

Tip: Right click on any provider to "Drill Through" and view their Evidence Package.

Provider	Total Paid	Recipients	PRPM	Util. per Recipient	Risk Score	Risk Tier
Provider DBC9852D - 4024584533	\$411,336	1,381	\$297.85	2.19	99.77	Tier 1: Critical Risk
Provider 37CF739A - 7286334202	\$337,172	1,935	\$174.25	2.47	99.02	Tier 1: Critical Risk
Provider 840243B4 - 9348038100	\$486,074	3,380	\$143.81	1.66	98.75	Tier 1: Critical Risk
Provider 34F932F1 - 2375489059	\$248,735	419	\$593.64	4.48	98.55	Tier 1: Critical Risk
Provider D9C39322 - 6192554454	\$28,405,730	97,343	\$291.81	2.99	98.45	Tier 1: Critical Risk
Provider 43A0A0AD - 1618963987	\$873,637	359	\$2,433.53	17.54	97.83	Tier 1: Critical Risk
Provider 1602B578 - 7227967023	\$232,686	2,020	\$115.14	3.23	97.63	Tier 1: Critical Risk
Provider EFA0CA7B - 127665738	\$1,345,142	6,159	\$218.40	4.27	96.84	Tier 1: Critical Risk
Provider D5718EF6 - 9376752160						
E1390 - Oxygen concentrator	\$119,654	501	\$238.83	1.01	96.79	Tier 1: Critical Risk
A7038 - Pos airway pressure filter	\$95	22	\$4.32	0.98	0.00	
E1392 - Portable oxygen concentrator	\$3,145	203	\$15.49	1.00	0.00	
Provider 8BEE4F10 - 3617713604	\$253,232	1,259	\$201.14	1.61	96.74	Tier 1: Critical Risk
Provider CBA43F33 - 9741659629	\$3,333,331	63,648	\$52.37	2.16	96.62	Tier 1: Critical Risk
Provider 6C59B44C - 6880115912	\$1,528,521	3,800	\$402.24	3.10	96.45	Tier 1: Critical Risk
Provider 999A4CA5 - 6094508552	\$75,646	300	\$252.15	1.90	96.44	Tier 1: Critical Risk
Provider 3411E2AA - 2398806247	\$372,986	1,132	\$329.49	4.05	95.90	Tier 1: Critical Risk
Provider A5252F78 - 6717963562	\$6,925,871	2,656	\$2,607.63	11.74	95.51	Tier 1: Critical Risk
Provider 240DFFAC - 6176794336	\$894,218	2,331	\$383.62	3.10	95.01	Tier 1: Critical Risk
Provider AB82533C - 5061737765	\$15,481,792	21,624	\$715.95	5.76	93.90	Tier 1: Critical Risk
Provider FOA6BBBF - 8389496579	\$18,195,349	10,936	\$1,663.80	9.69	93.38	Tier 1: Critical Risk
Provider 51C1499C - 3486826558	\$602,312	8,598	\$70.05	1.60	92.27	Tier 1: Critical Risk
Provider 67163A2B - 9431760417	\$1,782,804	10,309	\$172.94	2.02	92.10	Tier 1: Critical Risk
Provider D1A1A3D0 - 5601407544	\$165,576	1,777	\$93.18	2.61	91.85	Tier 1: Critical Risk
Provider 8248252F - 8779299135	\$141,736	84	\$1,687.33	14.83	90.96	Tier 1: Critical Risk

Note: A high risk score indicates statistically atypical patterns compared to peer providers. It does not by itself indicate intentional fraud, waste, or abuse.

Note: All information displayed in this dashboard is 100% synthetic and was generated solely for demonstration purposes. No real-world provider, member, claim, or financial information is included. Any resemblance to real individuals, providers, counties, billing patterns, or dollar amounts is entirely coincidental and not representative of real-world performance, risk, or outcomes.

## Risk-Ranked Provider Listing

Which providers exhibit the most statistically atypical billing patterns?

## ROI-Informed Prioritization

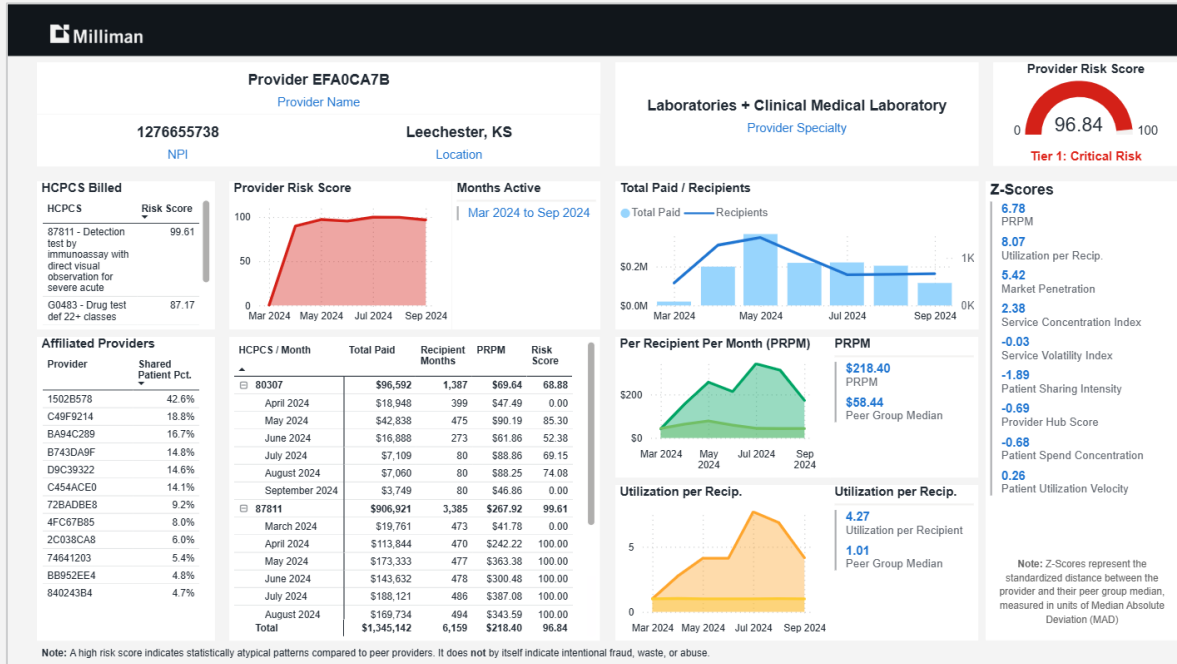
Provides the financial context a compliance officer or CFO needs to assess whether a flag warrants investigation.

## Filter Controls

The list can be scoped to a specific service, time period, or provider type, allowing compliance teams to focus on the areas of greatest concern.

# The Evidence Package: From Risk Score to Investigator-Ready Brief

A risk score alone does not support a referral to HHS-OIG. The platform generates a structured Evidence Package for every flagged provider: designed for **compliance officers and investigators, not data scientists.**



**Peer Group Baselines**  
 What is considered “normal” behavior? How far does this provider deviate from “normal”?

**Metric-by-Metric Deviation Summary**  
 Which specific features or services rendered drove the flag?

**Affiliated Providers**  
 Which other providers share patients with this entity?

**Financial Impact**  
 How many dollars are at risk? The figure needed to assess materiality and prioritization of the investigation queue.

Note: All information displayed in this dashboard is 100% synthetic and was generated solely for demonstration purposes. No real-world provider, member, claim, or financial information is included. Any resemblance to real individuals, providers, counties, billing patterns, or dollar amounts is entirely coincidental and not representative of real-world performance, risk, or outcomes.


# Blind Validation Against DOJ Enforcement Actions

The model was executed against the Medicare 5% LDS (2022–2024) with no prior knowledge of active investigations. Independent spot checks of Tier 1 – Critical Risk providers subsequently reviewed for convergence with known Department of Justice (DOJ) enforcement actions.

## CONFIRMED ENFORCEMENT ALIGNMENT – SELECTED CASES

Provider / Scheme	Risk Score	DOJ Action
TX Laboratory Collusion Ring	99.99–100.00	Owner charged – \$79M respiratory pathogen fraud scheme
FL/NC DME Fraud Ring	98–100	Owner plead guilty - \$100M money laundering conspiracy
Mobile Cardiac PET Provider	99.64	\$85M DOJ settlement
DME Supplier – Kickback Scheme	94.90	\$17M DOJ settlement
Laboratory – False Claims Act	95.16	Owner indicted on \$8.7M False Claims Act violations

The model identified these providers from **claims data alone**, without fraud labels or investigation knowledge.



For ACOs, these are precisely the types of non-participant providers whose billing may count against attributed beneficiaries' expenditures at reconciliation.

# From Methodology to Your Compliance Workflow

Systematic detection does not replace compliance workflows – it moves them from reactive to proactive, and from qualitative to quantifiable.



## For Compliance Officers

**Today:** Reactive investigations after financial damages surfaces at reconciliation. Ad hoc referrals to HHS-OIG supported by limited quantitative evidence.

**With systematic detection:** Proactive, prioritized flags before reconciliation, ranked by financial materiality. Structured Evidence Packages meeting investigator standards, ready for escalation.



## For CFOs and Finance Leaders

**Today:** No systematic way to quantify FWA exposure for the governing body. Financial impact of FWA discovered retroactively, if at all.

**With systematic detection:** ROI-supported risk tiers tied to specific providers and service codes. Continuous monitoring that quantifies exposure as it accumulates.



## For Data and Analytics Teams

**Today:** Manual CCLF analysis, often spreadsheet-based, dependent on individual analyst expertise.

**With systematic detection:** Automated scoring of every provider billing to the ACO's population. Every month, every service code, every provider.



Procedure-code-level detection could identify emerging patterns substantially earlier – at a stage where escalation and reporting may prevent the exposure from compounding across performance years.

# From Detection to Action

The methodology presented in this segment addresses **where to look** and **why it matters**.

What happens after a flag is raised – investigation, beneficiary outreach, evidence compilation, referral to CMS, and pursuit of remediation – is the operational reality ACOs must face.



## What the Methodology Produces

Actuarially-grounded provider risk scores, ranked by financial materiality.

Structured Evidence Packages decomposing each flag into peer group context, metric-level deviations, network affiliations, and financial impact.



## What Requires Human Judgment

Determination of whether anomalous billing constitutes fraud, waste, or legitimate variation.

That distinction requires clinical review, investigative context, and institutional knowledge that machine learning does not replace.



## What Comes Next

The operational reality ACOs must face requires institutional process, not additional analytics.

Amanda Larschan will present case studies and a documented workflow for evaluating suspected FWA, escalating confirmed cases to CPI, and referral letter templates that support that process.

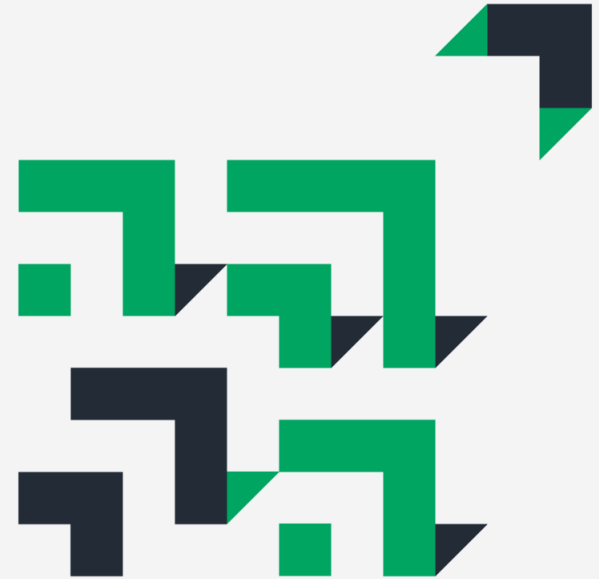


ACOs already receive **monthly CCLF files** containing the same claims fields used for the CMS Chili Cook Off. The gap is not data – it is the analytical infrastructure applied to it, and the connection between detection and action.

# Thank you

Adam Hearn

[adam.hearn@milliman.com](mailto:adam.hearn@milliman.com)



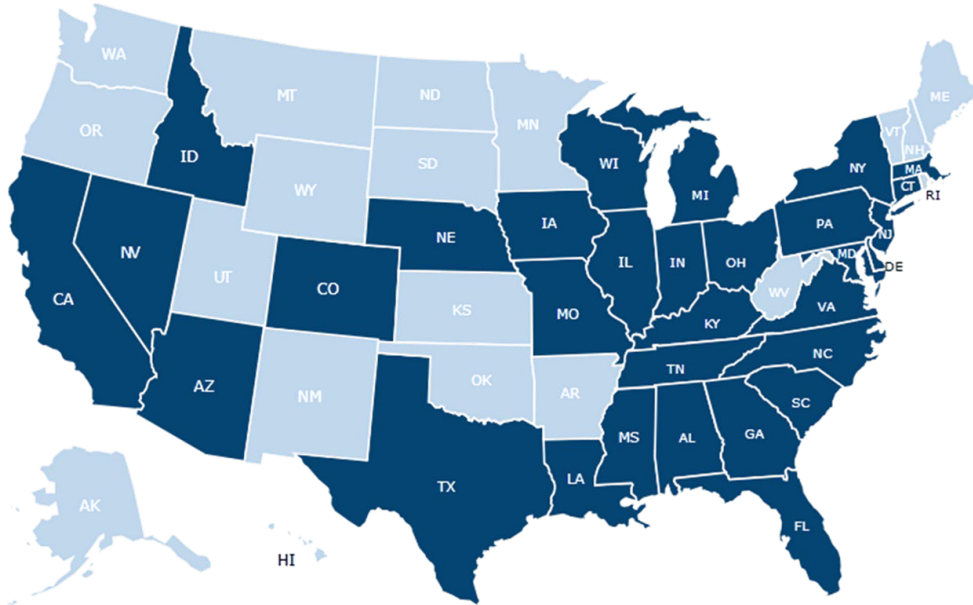


# PBACO

The Future of Fraud, Waste and Abuse:  
Tech-enabled Solutions for Early  
Detection and Reporting

Amanda Larschan  
*Chief Performance Officer*

# OUR NATIONAL FOOTPRINT



**\$6B+**  
Medical Spend Under Management

**680K+**  
PY26 Medicare, Commercial, ACO Reach & Institutional LUM

**30+**  
PY26 States (Plus DC)

**\$938M**  
Medicare Trust Fund Savings

**\$571M+**  
MSSP Revenue to PBACO

**15K+**  
Affiliated Providers PCPs, Specialists, PAs RNs

**93.32%**  
Avg Quality Score Since PY2013

**~\$467M**  
Total Distributions to Physicians

**Top 5**  
National Rank Since Inception



# Amanda Larschan

## Chief Performance Officer, PBACO

- Been at PBACO for 12 years! Started as Data Analyst in 2014
- Oversee enterprise-wide quality reporting across all value-based care contracts, ensuring accuracy, compliance, and alignment with organizational performance goals.
- Spearhead the development and delivery of actionable, data-driven insights to participant providers.
- Manages and mentors a high-performing team of 10+ analysts to ensure timely, actionable outcomes.
- Manages and mentors a team of 40+ field consultants, fostering collaboration, accountability, and high-quality execution of ACO initiatives across all markets.



# Fraud, Waste and Abuse (FWA): Why It Matters

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## The Scale of the Problem

- Medicare Fee-for-Service recorded approximately **\$147 billion** in improper payments from PY2020 to PY2024, averaging over \$30 billion per year (CMS CERT Program, 2024)
- Medicare fraud and abuse can occur anywhere: medical offices, hospitals, home health agencies, and DME suppliers

## Why FWA Hits ACOs Especially Hard

- Fraudulent claims billed by outside suppliers for ACO-attributed patients are counted in your total expenditures, inflating benchmarks and shrinking shared savings
- In 2023, a surge in fraudulent urinary catheter billing materially distorted ACO Shared Savings Program calculations, prompting CMS to issue a standalone final rule (CMS-1799-F, Sept. 2024)

## CMS Has Taken Notice

- CMS issued Final Rule CMS-1799-F (Sept. 2024) to mitigate the impact of Significant, Anomalous, and Highly Suspect (SAHS) billing on ACO financials
- A forward-looking SAHS policy is now codified in the CY2025 PFS Final Rule (CMS-1807-F)



# TYPES OF FRAUD PBACO TRACKS

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## **Part B Durable Medical Equipment (DME) Fraud:**

### Collection:

- PBACO continuously monitors high-volume suppliers, duplicate claims, and questionable billing trends.

### Investigation:

- Patient-reported cases where Medicare billed and paid for equipment the patient did not receive (MDPPDNR).

## **Part B Skin Graft Fraud:**

### Collection:

- PBACO reviews outlier utilization and excessive grafting or debridement claims.

### Investigation:

- Patient-reported cases where services appeared on Medicare statements but were not rendered.

## **Part B Genetic Testing Fraud:**

### Collection:

- PBACO analyzes excessive billing patterns and provider/patient mismatches.

### Investigation:

- Patient-reported cases where genetic testing services appeared on Medicare statements but were not rendered.

**\*Suppliers often operate across multiple states, rotate beneficiary lists, and exploit ordering providers**



# IDENTIFY AND PREVENT: HOW WE DO THIS

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# Process Begins After Data Load: Claims analysis

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## Identification

- Flag companies submitting suspicious or potentially fraudulent claims.
- Assess supplier or rendering provider expenses (total, per visit, and per patient) to identify cost outliers.
- Scrutinize ordering patterns and service frequency for anomalies.

## Validation

- Confirm whether the ordering provider had a related E&M (Part A or Part B) service.
- Contact providers directly by phone or mail when clarification is needed.
- Review external sources (Better Business Bureau, Google, Yelp) for fraud indicators.

This process is completed **after each CMS data load**, to detect **Significant, Anomalous, and Highly Suspect (SAHS)** billing activity early and guide further review.



# BCDA: Faster Data, Earlier Detection

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## What Is BCDA (Beneficiary Claims Data API)?

- A CMS-provided API that gives ACOs faster, more frequent access to Medicare claims data for their attributed beneficiaries
- Delivers data between standard CMS data loads, reducing the lag between when fraud occurs and when an ACO can detect it

## How PBACO Uses BCDA for Fraud Detection

- Detect unusual billing spikes by DME suppliers and outside vendors earlier in the calendar year
- Cross-reference claims against known SAHS billing patterns before formal CMS data loads arrive
- Identify suppliers billing for attributed patients across multiple categories simultaneously, a key fraud indicator
- Shortens the time between detection and submission, strengthening the overall case

## How PBACO Uses BCDA for Performance

- Identify care gaps and utilization trends in near real time
- Monitor high-cost patients and flag unexpected changes in service patterns
- Support proactive outreach before the end of a performance year
- BCDA captures CPT II quality codes from Part B claims, providing a more timely view of quality performance between data loads



# PBACO Submission Process

**Only once 7 unique patients have provided verbal attestations can a company be submitted**

Submissions go to:

1. Unified Program Integrity Contractor – UPIC (**Safeguard Services**),
2. The Office of **Inspector General (OIG)** (<https://oig.hhs.gov/fraud/report-fraud/>)
3. CMS via the dedicated **ACO FWA inbox (ACO\_FWA@cms.hhs.gov)**
  - MSSP ACO referrals: CC SharedSavingsProgram@cms.hhs.gov
  - ACO REACH referrals: CC ACOREACH@cms.hhs.gov

**Each submission must include:**

1. Excel document with patient claims and verbal attestations noted
2. Summary of companies and paid amounts (pivot table) on a separate sheet
3. Company information Word document
4. Cover letter with signature of ACO Executive
5. Summary of all companies submitted with submission dates
6. CMS ACO Fraud Referral Worksheet, completed using the standardized template provided by CMS

**If PDF attestations apply, add:**

- Signed patient attestations forms
- Excel document with patient claims and PDF attestations noted



# Submission Confirmation

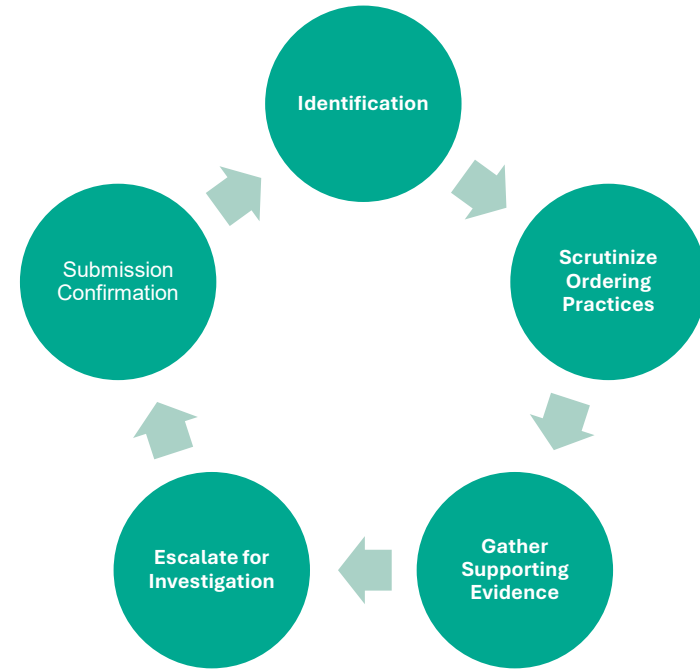
An Ongoing, Continuous Cycle

## What Happens After Submission

- PBACO receives written confirmation from OIG, UPIC (Safeguard Services), and CMS upon receipt of each submission
- Confirmations serve as formal acknowledgment that files were delivered to the correct entities and are under review
- All confirmations are retained within PBACO's fraud tracking system as part of the permanent audit record

## What Happens Next

- OIG, UPIC, and CMS review submissions and may open formal investigations
- CMS may adjust payments, though outcomes and timing are not guaranteed
- PBACO continues monitoring flagged companies for new activity even after submission



# 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 Provider

### Authorization to Disclose Health Information

- I authorize the use or disclosure of the above-named individual's health information as described below.
- 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.**
- This information may be disclosed to and used by the following individuals: **Federal and local law enforcement for the purpose of Medicare compliance and payment recoupment, if applicable.**
- I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the organization noted in the footer. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest 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, this authorization will expire in six (6) months.
- 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 for 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)

- **289 companies** reported to oversight agencies
- **2,972 verbal** and **1,705 written** attestations collected
- **~\$25M** successfully recouped



# FRAUDULENT PART B DME CLAIMS

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**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.



# NEXT STEPS AND PATH FORWARD

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## Healthcare Fraud Prevention Partnership (HFPP)

- Join HFPP, a government-led collaboration portal that shares provider alerts, emerging fraud trends, and national insights.
- Access will enhance PBACO's ability to identify new schemes early and coordinate with federal and private partners.

## Streamlined Processes

- Implemented faster, automated workflows for claim review and data analysis.
- Improved detection through standardized CPT monitoring and consistent follow-up procedures after each CMS data load.

## Prefilled Provider Letters

- Created prefilled templates for providers to send directly to rendering providers, requesting medical records or clarification.
- Encourages collaboration, transparency, and shared accountability to ensure appropriate patient care.

## Dedicated FWA Personnel

- Established a Fraud, Waste, and Abuse (FWA) team focused exclusively on monitoring, outreach, and reporting.
- Enhances PBACO's ability to act quickly and efficiently on identified SAHS billing activity.



# HOW CAN YOU HELP?

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## Submit Information About Fraudulent Activity to Medicare

It is recommended that affected **patients as well as the primary care provider** report the fraud through one of the options below:

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

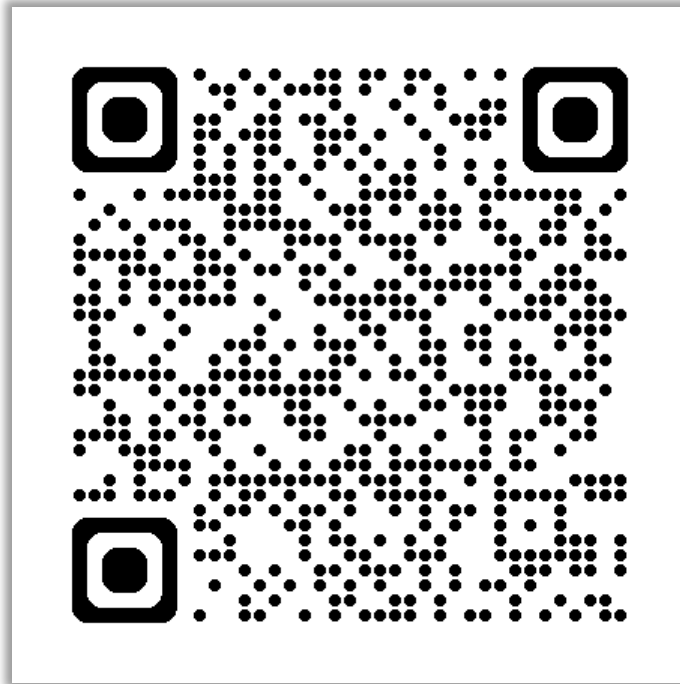
It is also recommended that patients with multiple fraudulent claims request a new Medicare ID number:

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



# Process for Review

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# THANK YOU

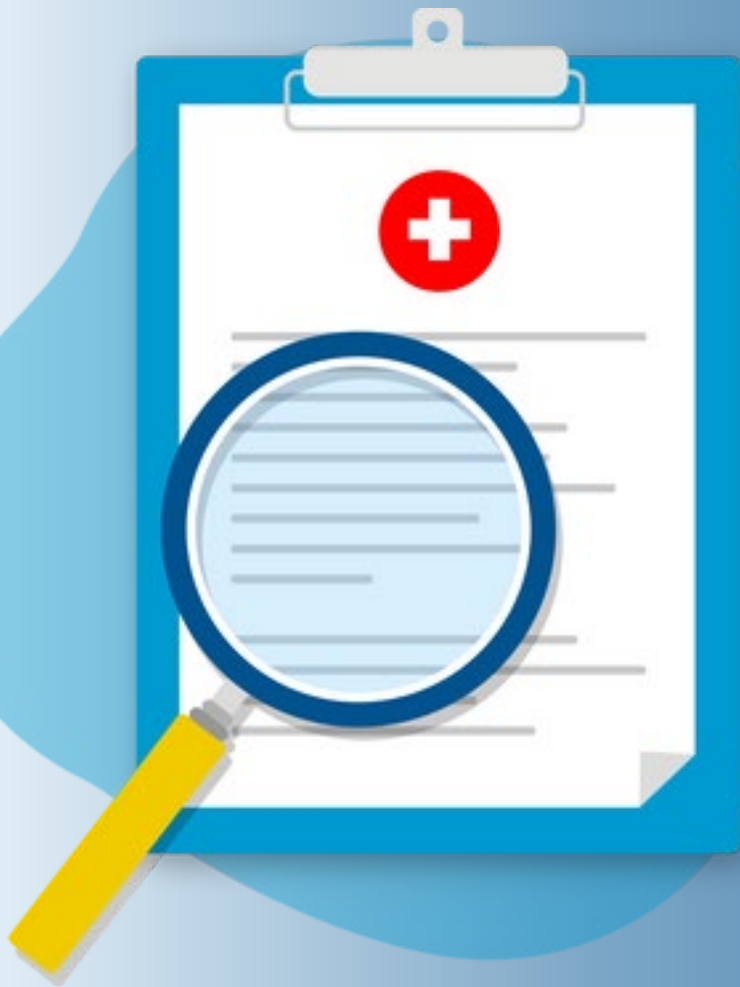
Amanda Larschan, Chief Performance Officer  
alarschan@pbaco.org



 [www.pbaco.org](http://www.pbaco.org)

 561-429-2680





## **CRUSHING FRAUD**

**CMS' STRATEGY TO  
COMBAT FRAUD,  
WASTE, AND ABUSE**



# MEET OUR SPEAKER



**Jeneen Iwugo**

Acting Deputy Administrator & Director  
Center for Program Integrity (CPI)



# WHAT'S AT STAKE

Scope of FWA is massive, and CMS is cracking down!

Examples of systemic FWA include:



**\$2.1B:** Payments halted by CMS' War Room to providers suspected of fraud, including billing for deceased patients and non-existent care



**1.8M:** Medicare beneficiaries enrolled in hospice care in 2025 which is a 12% increase from 2020 hospice enrollment levels



**\$14B:** Individuals enrolled in multiple state Medicaid programs or both a Medicaid and Marketplace plan in 2025



**\$2.3B+:** Improper payments related to Durable Medical Equipment (DME) in FY 2025



# FRAUD DEFENSE OPERATIONS CENTER (FDOC)

## “Fraud War Room”

- Leverages rigorous, data-driven analyses to proactively detect, address, and prevent FWA in **real time**

## 2025 Results

- Suspended over **\$1.8B** in payments to over **350 providers**
- **\$1.5B** (83%) in DME alone
- Revoked billing privileges for **125+** provider

## Cross-functional expertise

- Specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement





# CRUSHING FRAUD WITH ADVANCED ANALYTICS

## Fraud Prevention System (FPS)

- Predictive analytic system incorporating artificial intelligence and real-time monitoring to evaluate incoming claims for potential FWA
  - Ever evolving, currently comprised of **280 FPS models & 83 FPS edits**
- Providers flagged by FPS models are investigated further
  - Investigations stemming from these models often identify evidence of FWA
    - **CPI converting models into prepayment edits that automatically deny claims associated with extreme billing**



# HOSPICE & DME

## Enhanced Site Visits (Hospice & DME)

- Shift from observational assessments to comprehensive, on-site compliance reviews

## Provisional Period of Enhanced Oversight (Hospice)

- Prepayment reviews on all incoming claims for newly Medicare-enrolled hospices and hospices that underwent a change of ownership
- 4-state pilot resulted in **155 Medicare revocations**
- Expanded into 2 additional states on December 30, 2025

## National DME Moratorium (DME)

- Temporary pause on all new Medicare enrollments for certain DME supplier categories



# COLLABORATION WITH PRIVATE INSURERS

## Healthcare Fraud Prevention Partnership (HFPP)

- Provides analysis of a public-private dataset of professional, institutional and pharmacy claims that allows us to detect industry-wide fraud schemes
- Includes over 300 partners or members across federal agencies, law enforcement, private payors, State Medicaid Agencies, and health care industry associations





# PUBLIC DATA SHARING

## Revocation Data

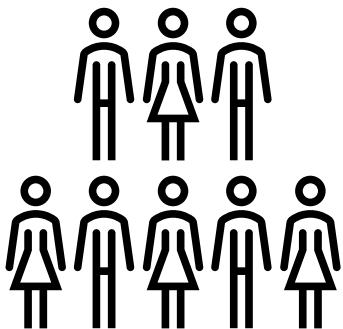
- CMS recently released a publicly available list of revoked Medicare enrollments at **data.cms.gov**
- Monumental milestone and significant step forward for both **boosting transparency** and providing external partners with a **powerful tool for crushing fraud**
- Data to be refreshed quarterly and includes:
  - Provider/supplier names
  - NPIs
  - Revocation authorities
  - Revocation effective dates
  - Re-enrollment bar expiration dates





# COLLABORATION WITH PUBLIC

## Request for Information (RFI) Related to Comprehensive Regulations To Uncover Suspicious Healthcare (CRUSH)



- Solicited public feedback on potential regulatory changes that may make CMS more effective in its crushing fraud efforts
- Comment period: February 27<sup>th</sup> – March 30<sup>th</sup>
- Received over 500 public comments



# COLLABORATION WITH INDUSTRY

## Crushing Fraud Chili Cook-Off Competition

- Goal: Learning opportunity for CMS to better understand advanced technologies within the private sector leveraging artificial intelligence to detect anomalies and trends in Medicare FFS claims indicative of FWA
- **250+** submissions from **34 states and Washington D.C.**
- 10 finalists selected to demonstrate their solutions at in-person event
- CMS selected **Milliman, Inc** as the competition winner



# COLLABORATION WITH INDUSTRY



## CMS IDEa Challenge

- In December 2025, CMS hosted the **CMS IDEa Challenge**, a series of in-person, solution-oriented events designed to generate **actionable ideas to address MBI theft and misuse**
- Attendees worked in teams **to identify a top problem** with MBI theft and **develop a pitch** to address their top problem





**CONTACT INFORMATION**  
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**REPORT SUSPECTED FRAUD**  
[aco\\_fwa@cms.hhs.gov](mailto:aco_fwa@cms.hhs.gov)