ALLIANCE FOR HEALTH POLICY

Medicare Fraud: Policy Resources, Roles, and Realities

Thursday, October 29, 2026
1:00 p.m. - 2:30 p.m. ET

Welcome Remarks



Claire Sheahan, M.Sc.
President & CEO
Alliance for Health Policy

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WEBINAR:

MEDICARE FRAUD:
POLICY RESOURCES, ROLES, AND REALITIES

Thurs, Oct 29, 2026 | 1:00 - 2:30 PM ET



Leslie V. Gordon, MPP

Director,
U.S. Government Accountability Office (GAO)
Moderator



Kimberly Brandt, J.D., M.A.

Deputy Administrator & Chief Operating Officer,
U.S. Centers for Medicare & Medicaid Services



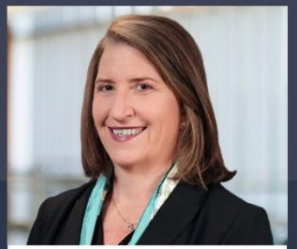
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Federal Policy Director,
Medicare Rights Center



Lisa M. Re, J.D., M.A.

Life Sciences & Healthcare Regulatory Partner,
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Louis Saccoccio, J.D.

CEO, National Health Care Anti-Fraud Association (NHCAA)

ALLIANCE FOR HEALTH POLICY

Today's Moderator



Leslie V. Gordon, MPP (Moderator)
Director
U.S. Government Accountability Office

Panelists



Kimberly Brandt, J.D., M.A.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services



A. Bartley Bryt, M.D., MPH
Chief Medical Officer
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Louis Saccoccio, J.D.
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Deputy Administrator and Chief Operating Officer
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Crushing Fraud, Waste, and Abuse: CMS Program Integrity in Action

Alliance for Health Policy

October 29, 2026

MAKE AMERICA HEALTHY AGAIN

CMS Mission

Ensure our most vulnerable receive
high-value care by leading all payors and supporting providers.

Strategic Objectives

Leading Payor

Establish the CMS team as the indisputable leading payor in the country

Unleashing Affordability

Making medication affordable

Make America Healthy Again

Empowering beneficiaries and focusing on prevention

Crush Fraud

Crush fraud and reduce inappropriate spending

FROM "PAY AND CHASE" TO "DETECT AND PREVENT"

- Traditionally, CMS identified FWA **after** payments were made then attempted to recover funds retroactively.
- Recovery rates under the pay-and-chase model are low once money leaves the program
- CMS has fundamentally shifted its approach: use advanced analytics and enhanced mitigation tools to **detect and prevent FWA before money goes out the door**.
- This shift is supported by new technology, stronger enforcement authorities, and cross-agency collaboration





CMS' STRATEGIES AND ACTIONS TO CRUSH FRAUD

Advanced Detection: Rapidly assessed 608 providers through CMS' FDOC for inappropriate billing and other fraudulent behavior and successfully suspended over $2.3 billion in potentially fraudulent claims.

Robust Oversight: Instituted a national Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS), home health, and hospice enrollment moratorium

Collaborative Action: Partnering with HHS-OIG, DOJ, FBI, and other federal partners to investigate fraud, waste, and abuse in CMS' programs at the state level.

Education and Outreach: Continuing to educate and inform Medicare beneficiaries and their loved ones on how they can help stop fraud, waste, and abuse through Medicare.gov



RECENT, MAJOR ACTIONS TAKEN BY CMS

Beyond enforcement metrics, CMS is taking a series of landmark structural actions to fundamentally reshape the fight against fraud, waste, and abuse.

- **National Agent/Broker Enrollment Moratorium:** On September 22, 2026, CMS announced a temporary moratorium on new registration for the 2027 plan year for agents and brokers without an active Exchange Agreement for 2026

- **National DME Enrollment Moratorium**: From February to August 2026, CMS imposed a six-month national moratorium on Medicare enrollment for certain DME supplier types, addressing $2.3B in FY 2025 improper payments

- **Home Health & Hospice Enrollment Moratorium**: On May 13, 2026, CMS announced a nationwide six-month moratorium on new Medicare enrollment for home health agencies and hospices, alongside the Vice President and the White House Fraud Task Force. **More than 1,000 hospices—a 47% reduction—have been removed from Medicare** since the start of the Trump administration



For questions, please email Kim Brandt at kimberly.brandt@cms.hhs.gov. We will respond to your questions as soon as possible.



A. Bartley Bryt, M.D., MPH
Chief Medical Officer
Privia Health



Privia' Health and Privia Medical Group
Managing the Risk of Fraud, Waste, and Abuse

2026.10.29

Privia Medical Group and Privia Health

Perspectives on fraud, waste and abuse

A PHYSICIAN LED ENTERPRISE WITH TWO ARMS

Privia Medical Group (PMG)- independent, community based, single TIN integrated EMR

- PMG members each own of their care center and employ staff
- 65% primary care; 35% medical/surgical specialties
- 25 states, 5600+ clinicians across more than 1300 locations
- 6.1 M patients/ 1.6M across 130+ VBC contracts, all payers, rural/urban/suburban locales
- Dedicated partners with Privia Health

Privia Health is PMG's administrative partner and management services organization

- Contract for all FFS, VBC, & financial risk contract types
- Administration of the EMR, revenue cycle, credentialing, training, etc.
- Does not employ the physicians or run the care center
- ANALYTICS and REPORTING --→ FWA detection

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Case Study 1

System wide observation

Detection

- Multiple ACOs' see claims activity for A6197;
- Dates of service in H2 2024; claims submission dates in H1 2025
- Additional codes identified
- Claim counts increased by 38x
- Cost/paid per claim increased 7.5x period over period

Investigation

- CMS claim line file (CCLF) identified patients and clinicians
- Claims showed a range of ordering clinicians
- Patient chart audit revealed no order/consult to explain the service or the claim
- Interviews supported the findings

Remediation

- Broad communication to medical group
- Reporting to government agencies
- Advocacy to remove claims from MSSP risk
- Applicable codes removed

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Case Study 2

Individual observation

Detection

- Care Center awareness of FWA risk
- Clinician shares risk awareness with patients about HHC and DME
- Patient reports event
- Care center forwards to compliance

Investigation

- Chart audit showed patient has condition applicable to order
- Order was reasonable in service and volume
- Clinician validated service and findings
- Data query unrevealing
- Service provider had no publicly reported activity or suspicion

Remediation

- None necessary

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3 Pronged Approach



Prevent

- Data security
- Billing and Coding Training
- Req'd Compliance Training
- Education and awareness at the point of care
- Preferred network



Detect

- Analytics and Reporting
- Monitor public reporting
- Invite case reporting
- Compliance department
- Audit
- Investigate



Remediate

- Understand the exposure
- Specific prevention tactics
- Communicate widely
- Agency reporting
- Terminate relationship
- Advocate for protection

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Lisa M. Re
Partner
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Arnold & Porter

Innovative. Integrated. Industry-Focused.

When prevention fails

Investigation, Enforcement, and Accountability

Lisa M. Re | Partner, Washington, D.C.

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Health Care Fraud Enforcement: The Laws and the Agencies

- Three enforcement tracks, one body of conduct
  - Civil: the False Claims Act (FCA) imposes money damages and penalties for knowingly false claims to federal health care programs.
  - Criminal: the Anti-Kickback Statute (AKS) bars paying or receiving anything of value to induce referrals of federal program business.
  - Administrative: HHS-OIG (the Office of Inspector General) can impose civil monetary penalties and exclude individuals and companies from federal programs.
  - The Stark Law, which restricts physician self-referrals, is a strict-liability statute with no intent element; Stark and AKS violations also feed FCA liability.
- Who does what
  - HHS-OIG: investigates, runs the administrative penalty and exclusion authorities, and publishes the data and reports that point to risk areas.
  - DOJ: brings civil FCA and criminal cases and decides whether to take over whistleblower suits.
  - CMS (Centers for Medicare & Medicaid Services): controls payment and enrollment, including payment suspensions and revocation of billing privileges.
  - The DOJ–HHS False Claims Act Working Group links HHS (including CMS and OIG counsel) with DOJ's Civil Division; HHS refers potential FCA violations to DOJ.
  - Takeaway: the same facts can reach all three tracks, and the agencies coordinate.

Three Core Tools: False Claims Act, Anti-Kickback Statute, Exclusion

- False Claims Act — 31 U.S.C. § 3729
  - Liability for knowingly presenting a false or fraudulent claim for payment. The elements are knowledge, falsity, materiality, and damages to the government.
  - "Knowingly" is deliberately broad: actual knowledge, deliberate ignorance, or reckless disregard. No specific intent to defraud is required.
  - Remedies: up to three times the government's damages, plus a per-claim civil penalty.
  - A "reverse false claim" reaches knowingly keeping money owed back to the government.
- Anti-Kickback Statute — 42 U.S.C. § 1320a-7b(b)
  - A criminal law against knowingly and willfully offering, paying, soliciting, or receiving "remuneration" to induce or reward federal program referrals.
  - Under the "one purpose" test, an arrangement is unlawful if even one purpose is to induce referrals.
  - Penalties include up to 10 years' imprisonment per violation, fines, and exclusion. A claim resulting from a kickback is also a false claim under the FCA.
- Exclusion — 42 U.S.C. § 1320a-7
  - HHS-OIG can bar individuals and entities from participating in federal health care programs.
  - Billing for services furnished by an excluded person is itself a false claim and carries civil monetary penalties.
  - Takeaway: the kickback law supplies the conduct, the FCA the multiplier, and exclusion the loss of program access.

How Cases Are Found: Data, Whistleblowers, and Priorities

- Data analytics
  - OIG reports, data briefs, and public Medicare datasets (such as utilization and Open Payments data) are mined by DOJ and by private whistleblower lawyers to find outliers.
  - CMS has moved from "pay and chase" toward using AI and data analytics to stop improper payments before they go out.
  - The DOJ–HHS Working Group's mandate includes enhanced data mining of HHS data to surface new leads.
- Whistleblowers
  - Under the FCA, a private whistleblower (a "relator") sues on the government's behalf. The complaint is filed under seal while the government investigates.
  - The government's 60-day window to decide whether to intervene is routinely extended, and seals often run one to three years or more.
  - The reward drives the system: a relator's share is 15–25% of the recovery if the government intervenes and 25–30% if it does not.
- Enforcement priorities
  - The Working Group's six priority areas: Medicare Advantage; drug, device, and biologics pricing; kickbacks; defective devices; barriers to care and network adequacy; and electronic health record manipulation.
  - FY2025 set a record: over $6.8B in FCA settlements and judgments, including over $5.7B from health care matters.
  - Takeaway: unusual data gets a case looked at, and insiders often start it.

Civil, Criminal, or Administrative: Three Enforcement Tracks

- Criminal
  - Requires proof of knowing and willful conduct. Under the AKS, penalties reach up to 10 years' imprisonment per violation, plus fines and exclusion.
  - Individuals, not just companies, are exposed to prison.
- Civil
  - The FCA reaches reckless disregard, with no specific intent required.
  - The remedy is money: up to three times damages plus per-claim penalties. Cases are brought by DOJ or by whistleblowers.
- Administrative
  - HHS-OIG's civil monetary penalties cover false claims, kickbacks, employing excluded persons, failing to return overpayments, and more.
  - OIG must prove its case by a preponderance of the evidence, in an administrative hearing process, within a six-year limitations period; it may also seek exclusion.
- The tracks overlap
  - An AKS violation also creates FCA exposure and can lead to exclusion, and OIG coordinates with DOJ on resolutions.
  - Takeaway: the intent standard is one key difference among the tracks.

How FCA Cases Are Resolved: Settlement, Multipliers, and CIAs

- Settlement or litigation
  - After the seal period, the government decides whether to intervene. If it declines, the whistleblower can press the case alone.
  - Resolutions are negotiated agreements or court judgments; the government and relator each have a stake in the outcome.
- Monetary exposure
  - FCA litigation exposure is up to three times the government's damages, plus per-claim penalties.
  - Self-disclosure to OIG generally resolves at about 1.5 times single damages, in exchange for cooperation, with a presumption against a CIA. The benefit is lost once the government already has the matter.
- Corporate integrity agreement (CIA) or exclusion
  - A CIA is a compliance agreement with HHS-OIG, typically paired with an FCA settlement, in exchange for OIG's release of its exclusion authority.
  - OIG monitors compliance. Breach can bring stipulated penalties and, for material breach, exclusion.
  - Exclusion remains one of the government's most powerful tools: it ends a provider's ability to bill federal programs.
- Why it matters
  - Takeaway: enforcement is intensifying and data-driven, and a strong, well-documented, operational compliance program is the best defense.



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NHCAA
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Medicare Fraud: Policy Resources, Roles, and Realities

Topic: Medicare Fraud in Practice

Alliance for Health Policy
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Collaboration is Key

- The U.S. Health Care system is complex with a vast range of possible entry points for attempted fraud:
  - Multiple payers—federal, state, and local governments; private insurers; employers; etc. Entices submission of false billings among many payers simultaneously.
  - Entire population of our nation's patients, with Medicare enrollees often targeted;
  - Entire range of potential medical conditions & treatments on which to base false claims.
  - Complex billing processes and an obligation to ensure patient access.
- In this environment, collaboration and partnership among anti-fraud professionals and payer organizations are absolutely essential.
- NHCAA's four decades as a private-public partnership affirms this.
- Create venues for information sharing that build trust among partners.

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Medicare Fraud Schemes

- Durable Medical Equipment (DME)
  - Nonexistent or Phantom Provider Schemes
  - Telemarketing Schemes
  - Urinary Catheter Schemes
- Unnecessary and/or Fabricated Laboratory Testing Schemes
- Genetic Testing Schemes

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AI and Health Care Fraud

- Artificial Intelligence will continue to impact health care fraud—
  - As a means for developing and committing fraud schemes (for bad)
  - As a tool for shaping and imagining health care fraud detection and prevention solutions (for good).
- NHCAA Subcommittee on Artificial Intelligence; White paper—GenAI last summer; now incorporates AgenticAI, living document.
- Critically important control: “Human at the Helm” approach. Health care fraud investigators, analysts are vital and essential.

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Prevention Mindset

- Pay and chase no longer serves us. Recoveries can no longer be the goal.
- Emphasis must be on prevention and putting the right tools and guardrails in place to protect our finite health care resources from loss to fraud.
- Many new and enhanced tools over the last 10-15 years:
  - ACA implemented several new provider screening requirements and other anti-fraud provisions.
  - CMS now releases revocations data ("Revoked Medicare Providers and Suppliers dataset") https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/revoked-medicare-providers-and-suppliers
  - Empowering Medicare beneficiaries through the Senior Medicare Patrol.



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MEDICARE RIGHTS CENTER

Getting Medicare right

Protecting Medicare Beneficiaries: What "Good" Looks Like

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Fraud, Waste, and Abuse: The Beneficiary Experience

Health and Access	Unnecessary services; inappropriate treatment; care delays, denials, and disruptions
Financial and Administrative	Unexpected cost-sharing, confusing notices, difficulty resolving problems
Privacy and Security	Misleading offers, misuse of Medicare and personal health information
Trust and Time	Unclear processes, repeated calls, burdensome paperwork, complex appeals, and anxiety about whether coverage is secure.

Beneficiary-Centered Program Integrity Principles

1

Protect Beneficiaries

- Good program integrity prevents people from being harmed and exploited.

2

Preserve Access to Care

- Stopping bad actors should not mean creating unnecessary barriers for everyone else.

3

Build and Maintain Trust

- People need to trust that Medicare is protecting their benefits and their ability to use them, as well as their rights, autonomy, and dignity.

4

Minimize Beneficiary Burden

- The responsibility for protecting Medicare should lie primarily with those who administer and oversee it.



Make Beneficiary Impact a Core Measure

When considering a proposal, ask:

- Does it protect beneficiaries? Will it prevent fraudulent or unnecessary services, misuse of beneficiary information, or other harms?
- Does it preserve access? How will the strategy distinguish bad actors from legitimate providers and services? What safeguards will prevent inappropriate denials, disruptions, and delays?
- Does it build trust? Will beneficiaries understand what is happening and why, know where to go for help, and have a meaningful way to correct errors?
- Does it minimize burden? How much time, paperwork, confusion, or effort will beneficiaries be expected to absorb?

A Beneficiary Impact Framework

What to Ask	What to Measure
Does it protect beneficiaries?	Fraud prevented, harmful services stopped, and beneficiary complaints about suspected fraud resolved
Does it preserve access to care?	Inappropriate denials, delays in care, disruptions to providers, and time to restore access
Does it build trust?	Minimal disruptions, clear notices, ease of resolution, and beneficiary understanding
Does it minimize burden?	Paperwork, time spent resolving issues, repeat requests for information, and accessibility of assistance

What Does Success Look Like?



Prevent fraud and protect beneficiaries from unsafe, unnecessary, and exploitative practices.



Preserve timely, uninterrupted access to care.



Hold wrongdoers responsible, swiftly resolve beneficiary problems, and measure whether people are better protected.

Closing Remarks



Aharisi Bonner, MPH
Senior Insights Program Manager
Alliance for Health Policy

Thank you for attending!

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