Medicare Fraud, Waste, and Abuse Historical Context

Risks, Mitigation Strategies, and Future Directions

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Contents

What Is Medicare Fraud and Why Should We Care? 1

How Is the Federal Government Organized to Fight Medicare Fraud? 4
- CMS and Contractors 4
- HHS OIG and U.S. DOJ 7
- Other Organizations 7

What Is the Legal and Regulatory Framework for Medicare Fraud? 8

What Are Some Common Medicare Fraud Risks? 10

What Are Common Approaches and Strategies to Mitigate Medicare Fraud? 12

Risks Associated With New Payment and Care Delivery Systems 16

Next Steps 19

Acknowledgments 20

References 21

Exhibits

Exhibit 1. Error Rates and Improper Payments (in Billions) for Medicare, 2021–2025 3

Exhibit 2. Program Integrity Organizational Chart 5

Exhibit 3. HCFAC Program Funding (Millions) 8

Table of Abbreviations

AKS	Anti-Kickback Statute
CERT	Comprehensive Error Rate Testing
CIA	Corporate Integrity Agreement
CMMI	Center for Medicare and Medicaid Innovation
CMP	Civil Monetary Penalties
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DOJ	U.S. Department of Justice
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FFS	Fee for Service
FTC	Federal Trade Commission
FY	Fiscal Year
GAO	U.S. Government Accountability Office
HCFAC	Health Care Fraud and Abuse Control
HFPP	Healthcare Fraud Prevention Partnership
HHS	U.S. Department of Health and Human Services
HHS OIG	U.S. Department of Health and Human Services, Office of Inspector General
HIPAA	Health Insurance Portability and Accountability Act
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MAO	Medicare Advantage Organization
MEDIC	Medicare Drug Integrity Contractor
NCCI	National Correct Coding Initiative
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
SMRC	Supplemental Medical Review Contractor
UPIC	Unified Program Integrity Contractor

What Is Medicare Fraud and Why Should We Care?

Signed into law in 1965, Medicare provided health coverage and increased financial security for older Americans who typically couldn't afford private health insurance (Fee, 2015). Hospital coverage (Medicare Part A) constituted Medicare's main benefit with automatic enrollment of eligible beneficiaries aged 65 years and older (Lankford, 2023). Coverage of physician services (Part B) was offered as optional, supplementary insurance and required beneficiaries to pay a monthly premium (Lankford, 2023). Supplemental insurance policies, known as Medigap, soon emerged to help Medicare beneficiaries cover out-of-pocket costs such as deductibles, coinsurance, and copayments (Malloy, 2023).

In the 1990s, as private health insurance adopted managed-care approaches, Congress created Medicare Part C in 1997—now known as Medicare Advantage (MA)—allowing private insurers to offer managed-care health plans to seniors in lieu of traditional Medicare Parts A and B coverage (Lankford, 2023). Medicare Part C integrated hospital and physician services, and health plans were required to cover all Medicare-approved services. In the 2003 Medicare Prescription Drug, Improvement, and Modernization Act, Congress added a prescription drug benefit to Medicare (Part D), reflecting the increased importance and costs of prescription drugs in medical care (Centers for Medicare & Medicaid Services [CMS], 2015). Drug coverage is available through MA plans or stand-alone prescription drug plans.

Medicare is now the primary source of health care coverage for nearly 70 million older U.S. adults and younger people with disabilities, whom the program has covered since 1972 (CMS, 2026a). Spending on Medicare benefits totals around $1.1 trillion annually (CMS, 2026b). MA plans now enroll more than half of all Medicare beneficiaries—51%, or about 35.6 million people (CMS, 2026a).

Given the size and importance of Medicare, proactively combating fraud, waste, and abuse is key to Medicare sustainability. Public confidence in Medicare's sustainability is important in maintaining public support. A recent Kaiser Family Foundation poll found that more than 8 in 10 Americans view Medicare favorably, but a similar share (81%) worry that the same level of Medicare benefits will not be available in the future (Kirzinger et al., 2025).

FRAUD HEIGHTENS PERCEPTION OF PROGRAM VULNERABILITY

Individual cases of fraud, waste, and abuse can highlight Medicare vulnerabilities and contribute to public perceptions of the scope of fraud, waste, and abuse.

- In February 2025, a New York doctor was convicted of the submission of fraudulent claims to Medicare for medically unnecessary lab tests and orthotic braces (Department of Justice [DOJ], 2025a).
  - Resulted in more than $24 million in fraudulent Medicare claims.
  - The doctor received tens of thousands of dollars in illegal kickbacks and bribes.
- A 2023 case alleged that DMERx, an online platform that created and sold templates of doctors' orders, used the platform to submit claims for medically unnecessary items in exchange for kickbacks and bribes (Diaz, 2023). The vice president of DMERx pleaded guilty to health care fraud charges (DOJ, 2025b).
  - DOJ officials described the scheme as one of the largest health care fraud schemes ever prosecuted.
  - The scheme resulted in more than $1 billion in fraudulent claims submitted to Medicare.

The terms *fraud*, *waste*, and *abuse* can easily be conflated, but CMS clearly defines the distinctions among the three as they relate to Medicare (CMS, 2025a). According to CMS definitions, *fraud* is when someone knowingly deceives, conceals, or misrepresents to obtain money or property from a federal health care program. Medicare fraud is considered a criminal act. *Waste* is overusing services or other practices that directly or indirectly result in unnecessary costs to Medicare. Examples of waste include conducting excessive office visits, prescribing more medications than necessary, and ordering excessive laboratory tests. *Abuse* is practices that directly or indirectly result in unnecessary costs to Medicare. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards. Examples of abuse are billing for services that aren't medically necessary, overcharging for services or supplies, and misusing billing codes to increase reimbursement. The difference among the three depends on circumstances, intent, and knowledge.

Fraud, Waste, and Abuse

Fraud. Intentional deception or misrepresentation resulting in an unauthorized benefit

Waste. Misuse of resources due to inefficiencies

Abuse. Improper behaviors or billing practices

Identifying and preventing fraud, waste, and abuse in Medicare falls largely on CMS and other federal agencies. Such activities are often referred to as "program integrity" activities, designed to ensure taxpayer dollars are spent appropriately to deliver quality, medically necessary care by preventing fraud, waste, and abuse. The program integrity activities conducted by CMS and other agencies have proved to be quite cost-effective: For every $1 spent on program integrity, more than $8 is recovered, and health care fraud

enforcement activities consistently return more than $10 billion to the Medicare Trust Funds every year (Department of Health and Human Services [HHS], 2025). However, program integrity funding has not kept pace with increases in Medicare spending during the past several years, limiting efforts to identify and prevent fraud, waste, and abuse (HHS, 2024). Program integrity activities will be discussed in more detail in the next section.

Medicare fraud, waste, and abuse are costly to taxpayers and divert resources that otherwise could be spent on beneficiaries' care or other societal priorities and needs. While not a measure of fraud, CMS estimates that improper payments—those that should not have been made or were made in the incorrect amount due to errors or fraud across traditional Medicare, MA, and prescription drug plans—cost Medicare more than $56 billion in fiscal year (FY) 2025 (CMS, 2026c). According to the U.S. Government Accountability Office (GAO), improper Medicare payments accounted for 34% of all improper payments across 68 U.S. government programs in FY 2024 (GAO, 2025). CMS estimates improper payments based on annual improper payment rates, also known as *error rates*, using different approaches for each program. Error rates for traditional Medicare are calculated through the Comprehensive Error Rate Testing (CERT) program. Under CERT, a statistically valid random sample of Medicare fee-for service (FFS) claims is examined to determine whether claims were paid properly based on Medicare coverage, coding, and payment rules (CMS, 2024a). Error rates for MA and Part D are calculated by examining medical and prescription record documentation from samples of enrollees to ensure that the diagnoses (for MA) and drug prescription and claim details (for Part D) that determine payment rates are substantiated (CMS, 2025b; CMS, 2025c). **Exhibit 1** shows 2010–2025 error rates and improper payment amount estimates (in billions) for Medicare FFS, MA, and Medicare Part D.

Exhibit 1. Error Rates and Improper Payments (in Billions) for Medicare, 2021–2025

Program	Error Rate 2021	Improper Payments 2021	Error Rate 2022	Improper Payments 2022	Error Rate 2023	Improper Payments 2023	Error Rate 2024	Improper Payments 2024	Error Rate 2025	Improper Payments 2025
Traditional Medicare	6.26%	$25.03	7.46%	$31.46	7.38%	$31.23	7.66%	$31.70	6.55%	$28.83
Medicare Advantage	10.28%	$23.19	5.42%	$13.94	6.01%	$16.55	5.61%	$19.07	6.09%	$23.67
Medicare Part D	1.33%	$1.15	1.54%	$1.36	3.72%	$3.35	3.70%	$3.58	4.00%	$3.70

Sources: CMS, 2026d–f

While useful tools to help program managers target enforcement and education activities, improper payment rates are not measures of fraud and are largely caused by improper or inadequate documentation or other claims processing compliance issues. They do not measure willful misconduct or sophisticated schemes on the part of providers or beneficiaries to steal Medicare dollars. However, some portion of improper payments are fraudulent.

How Is the Federal Government Organized to Fight Medicare Fraud?

At the federal level, the organizational structure for addressing Medicare fraud, waste, and abuse is complex and multifaceted (**Exhibit 2**). There is no one federal agency responsible for identifying and preventing fraud, waste, and abuse; rather, accountability for program integrity is spread across numerous agencies and support contractors.

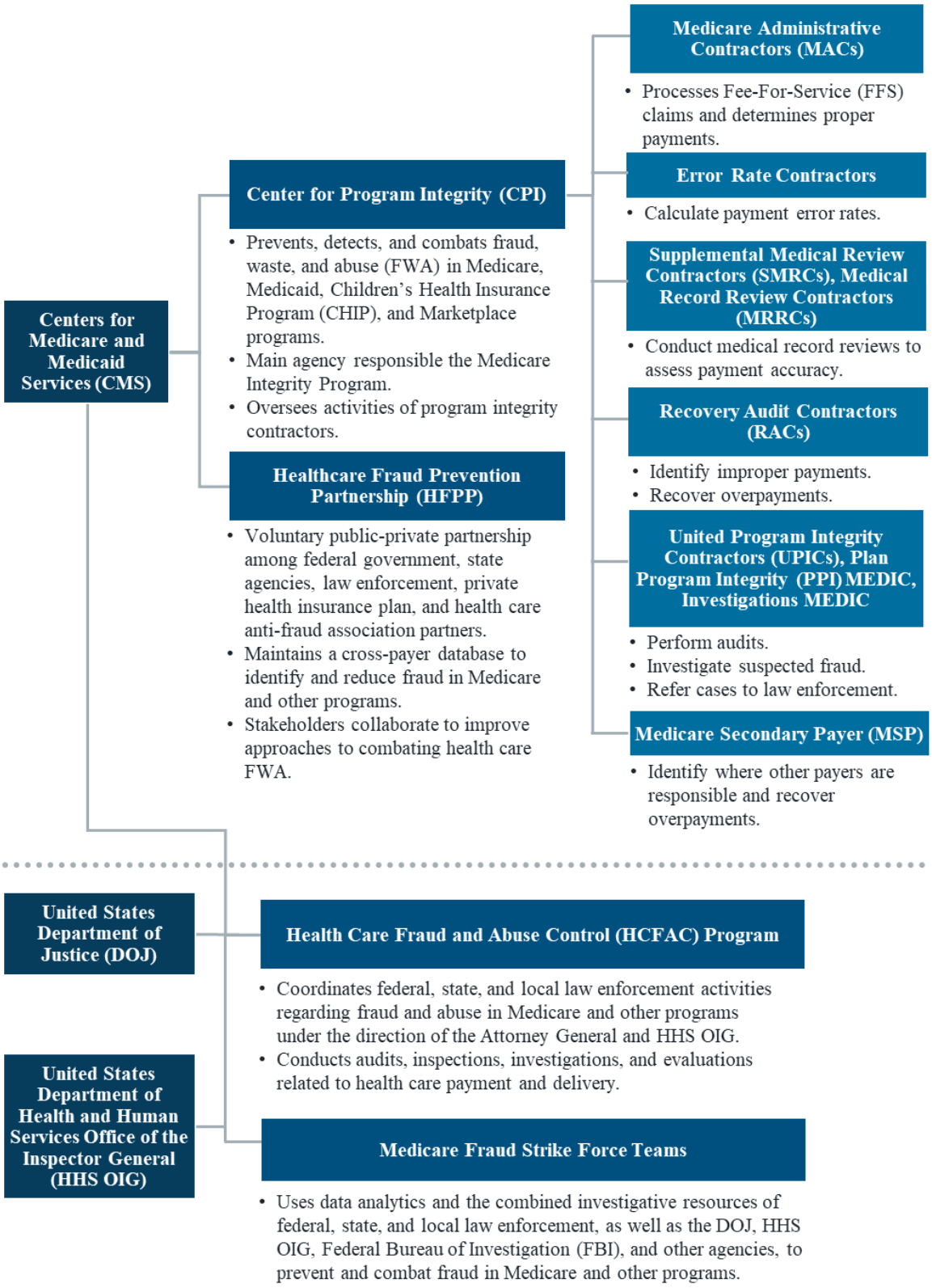
CMS and Contractors

CMS is responsible for highly complex and far-reaching program integrity efforts for Medicare and other programs. The Center for Program Integrity (CPI) is CMS's central unit for program integrity and fraud and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CMS, 2025d). CPI oversees collaborations with stakeholders—including state law enforcement, DOJ, HHS OIG, and other CMS components—to detect, deter, monitor, and take corrective action against health care fraud and abuse (CMS, 2025d; CMS, 2025e). CPI uses a range of methods and tools—including provider and contractor audits, policy reviews, identification and monitoring of program vulnerabilities, assistance and support to states, and recommendations and support for program and operations improvements—to reduce fraud and abuse (CMS, 2025d; CMS, 2025e). One example is the Fraud Defense Operations Center, a pilot established in 2025 that involves a cross-functional team using analytics to identify, investigate, and suspend payments for suspected fraud (CMS, 2026g).

CMS uses a variety of private-sector contractors to conduct program integrity activities, including Medicare Administrative Contractors (MACs), error rate contractors, medical record review contractors, Recovery Audit Contractors (RACs), and program integrity contractors (CMS, 2024b; CMS, 2025d). All contractors have distinct roles and responsibilities:

MACs. The MACs process claims for services covered under Medicare Parts A and B, enroll providers and suppliers in Medicare, handle provider reimbursements, process first-level appeals, educate providers about Medicare, and respond to provider inquiries within assigned geographic jurisdictions (CMS, 2024c). MACs also have an important role in program integrity by ensuring claims are reviewed and paid accurately, auditing provider cost reports, conducting pre- and post-payment medical review and prior authorization, and analyzing claims to identify patterns of errors and outliers (CMS, 2025d).

Exhibit 2. Program Integrity Organizational Chart



Sources: CMS, 2025d, 2025e, 2024c, 2024e, 2024d, 2025g, n.d.a; HHS OIG, 2024a, 2023a; DOJ, 2025c

Error Rate Contractors. CERT contractors select and review random samples of Medicare Parts A and B claims, identify causes of improper payments, and measure them by calculating Medicare FFS improper payment rates (CMS, 2024e). The MACs adjust payments when a CERT contractor identifies errors and use CERT findings to reduce Medicare vulnerabilities (CMS, 2024e). Risk Adjustment Data Validation (RADV) and Medicare Drug Integrity Contractor (MEDIC) contractors similarly calculate improper payment rates for MA and Part D, respectively, along with conducting other audit responsibilities (CMS, 2025d).

Medical Record Review Contractors. The Supplemental Medical Review Contractor's (SMRC) responsibilities include conducting nationwide medical reviews to determine whether Medicare FFS claims follow coverage, coding, payment, and billing requirements and providing expertise to help reduce improper payments, fraud, and abuse in federal health care programs (CMS, 2024d). The SMRC may focus reviews on vulnerabilities identified by CMS and other federal agencies, such as HHS OIG and GAO, and may work on other projects to protect the Medicare Trust Fund (CMS, 2024d). Medical record review contractors have a similar role for MA, particularly reviewing medical records to determine the accuracy of diagnosis codes that determine plan payments, as part of the RADV program (System for Award Management, 2018).

RACs. RACs for Medicare Parts A and B conduct complex medical record reviews and automated post-payment reviews of Medicare claims and encounters to identify underpayments, recoup overpayments, and provide information on vulnerabilities to CMS and review contractors to prevent future improper payments (CMS, 2025f; CMS, 2024e). Although the RAC program was originally intended to expand to include MA and Part D, CMS has instead covered similar functions through RADV and MEDIC contracts, respectively (CMS, 2025d).

Program Integrity Investigations and Audits. The Unified Program Integrity Contractors (UPICs) review claim payments for compliance with requirements and audit and investigate potential fraud, waste, and abuse in Medicare Parts A and B, durable medical equipment, home health, and hospice, as well as Medicaid (CMS, 2025g). The UPICs act on referrals from the MACs and RACs and, in turn, refer cases to the HHS OIG or law enforcement for additional investigation (CMS, 2024f). They also work with MACs and other partners to implement procedures such as automatic denials to prevent fraud and are responsible for integrating Medicare and Medicaid audits (CMS, 2024g). To support program integrity efforts in Medicare Parts C and D, CMS has used two types of MEDIC contractors. The Investigations MEDIC conducts investigations, recommends administrative actions, and submits referrals to law enforcement (CMS, 2025g). The Plan Program Integrity MEDIC analyzes Parts C and D data, conducts audits of plan sponsors, and supports outreach and education efforts (CMS, 2025g). For MA and Part D,

additional contractors perform RADV audits, cost report audits, and financial audits (CMS, 2025d; CMS, 2025g; System for Award Management, 2018).

Medicare Secondary Payer (MSP). The MSP program also has a role in program integrity by ensuring that medical expenses that should be covered by other payers are not paid by Medicare, avoiding double billing, and recovering payments when another payer should have been billed (CMS, 2025g).

HHS OIG and U.S. DOJ

The HHS OIG works with HHS, DOJ, state governments, Congress, private-sector organizations, and other executive agencies to improve compliance, recover mis-spent funds, and take enforcement actions related to all HHS programs, including Medicare. The Health Care Fraud and Abuse Control (HCFAC) Program is a coordinated effort between HHS OIG and DOJ, established through the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to combat health care fraud, primarily in Medicare and Medicaid (HHS OIG, 2024a). HCFAC brings together investigative and analytical resources from HHS OIG, DOJ, CMS, state agencies, and others (HHS OIG, 2024a). The HCFAC Program formed regional Medicare Fraud Strike Force teams in 2007 to prevent and combat health care fraud, waste, and abuse (HHS OIG, 2023a). A coordinated effort by HHS OIG, the DOJ Health Care Fraud Unit, U.S. Attorneys, the Federal Bureau of Investigation (FBI), state and local law enforcement, and others, the Strike Force teams use data analytics and investigative intelligence to identify fraud and prosecute criminals, including charging more than 1,600 defendants over the four years ending in FY 2023 (CMS, 2025g). The DOJ's Health Care Fraud Unit, comprising more than 80 prosecutors, focuses primarily on prosecuting complex health care fraud cases in Medicare and other programs, using advanced data analytics and algorithmic methods to identify emerging health care fraud schemes and target fraudsters (DOJ, 2025c).

Other Organizations

Other agencies engaged in preventing fraud, waste, and abuse play lesser roles in program integrity. For example, the Federal Trade Commission (FTC) enforces federal competition and consumer protection laws to prevent fraudulent activities (FTC, 2023). The FTC enforces the Health Breach Notification Rule and the FTC Act to protect consumer health care data. These regulations require businesses covered by HIPAA and certain noncovered businesses, such as health insurance plans, to notify consumers, the FTC, and sometimes the media if there is a data breach (FTC, 2023).

What Is the Legal and Regulatory Framework for Medicare Fraud?

The Social Security Act is the fundamental statutory underpinning for Medicare, providing authority for program payment, coverage, and eligibility. In addition, amendments to the Social Security Act and stand-alone statutes provide additional enforcement and contracting authority and funding to government agencies to set up and monitor programs to protect Medicare from fraud, waste, and abuse. This complex statutory framework governing the federal government's program integrity efforts builds on a series of changes to the Social Security Act and other longstanding statutes. The federal False Claims Act (FCA), anti-kickback statute (AKS), physician self-referral law, health care fraud statute, beneficiary inducement statute, and HIPAA provide the foundation for Medicare and other federal health care program integrity efforts and interagency collaboration.

HIPAA established the HCFAC Program and authorizes CMS to fund and contract for program integrity efforts. Medicare HCFAC program integrity activities are funded through the CMS budget and split among CMS, HHS OIG, and DOJ, providing the majority of these agencies' budgets for health care program integrity (CMS, 2025g). In FY 2026, CMS requested $2,631 million in funding for the HCFAC Program (CMS, 2025g), a small increase over previous years (see Exhibit 3). The HCFAC Program directs DOJ and HHS to coordinate law enforcement activities at federal, state, and local levels to combat health care fraud, waste, and abuse (HHS OIG, 2024a). The HCFAC Program is the primary federal investment for addressing health care fraud via coordinated efforts among agencies (HHS, 2025). As of December 2024, HCFAC Program priority areas included program integrity related to prescription drug abuse, non-institutional care settings such as home health and hospice, and Medicaid, and pursued wide-ranging civil and criminal investigations, such as fraudulent billing for ambulance and medical services and durable medical equipment, wire fraud and money laundering related to personal protective equipment, kickbacks for use of diagnostic tests and referrals to home health and hospice services, and submitting inaccurate diagnosis codes to increase Medicare Advantage payments (HHS OIG, 2024a). In FY 2023, the federal government negotiated or won more than $1.8 billion in health care fraud judgments and settlements through the HCFAC Program (HHS OIG, 2024a).

Exhibit 3. HCFAC Program Funding (Millions)

	CMS	HHS OIG	DOJ	FBI	Total
FY 2021	$1,556	$353	$159	$152	$2,220
FY 2022	$1,622	$358	$179	$153	$2,312
FY 2023	$1,690	$373	$192	$160	$2,416
FY 2024	$1,751	$389	$206	$168	$2,515
FY 2025	$1,808	$399	$209	$174	$2,590

Sources: CMS, 2022, 2023a, 2024h, 2025g

The civil FCA, a statute that dates to the Civil War, protects the federal government from being overcharged or sold inferior goods and services (DOJ, 2025d). The FCA provides that any person who knowingly submits, or causes to submit, false claims to the government is liable for three times the government's damages plus a penalty linked to inflation (DOJ, 2025d). In addition to enabling the United States to pursue fraud perpetrators, the FCA authorizes private citizens to file suits on behalf of the government (known as qui tam suits) against those who allegedly have defrauded the government (DOJ, 2025d). Private individuals, known as relators, who successfully bring qui tam actions receive a portion of the government's recovery (DOJ, 2025d). The FCA qui tam provisions have been particularly useful in efforts to recover funds lost due to health care fraud and abuse.

Two laws, the AKS and the physician self-referral law (also known as the Stark law), prevent physicians and others from receiving or paying inappropriate remuneration for patient referrals. The AKS, a criminal law that applies to all federal health care programs (HHS OIG, n.d.b), prohibits anyone from knowingly and willingly giving, offering, or receiving remuneration to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (HHS OIG, n.d.b). Criminal penalties and administrative sanctions for violating the AKS include jail terms, fines, and exclusion from participation in federal health care programs. The beneficiary inducement statute similarly prohibits offering or transferring items or services to beneficiaries to influence their choice of provider or supplier.

Some complex cases involve more than one type of fraud. For example, in an October 2023 case, a mobile cardiac positron emission tomography scan provider allegedly paid excessive fees to cardiologists for patient referrals, potentially violating both the AKS and the Stark law (DOJ, 2023c). The company and CEO paid a combined $85 million to resolve an FCA case related to the allegations. In another example, the HHS OIG issued a special alert to practitioners in 2022, advising them to be wary of telehealth companies, as the office investigated dozens of fraud schemes involving telehealth where companies paid unauthorized referral fees to physicians in addition to submitting claims for medically unnecessary services to Medicare (HHS OIG, 2022b).

The Stark law, which generally applies to Medicare but can include Medicaid under a dual billing scenario where services are also billed to Medicare, prohibits physicians from referring patients for designated services from an entity with which the physician or an immediate family member has a financial relationship or interest, with some exceptions (HHS OIG, n.d.b). The entity is also prohibited from submitting claims to Medicare for services that result from such a referral. The Stark law provides for civil penalties and fines as well as exclusion from federal health care programs (HHS OIG, n.d.b). A West Virginia hospital paid $1.5 million in 2022 to

settle alleged violations of the Stark law and the FCA (DOJ, 2022). Furthermore, the DOJ's summary of FCA cases from FY 2022 details five cases with AKS and/or Stark law allegations that resulted in providers paying more than $890 million in settlements (DOJ, 2023a).

In addition, HHS OIG, under the Civil Monetary Penalties (CMP) Law, can address improper conduct related to federal health care programs (HHS OIG, 2023b). The HHS OIG's CMP authorities closely parallel those of the FCA and can be applied across HHS programs. While FCA cases are pursued by DOJ on behalf of HHS in federal court, CMP cases are administrative and pursued by HHS OIG before an HHS administrative law judge. DOJ also can pursue criminal cases of defrauding Medicare or other programs under the health care fraud statute. Under exclusion provisions in the Social Security Act, HHS OIG can exclude providers and suppliers from participating in federal health care programs if they have convictions for fraud or other crimes or have participated in prohibited activities such as kickbacks and false statements (HHS OIG, n.d.b).

What Are Some Common Medicare Fraud Risks?

Describing the types of fraud and the entities committing fraud is subject only to the imagination of people trying to steal money from taxpayers. Whether carried out by small "mom-and-pop" providers, sophisticated organized criminal networks, or corporations seeking to maximize revenue, common types of health care fraud that occur in Medicare as well as other programs include:

- Billing fraud, such as billing for services or supplies that were not provided, submitting multiple claims for the same service, or billing for a more expensive service than the one that was provided;
- Identity theft or swapping, including using another person's health insurance with or without the approval of the insured individual;
- Bogus marketing schemes, such as to steal identities, bill for non-provided services, or enroll individuals in health plans without their consent;
- Illegal kickbacks to insured individuals, providers, or suppliers;
- Impersonation of a health professional, such as billing for services without an appropriate license; and
- Prescription fraud, including prescription forgery, doctor shopping, and diversion of prescription drugs for illegal purposes (FBI, n.d.).

TELEHEALTH: A NEW POST-PANDEMIC PROGRAM INTEGRITY RISK

The rising popularity of telehealth during and following the COVID-19 pandemic presents a novel potential risk to Medicare program integrity.

- An HHS OIG study identified 1,714 providers from a sample of about 742,000 whose telehealth billing practices during the first year of the pandemic presented a possible risk (HHS OIG, 2022c).
  - These providers were chosen based on concerning billing practices indicating potential program integrity issues.
  - The providers billed telehealth services to Medicare for about half a million beneficiaries and received $127.7 million in Medicare FFS payments.
  - The report concluded that these providers' billing practices warranted further scrutiny, and as a result, OIG recommended that CMS consider targeted oversight and increased monitoring of telehealth services, as well as providing educational resources for providers on proper telehealth billing procedures.

UPCODING: SUBMITTING INACCURATE BILLING CODES TO INCREASE REIMBURSEMENT

- A study examining more than 490,000 providers who billed Medicare for office visits found more than 1,250 providers upcoded (Ornstein & Jones, 2017).
  - For every office visit—even for established patients—providers submitted a billing code intended for use for an initial consultation, which is more time consuming.
- An HHS OIG study analyzing Medicare Part A claims from 2014 to 2019 found that hospitals were billing a large proportion of inpatient stays at the highest severity level (HHS OIG, 2021a).
  - The number of stays of this type increased by almost 20% over this time and accounted for about half of all Medicare spending on inpatient hospital stays.
  - About 30% of inpatient stays billed at the highest severity lasted a short amount of time and more than half were at this level due to one diagnosis.
  - This could suggest upcoding, as the patient may be less sick than the coding indicates.

What Are Common Approaches and Strategies to Mitigate Medicare Fraud?

CMS and other organizations employ multiple mitigation strategies to prevent and detect fraud, waste, and abuse.

Claims Review. One group of strategies known as *prepayment claim review programs* are designed to prevent improper payments before they happen by reviewing claims for errors before the claim is paid by Medicare. Some complex prepayment claim reviews require medical records or other documentation to complete, while other prepayment reviews are less complex and can be completed using only the claim itself (CMS, 2024i).

- One example of a noncomplex review is National Correct Coding Initiative (NCCI) procedure-to-procedure edits. CMS developed the NCCI to promote correct coding methods and prevent improper coding and, therefore, improper payments. NCCI edits occur when incorrect code combinations appear. They are based on multiple sources of coding conventions and are updated quarterly (CMS, 2026h).
- Similarly, medically unlikely edits are automated prepayment coding edits performed by MACs to find unusually high units of service that, based on statistical analysis, are unlikely to be accurate (CMS, 2026h).
- Add-on code edits are automated prepayment coding edits to identify services that almost always should be provided in combination with another service (CMS, 2026h).
- MACs use a fourth type of prepayment claim review—medical review—in cases of suspected inappropriate billing, such as from claims data analysis, complaints, or alerts from other program integrity agencies or contractors. This type of review is complex and requires providers to submit supporting medical records so that coding can be verified (CMS, 2024i).

Post-payment claim review also can involve medical record review by a MAC, RAC, UPIC, or SMRC (CMS, 2024i). This type of review is particularly burdensome for CMS and providers because it requires the production of medical record documentation to support a claim after the claim is adjudicated.

- Post-payment reviews involve reviewing past Medicare FFS claims for alignment with Medicare regulations, billing instructions, and coverage guidelines to identify improper payments. Reviews can identify underpayment or overpayment, billing for non-covered or unnecessary services, incorrectly coded services, duplicate services, and claims that

do not meet other Medicare requirements for payment (CMS, 2024i). Reviews may or may not require medical record review.

- The CERT program includes another type of post-payment claim review. The program involves using a randomly selected sample of processed Medicare FFS claims to calculate a national Medicare FFS improper payment rate (CMS, 2024e). For the selected sample, CERT obtains medical records or documentation from the provider of the claim and performs a complex review to determine whether the claim was paid appropriately according to all applicable rules (CMS, 2024e).

Provider Enrollment. Provider enrollment is a tool that CMS uses to ensure that providers interacting with Medicare and providing services to beneficiaries are screened and reviewed to mitigate the likelihood of a "bad actor" participating in the program (CMS, 2025h).

Advanced Analytics. In addition to the data analysis and methods used by CMS contractors, CMS has deployed advanced analytics to identify and eliminate fraud, waste, and abuse. The Fraud Prevention System uses predictive analytics to identify and prevent payment of fraudulent claims in Medicare FFS (Peraton, 2024). The predictive modeling helps CMS prevent fraud more proactively. When advanced analytics identify a potential risk, further investigation or other oversight processes are triggered.

Transparency. To promote transparency and provider education, CMS launched the Open Payments programs, the NCCI, and various trainings. The Open Payments program is a statutorily required national disclosure program and houses a publicly accessible database (CMS, 2023b). Reporting entities, such as pharmaceutical and medical device manufacturers, are required to report payments made to recipients, such as physicians and teaching hospitals, as well as ownership and investment interests held by physicians or their immediate family members (CMS, 2023b). In 2024, reporting entities collectively reported $13.18 billion in reportable payments, ownership, and investment interests (CMS, 2025i).

Provider and Beneficiary Education. Educating Medicare providers and suppliers, as well as beneficiaries, is an essential tool in establishing a broader culture of compliance and improved integrity by ensuring that Medicare rules and regulations are properly understood and implemented (CMS, 2025d). This education can take many forms:

- CMS hosts webinars relevant to program activities, such as data submission and reporting requirements, and has developed a help desk to provide technical assistance (CMS, 2023d). In addition, CMS provides monthly stakeholder calls, working groups, and speakers through various means, such as Physician Open Door Forums, and runs media campaigns to communicate with various stakeholders (CMS, 2023d).

- CMS provides training materials on combating Medicare fraud, waste, and abuse through the Medicare Learning Network® (CMS, 2025d). CMS also requires MA plans to provide annual fraud, waste, and abuse training to their employees (GAO, 2018).
- CMS provides website resources to educate beneficiaries about how to protect themselves from Medicare fraud. For example, beneficiary-targeted Fraud Prevention Toolkits provide information about fraud, waste, and improper payment reduction, including how to report suspected fraud (CMS, 2025j). The long-running Guard Your Card program is another example of beneficiary education (CMS, 2018).

Policy Changes. CMS also mitigates fraud and abuse risk by changing or creating policies or rules aimed at preventing fraud, waste, and abuse. Using trends and patterns from improper payment analysis, the government can develop additional rules or guidance for MACs, other contractors, Medicare Advantage Organizations (MAOs), and others. One example is the recent change to Medicare payment policy for skin substitutes. Following significant growth in Medicare spending on skin substitutes, including cases of improper payments and concerns about abusive pricing, as of 2026, CMS introduced standard national coverage requirements and reducing the amount it would pay for skin substitutes, thereby reducing both the opportunity and the incentive for fraud (CMS, 2025k).

Public-Private Partnerships. CMS provides oversight of the Healthcare Fraud Prevention Partnership (HFPP), a voluntary public-private partnership for sharing information and detecting and preventing fraud, waste, and abuse (CMS, 2024j). As of December 2024, the HFPP included 310 members from various organizations, such as private health insurance plans, health care anti-fraud associations, and state agencies (CMS, 2024j). HFPP analyzes data to identify fraudulent billing patterns, provides education, sends fraud scheme alerts, and conducts outreach to partners (CMS, 2024j). The HFPP also holds events to facilitate information sharing among partners, share study results, and provide fraud analytic services (CMS, 2024j). The partners reported more than $11.4 million dollars in hard-dollar savings, defined as money recovered or received, such as overpayment collection. Nonfederal partners reported $19.9 million in soft dollar savings, defined as money calculated and anticipated by an organization to be recovered or collected at a future date (CMS, 2023c).

Strategies Unique to HHS OIG. Strategies deployed by the HHS OIG include issuing exclusions and advisory opinions, negotiating corporate integrity agreements (CIAs), and disseminating compliance guidance and resources.

- The HHS OIG has the authority, under sections 1128 and 1156 of the Social Security Act, to exclude individuals or entities from federally funded health care programs, including Medicare (HHS OIG, 2023b). Those excluded cannot receive any payments for any items

or services provided (HHS OIG, 2023b). Anyone who employs or contracts with excluded individuals or entities also can be penalized (HHS OIG, 2023b). For example, a court sentenced an individual to pay $48 million and serve 14 months in prison for selling fraudulent prescriptions through call centers, and the HHS OIG excluded him from federal programs for 38 years (HHS OIG, 2025).

- In consultation with DOJ, HHS OIG also issues advisory opinions to requesting parties regarding the application of fraud and abuse authorities to a party's existing or proposed business arrangement (HHS OIG, n.d.c). Section 1128 D of HIPAA directs HHS OIG to issue advisory opinions (HHS OIG, n.d.c). Although advisory opinions are voluntary, they are legally binding on HHS and the requesting entity. In 2025 HHS OIG issued 12 advisory opinions on federally funded programs (HHS OIG, n.d.c).
- CIAs are used when providers and other entities agree to settle fraud allegations (HHS OIG, n.d.a). Providers or entities agree to certain obligations, and in exchange, HHS OIG agrees not to exclude them from participating in Medicare or other federal health care programs (HHS OIG, n.d.a). Under the CIA, a provider or entity commits to establishing a compliance program and taking necessary steps to ensure future compliance with Medicare regulations (HHS OIG, n.d.a).
- To help providers comply with health care regulations, HHS OIG produces compliance resources. One of them is the General Compliance Program Guidance, a document that provides information about compliance risks, relevant regulations, and HHS OIG resources (HHS OIG, 2023b). The guidance is voluntary and nonbinding and offers recommended practices to prevent fraud, waste, and abuse (HHS OIG, 2023b). Another HHS OIG resource is the Health Care Fraud Self-Disclosure Protocol. Created in 1998, the self-disclosure protocol enables health care providers, suppliers, and other entities to voluntarily disclose self-discovered evidence of potential fraud (OIG) and avoid costs associated with government investigations and civil litigation (HHS OIG, 2021).

Whistleblowers. Qui tam actions are another mitigation strategy with significant impact on efforts to fight fraud, waste, and abuse (DOJ, 2011). The FCA allows private individuals to file lawsuits alleging FCA violations on behalf of the government (DOJ, 2011). If the government intervenes in a qui tam action, the private individual is entitled to receive between 15% and 25% of the amount recovered by the government (DOJ, 2011). If the government chooses not to intervene in the action, the individual's share may increase to between 25% and 30% if the suit is successful (DOJ, 2011). Under certain circumstances, the individual's share might decrease (DOJ, 2011). However, if the individual planned and initiated a fraud, the court may reduce the award without limitation (DOJ, 2011). The individual's share is paid to the relator by the government out of the payment received by the government from the defendant (DOJ,

2011). If a qui tam action is successful, the individual is also entitled to legal fees and other expenses of the action from the defendant (DOJ, 2011). For example, the DOJ announced on September 30, 2023, that the Cigna Group agreed to pay more than $172 million to resolve FCA allegations that it submitted and failed to withdraw inaccurate and untruthful diagnosis codes for beneficiaries in MA plans to increase Medicare payments (DOJ, 2023b).

A Note on Limitations. While CMS and its partners have many strategies available to support program integrity efforts, there are challenges that limit their effectiveness.

- Given that Medicare is continuing to evolve and health care fraud is increasingly complex, increased funding is needed to provide effective oversight. Despite a strong return on investment, HCFAC Program funding levels have increased minimally, at a rate of just 2% to 4% per year in recent years (Exhibit 3). The increased gap between HCFAC funding and Medicare's growth—7.8% in 2024 (CMS, 2026b)—has resulted in agencies having insufficient resources to act and to hire staff, creating a backlog of fraud cases. For example, in 2022, HHS OIG did not have the resources to act on 400 criminal and civil cases, 648 CMS referrals, and approximately 3,500 hotline complaints, and the DOJ workforce was similarly insufficient for its potential caseloads (HHS, 2023).
- Challenges in addressing Medicare fraud, waste, and abuse evolve constantly and quickly. Potential abuse of telehealth services, mentioned earlier, is one example of how changing and evolving technologies can present novel obstacles to safeguarding Medicare program integrity. Ever-changing technology also presents additional opportunities for new scam techniques, such as phishing, smishing, and social engineering, and AI may increase the scale and complexity of fraud, waste, and abuse. Changes in presidential administrations also can result in both budgetary and attitude changes in the handling of health care fraud, waste, and abuse.

Risks Associated With New Payment and Care Delivery Systems

The underlying statutory framework, types of risks, and mitigation strategies discussed here and dominating the federal government's program integrity efforts generally assume a Medicare FFS care delivery model—that is, where a purchaser (in this case, CMS) pays health care providers directly for care provided to Medicare beneficiaries. The risks, and the associated program integrity approach, stem from FFS financial incentives that reward providers for delivering more services, as measured by greater volume or intensity of services delivered. Thus, FFS mitigation strategies are aimed largely at providers to ensure the amount and type of services delivered are appropriate.

This framework is disrupted by evolving care delivery and payment systems adopted and/or tested by CMS along two fronts: The first is payment and care delivery models, including accountable care organizations and those tested by the Center for Medicare and Medicaid Innovation (CMMI). In the last decade, CMMI has launched more than 80 models and demonstrations, with approximately 26 models operational now (either launched or continued) (CMS, 2026i). These models have tested potential improvements in health care payment and delivery for advanced primary care, episode-based care, accountable care, state-based transformation efforts, population health, and health care for specific populations, such as Medicare beneficiaries with end-stage renal disease, diabetes, and heart disease. Models involve payment incentives that differ from Medicare FFS, and many allow waivers of fraud and abuse requirements such as the anti-kickback statute and physician self-referral law (CMS, 2025l). While the impact of these models has been relatively small, they can create new program integrity risks that need to be monitored. CMS has promulgated regulations to ensure comprehensive compliance oversight, audit, and monitoring of CMMI models to identify and mitigate unique risks associated with the model (CFR 42 §§ 512.130, 512.135, 512.150, 512.160). These monitoring and compliance strategies may be helpful in determining appropriate safeguards if a model is expanded or scaled across Medicare.

The second, and far more immediate and direct risk, is the growth of MA, Medicare's managed-care program. In MA, care is still delivered to Medicare beneficiaries by providers, but from a CMS perspective, what is being purchased is *coverage* of Medicare-covered services for beneficiaries. Instead of paying piecemeal FFS claims for care provided to beneficiaries, CMS pays MAOs a fixed risk-adjusted amount per beneficiary, per month to provide all Parts A and B services covered by Medicare. Some MA plans also provide Part D prescription coverage. Such a payment approach is designed to encourage MAOs to ensure that providers deliver care in an efficient, high-quality manner that benefits both beneficiaries and Medicare. The risk of individual provider or beneficiary fraud or abuse is assumed by the MAO. At the same time, new risks to Medicare are introduced—for example, manipulating risk adjustment through coding intensity, using prior authorization to stint on needed care, or misleading beneficiaries to enroll in MA plans.

MA enrollment has grown steadily, from just 19% of Medicare beneficiaries enrolled in MA in 2007 to 54% in 2025 (Ochieng et al., 2025). Based on this trend, experts expect the program to continue to grow. According to Congressional Budget Office projections, the percentage of Medicare beneficiaries enrolled in MA plans is expected to increase to 64% by 2034 (Ochieng et al., 2025). Enrollment is concentrated among large MAOs, with two companies (UnitedHealthcare and Humana) covering nearly half (46%) of MA enrollees (Ochieng et al., 2025).

The program integrity efforts required by CMS and conducted by MAOs are modeled largely on the FFS approach taken by CMS generally, ensuring that individual services delivered by providers are appropriate and necessary. These include requiring training on fraud, waste, and abuse for employees; performing data analysis to monitor for potential fraud, waste, and abuse; and establishing special investigation units to investigate any findings of potential fraud, waste, or abuse (CMS, 2013). CMS also engages contractors such as the Plan Program Integrity MEDIC to help prevent and combat fraud, waste, and abuse in MA and Part D.

Relative to FFS, MA creates different risks to CMS due to the nature of how MAOs are paid and how they deliver services. This is particularly true regarding how CMS calculates MAO payments. While payment is generally made on a per-beneficiary, per-month, or capitated basis, the payments are risk adjusted to account for beneficiary health status and other factors that influence the potential need for additional services of individual beneficiaries. CMS and HHS OIG audits have revealed that the diagnosis data that MAOs submit to CMS for calculating beneficiary risk scores and payments are not always substantiated by underlying medical records; this is a major driver of improper payments (HHS OIG, 2024b). In addition, FCA cases alleging MAOs inflated risk scores to maximize Medicare payments are becoming common (e.g., DOJ, 2025e). CMS has implemented a program, the Medicare Advantage RADV program, to ensure accurate risk score calculations by auditing medical records from a sample of MAOs to confirm the validity of diagnosis codes submitted by MAOs to support beneficiary risk scores. MAOs, however, have challenged the RADV program in court, and a resulting ruling will make it difficult for CMS to implement the program as planned (Christ & Mason, 2025).

MA is also susceptible to risks related to denying medically necessary services covered by Medicare. According to the HHS OIG, the MA payment structure can incentivize MAOs to inappropriately deny or delay covered services to increase profits (HHS OIG, 2022a). CMS audits have revealed that these denials are a widespread and persistent issue in MA, leading to beneficiaries not receiving the care they need in a timely fashion (HHS OIG, 2022a). HHS OIG also has raised concerns about questionable marketing, referrals, and payments among MAOs, providers, and agents and brokers that can mislead beneficiaries in their choices of MA plans or providers (HHS OIG, 2024c).

Significant gaps in the data reported by MAOs limit CMS's ability to provide oversight in certain areas. For example, some MA plans offer supplemental benefits, such as dental, vision, and hearing services, that are not offered under traditional Medicare; however, data on spending and beneficiary utilization of these benefits have not been reported, resulting in vulnerabilities that could lead to fraud or abuse due to lack of oversight (Fuglesten Biniek et al., 2023). Payments made to MAOs for these supplemental benefits have increased significantly in recent

years, from $1,140 per enrollee in 2018 to $2,350 per enrollee in 2023, a jump that has raised questions about how the funds are being used (Fuglesten Biniek et al., 2023).

Other missing data pieces, such as prior authorization denial reasons, timeliness of prior authorization decisions, and claim payment denials, hinder CMS's ability to determine how well MA plans are addressing beneficiary needs (Fuglesten Biniek et al., 2023). Increased transparency for data that are collected and not reported publicly, such as beneficiary out-of-pocket liability and other payment information for MA plans, as well as additional reporting requirements for the data mentioned previously, would make comparison between traditional Medicare and MA more feasible and give beneficiaries more information when deciding between the two (Fuglesten Biniek et al., 2023).

HHS OIG has described MA as particularly susceptible to fraud, waste, and abuse due to MAOs upcoding to inflate the Medicare payments or denying appropriate care to beneficiaries (HHS OIG, 2026) and has made multiple recommendations for mitigating these risks. For example, HHS OIG's 2026 *Top Management & Performance Challenges Facing HHS* report recommended that CMS strengthen protections against upcoding, inappropriate denial of care, and excessive prior authorization; ensure MAOs are not engaging in deceptive marketing or inappropriately denying payments to providers; and ensure that complete and accurate MA plan payment data are available to support oversight of the program (HHS OIG, 2026).

Next Steps

As highlighted in this analysis, the policy and operational environment within which the federal government mounts efforts to fight fraud, waste, and abuse in Medicare is complex and evolving. Notably, continued MA growth as an alternative to Medicare's FFS delivery system invites further inquiry. A particularly important question is whether program integrity processes and systems used to mitigate the risk of fraud, waste, and abuse in traditional Medicare are applicable to MA. Furthermore, does the nature of MA itself (i.e., purchasing private insurance coverage on behalf of beneficiaries versus purchasing individual services on an FFS basis in traditional Medicare) create new or unique risks to Medicare that the federal government has yet to meaningfully contemplate or address? Our further work will begin to answer these questions, offering a rubric for policymakers and stakeholders to analyze MA from a fraud, waste, and abuse perspective.

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