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Week 14

Medicare and Medicaid Fraud Prevention

"Stop the theft before the check clears."

1. The Problem

CMS estimated approximately \$95.6 billion in improper payments across Medicare and Medicaid programs in FY2025 — confirmed from the CMS FY2025 Improper Payments Fact Sheet published January 2026. The critical distinction: CMS itself states that improper payments include documentation errors, administrative mistakes, and overpayments that are not necessarily fraud or abuse. More than 77% of Medicaid improper payments in FY2025 were attributed to insufficient documentation. The platform does not inflate this into fraud. But even the portion that is documentable fraud and intentional abuse represents billions of dollars in theft from programs that exist to serve elderly and low-income Americans. The system pays first and checks later. In many cases it never checks at all.

2. The Governing Principle

The distinction between documentation error and intentional fraud matters — but both are fixable with the same mechanism: check before you pay. A payment made without verifying the provider exists, the patient is alive, and the procedure was actually performed is an improper payment whether the cause is fraud or paperwork failure. Pre-payment verification catches both. The patient notification system catches fraud specifically. The result is fewer improper payments of both kinds — and a clear public record of what was caught and why.

3. The Specific Policy

The FY2025 Improper Payment Data — Verified from CMS (January 2026)

Program	Improper Payments	Rate	CMS Note on Cause
Medicare Fee-for-Service	\$28.83B	6.55%	Documentation errors and billing mistakes
Medicare Part C (Advantage)	\$23.67B	6.09%	Documentation not supporting diagnosis data
Medicare Part D	\$4.23B	4.00%	Pharmacy billing and eligibility errors
Medicaid	\$37.39B	6.12%	77% insufficient documentation — not necessarily fraud
CHIP	\$1.37B		56% insufficient documentation
TOTAL (all CMS programs)	~\$95.6B	7.05%	FY2025 — source: CMS fact sheet January 15, 2026

The honest distinction: improper payments are not all fraud. CMS defines an improper payment as any payment that should not have been made or was made in the wrong amount — including overpayments, underpayments, and payments where documentation was insufficient to determine propriety. A large share of improper payments are administrative errors and documentation failures, not intentional theft. The Week 14 reforms address both categories — pre-payment verification catches fraud and documentation failures simultaneously.

What Genuine Fraud Looks Like — Documented Cases

- **Ghost providers:** providers who do not exist or whose licenses have been revoked billing Medicare. CMS has paid claims from providers who were deceased, had surrendered their licenses, or never existed as licensed practitioners. Pre-payment provider verification eliminates this category entirely.
- **Ambulance billing fraud:** documented as one of the highest-fraud categories. Ambulance companies bill for rides that did not occur, for patients who could have used other transportation, and for distances that were not traveled. The lack of pre-payment verification enables this fraud to persist for years before detection.
- **Durable medical equipment fraud:** equipment billed but never delivered, equipment prescribed by providers who never saw the patient, equipment billed at premium rates for items that cost a fraction of the billed amount. DMEPOS is consistently among the highest-fraud categories in HHS OIG audits.
- **Home health fraud:** home health agencies billing for visits that never occurred, for patients who did not qualify, and through kickback arrangements with referring physicians. FBI and HHS OIG have prosecuted hundreds of home health fraud cases involving hundreds of millions of dollars.

The Pre-Payment Verification System

- **Check before you pay — the core reform:** the current system is pay-and-chase. CMS pays the claim and then attempts to recover improper payments after the fact. The recovery rate is a fraction of what was improperly paid. Pre-payment verification reverses the default — verify first, pay second.
- **Provider verification:** every provider verified as currently licensed and in good standing before receiving any payment. License status cross-referenced against state medical board databases in real time. Physical location verified for high-fraud provider categories. Re-verification every 12 months — not just at initial enrollment.
- **Patient notification:** every Medicare and Medicaid beneficiary notified within 48 hours when a claim is filed in their name — via text, email, or paper statement based on beneficiary preference. An unrecognized claim triggers an immediate hold on payment pending review. This single measure would catch billions in ghost billing annually at minimal cost.
- **AI-assisted claim screening:** AI flags patterns that no human auditor would identify — a provider billing identical procedures for hundreds of patients on the same day, claims for deceased patients, billing for mutually exclusive procedures, and geographic impossibilities. Applied to high-risk claim categories before payment is released.

MFCU Funding and Enforcement

- **Medicaid Fraud Control Units recovered over \$2 billion in criminal and civil actions in FY2025:** every dollar invested in MFCU enforcement returns \$6-8 in additional recoveries — confirmed by HHS OIG analysis.

- **MFCU funding increased from approximately \$800 million to \$1.6 billion per year:** at \$6-8 return per dollar, \$1.6 billion in MFCU funding produces \$9.6-12.8 billion in annual recoveries. State match requirement maintained — federal increase leverages additional state investment.

4. Estimated Cost Savings

Year 1 target: \$10-20 billion in prevented losses and recovered funds. Year 4 at full implementation: estimated \$25-40 billion per year in combined prevention and recovery. These figures are platform estimates — the actual savings depend on what share of improper payments are preventable through pre-payment screening versus what share reflect systemic administrative failures requiring process reform rather than fraud enforcement. Independent CMS actuarial review required. The platform does not claim all \$95.6 billion in improper payments is recoverable fraud.

5. Year 1 Implementation and Measurable Result

Year 1 measurable result: patient notification system operational for Medicare FFS within 180 days; provider license verification cross-reference with state medical boards operational within 90 days; AI claim screening deployed for the five highest-fraud categories within 180 days; MFCU funding increase enacted; Medicare FFS improper payment rate below 6.55% by end of Year 1. Source for baseline: CMS FY2025 Improper Payments Fact Sheet, cms.gov, January 15, 2026.