May 18, 2026

The Honorable John Joyce
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Submitted Electronically to: Annabelle.Huffman@mail.house.gov.

Re: Responses to Questions for the Record

Dear Chairman Joyce,

Thank you for the opportunity to testify at the Oversight and Investigations Subcommittee Hearing on Common Schemes, Real Harm: Examining Fraud in Medicare and Medicaid.

My responses to the questions for the record are attached.

Sincerely,

Stephen W. Nuckolls
Chief Executive Officer
Coastal Carolina Health Care, P.A.

cc: Annabelle Huffman, Legislative Clerk

Questions for the Record

The Honorable John Joyce (R-PA)

1. In Operation Gold Rush, the federal task force was successful in preventing more than 99 percent of the fraudulent claims being paid out because claim payments were suspended. Supplemental insurers, however, do not suspend claim payments, and the bad actors were able to defraud funds from them. **Do supplemental or secondary insurers then increase premiums on beneficiaries to cover these losses?**

- Operation Gold Rush demonstrated a critical asymmetry in Medicare's program integrity. While Medicare was able to suspend payment on more than **99 percent of fraudulent claims**, supplemental and secondary insurers often continued paying claims in the absence of real-time fraud flags.
- According to the DOJ indictment Medicare supplemental insurers and other secondary payers paid approximately **$900 million**.
- A key driver of these downstream losses was a DOJ investigative approach that required CMS to pay claims known, or suspected to be fraudulent, into escrow while the investigation proceeded.
- About **95% of the actual fraud loss** occurred from the lack of timely notification while suspect billing continued.
- Assuming this escrow policy remains active—and based on recent claims activity we believe it is—this approach can shift losses to beneficiaries, supplemental carriers, and other secondary payers and can block access to medically necessary care.
- While we don't have access to direct data from CMS or health plans, losses related to fraud can ultimately put upward pressure on future premiums and plan designs because supplemental insurers price premiums based on expected claims.
- The key lesson from Operation Gold Rush is that detection is necessary but not sufficient.

a) **What can be done to address secondary insurer vulnerability to either prevent or reduce premium increases to beneficiaries?**

- ACOs and Supplemental Plans face similar challenges when it comes to CMS' fraud notification system. Going forward we need more rapid notification, record correction, and cross-payer coordination so that fraud is stopped before it blocks legitimate care, shifts losses to beneficiaries, supplemental insurers, and the ACOs that are responsible for the majority of the cost.

2. **How can considerations of enhanced prior authorization requirements strike a balance that avoids overly burdensome regulations, yet increases oversight of potentially fraudulent or abusive claims before they are paid?**
    - ACOs help manage Medicare spending and improve care quality, but unlike MA plans, they lack certain tools (e.g., prior authorization; pre-payment review; network controls; and rapid suspension of suspect suppliers) to prevent improper billing and fraud before it impacts beneficiaries and taxpayers.
    - The Center for Medicare and Medicaid Innovation WISeR Model was developed to reduce wasteful and inappropriate Medicare spending through AI-assisted prior authorization and human clinical review. While it is encouraging that CMS is taking proactive steps to address fraud, any expansion of prior authorization in traditional Medicare should avoid adding unnecessary burdens for providers or restricting access to legitimate care. One important safeguard would be automatically granting ACO providers "gold card" exemptions to reduce administrative burdens. Strong guardrails are also needed to protect beneficiaries, including limiting the model to services with a demonstrated risk of fraud and abuse.
    - CMS should also require DME suppliers, as a condition of participation, to maintain an appropriate surety bond or similar financial guarantee to support repayment if fraud is identified. This would give MACs and UPICs more time to detect and stop fraudulent schemes while preserving a practical path to recover improper payments. Additionally, CMS should strengthen real-time data sharing and predictive analytics to identify suspicious billing patterns earlier and prevent fraudulent payments before they occur.

As an accountable care organization (ACO), you have access to claims data for your members. **How can ACOs that have visibility of spikes in fraudulent billing schemes use this data to sound the alarm on suspected fraud?**

- ACOs are on the front lines of identifying fraud, waste, and abuse because we regularly analyze Medicare Part A and B claims to identify gaps in care, opportunities for clinical intervention, and trends in utilization and spending. These same tools can also detect anomalous billing patterns that may signal fraud or abusive practices.
- Today, most ACOs participate in two-sided risk arrangements, meaning they are accountable not only for sharing in savings, but also for repaying CMS when spending exceeds established benchmarks.
- ACOs already play an important role in helping CMS identify fraudulent or suspicious billing activity and CMS can strengthen these efforts by:
    - Creating a streamlined, standardized reporting pathway for ACOs and clinicians to submit suspected fraud, waste, and abuse with clear data requirements and confirmation of receipt.

- CMS should also establish a formal feedback loop, such as a dedicated point of contact or case-tracking system, so ACOs receive updates from initial review through resolution.

The Honorable Russ Fulcher (R-ID)

How does widespread fraud affect reimbursement rates or incentives for legitimate providers?

- Medicare fraud is not just a budget issue—it causes real harm and confusion for beneficiaries, providers, and taxpayers.
- Rapid growth in fraudulent or abusive spending has created significant challenges for ACOs, particularly because benchmark updates often do not keep pace with sudden spikes in utilization and costs. As a result, ACOs can lose shared savings or face financial losses due to spending outside their control, undermining confidence in two-sided risk arrangements and value-based care.
- Medicare's Serious, Anomalous, and Highly Suspect (SAHS) policy is an important step toward addressing this issue, but its scope remains too limited. CMS has also taken positive action by addressing inappropriate skin substitute billing and announcing the exclusion of certain high-risk categories—such as catheters, dressings, and orthotics—from ACO calculations. These changes will help protect clinicians from fraudulent spending they cannot control and stabilize participation in accountable care models.
- CMS should continue strengthening these protections by ensuring fraudulent or suspect spending does not distort ACO benchmarks or national growth factors, including the Accountable Care Prospective Trend (ACPT). Prospective guardrails similar to those proposed in the LEAD Model could help limit the impact of outlier spending and improve benchmark stability.
- Stable and predictable benchmarks are especially important for primary care providers and other clinicians who invest heavily in care coordination, patient outreach, and services not typically reimbursed under fee-for-service Medicare. Maintaining accurate benchmarking methodologies will help sustain these investments and support continued participation in accountable care models.

The Honorable Earl L. "Buddy" Carter (R-GA)

How do foreign-driven fraud schemes like Operation Gold Rush distort financial benchmarks and reconciliations for accountable care organizations, and what retroactive adjustments or exclusions would best protect accountable care organizations from undue penalties without deterring value-based care participation?

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The Honorable Yvette D. Clarke (D-NY)

The Administration has highlighted expanded use of prior authorization as a tool to curb potentially fraudulent claims, including using artificial intelligence and automated claims review. However, reports and investigations have found that some health plans – including Medicare Advantage plans—have used AI-driven prior authorization and claims-review tools to deny medically necessary care at concerning rates and with limited human oversight. For example, a recent Senate investigation found that after implementing AI-based claims determinations, one large insurer's denial rate for certain post-acute care more than doubled, with approximately 90 percent of those denials later overturned on appeal.

a) **If health plans are encouraged to adopt AI-driven prior authorization and claims-review processes as anti-fraud tools, what regulatory safeguards and oversight mechanisms should be established to govern the use of AI in claim determinations and ensure that patient access to medically necessary care is not compromised in the name of combating fraud?**

- The Center for Medicare and Medicaid Innovation WISeR Model was developed to reduce wasteful and inappropriate Medicare spending through AI-assisted prior authorization and human clinical review. While it is encouraging that CMS is taking proactive steps to address fraud, any expansion of prior authorization in traditional Medicare should avoid adding unnecessary burdens for providers or restricting access to legitimate care. One important safeguard would be automatically granting ACO providers "gold card" exemptions to reduce administrative burden. Strong guardrails are also needed to protect beneficiaries, including limiting the model to services with a demonstrated risk of fraud and abuse.
- To further cut down on fraud, CMS should also strengthen DME requirements. As a condition of participation DME suppliers should be required to maintain an appropriate surety bond or similar financial guarantee to support repayment if fraud is identified. This would give MACs and UPICs more time to detect and stop fraudulent schemes while preserving a practical path to recover improper payments. Additionally, CMS should strengthen real-time data sharing and predictive analytics to identify suspicious billing patterns earlier and prevent fraudulent payments before they occur.
- CMS should also further safeguard beneficiaries from DME fraud by establishing a beneficiary-friendly record correction when DME or other high-risk items are billed in a beneficiary's name. This includes a simple mechanism for treating clinicians to attest that an item was not ordered and to restore eligibility for medically necessary care.