Written Testimony

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Subcommittee on Oversight and Investigations

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I. Introduction

Chairman Guthrie, Chairman Joyce, Ranking Member Pallone, Ranking Member Clarke, and Members of the Subcommittee, thank you for the opportunity to testify.

My name is Stephen Nuckolls. Coastal Carolina Health Care, P.A. is an independent, physician-led multi-specialty medical practice in eastern North Carolina that operates and participates in accountable care organizations. In addition, I am a board member of the National Association of ACOs (NAACOS).

I view fraud, waste, and abuse in Medicare and Medicaid through two complementary lenses: (1) a rural, independent medical practice caring for beneficiaries where fraudulent billing can directly disrupt access to legitimate care; and (2) an accountable care organization (ACO) held responsible for total cost and quality, including avoidable and wasteful spending, where we routinely analyze claims data to identify unusual billing patterns.

Fraud is not an abstract budget problem. It creates real harm: confusion for beneficiaries, delayed or denied medically necessary services, and higher costs that ultimately flow back to taxpayers and families through premiums and cost sharing. It also harms accountable care organizations, especially the many ACOs in two-sided risk arrangements that must repay Medicare when program spending exceeds the benchmark.

II. Why ACOs are positioned to help identify fraud, waste, and abuse

Accountable care organizations are on the front lines of identifying fraud, waste, and abuse (FWA) because we regularly analyze Part A and B claims to find gaps in care, opportunities for clinical intervention, and trends in utilization and spending. Those same tools can reveal anomalous billing patterns that may indicate fraud or abusive practices.

Today, the vast majority of ACOs participate in two-sided risk arrangements. In these models, ACOs do not just share in savings - we are also responsible for repayment when spending exceeds the benchmark.

In many tracks, the repayment share is substantial, commonly 75% or more of the amount over budget (subject to program limits). That structure creates a strong, practical incentive for ACOs to find fraud and other avoidable spending quickly, because we have a high portion of dollars at risk.

This stewardship also benefits other payers that cover Medicare beneficiaries. When ACOs help identify and stop improper billing, it can reduce costs borne by Medicaid for dually eligible beneficiaries and by Medicare supplemental insurers, helping protect beneficiaries from higher premiums and cost sharing.

III. Operation Gold Rush: a case study in transnational fraud and cross-payer impact

Operation Gold Rush illustrates both the progress CMS has made in detecting large-scale fraud and the unintended consequences that can occur when investigative and payment policies are not aligned with beneficiary protection and cross-payer coordination.

According to the indictment, a transnational criminal organization used stolen identities and purchased DME companies to submit approximately $10.6 billion in false Medicare claims. CMS paid roughly $41 million before stopping payments, meaning the Medicare program prevented payment of about 99.6% of the billed amount.

That point deserves emphasis: the CMS fraud detection systems that many providers feared were not working performed exceptionally well in this case by identifying and stopping the overwhelming majority of the billed amount.

CMS's pre-payment and analytic safeguards worked in Operation Gold Rush; the failure was not detection, but coordination and beneficiary protection after detection.

Yet the indictment and related case information show that Medicare supplemental insurers and other secondary payers paid approximately $900 million associated with the same scheme. The question is not whether Medicare was protected; it is whether beneficiaries, ACOs and other payers were protected quickly enough once the pattern was detected.

Based on our understanding of the indictment, a key driver of 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, without timely notification to ACOs, Medicare supplemental insurers, or other secondary payers. The indictment shows that CMS detection worked relatively well. Unfortunately, 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.

In our case, we reported suspected fraudulent claims for many months through routine channels including HHS Office of Inspector General, CMS, or the relevant Medicare Administrative Contractors (MACs) without any resolution or confirmation that the information was received and investigated. For ACOs, this has meant bringing fraud to national attention through outreach to the CMS Administrator, members of Congress and the press. Ideally, we would have more streamlined approaches for resolution.

This escrow without notification approach can translate into direct patient harm. When fraudulent DME claims appear in a beneficiary's record, legitimate medically necessary items may be delayed or denied because coverage eligibility appears to have been exhausted. The patient example later in this testimony, involving diabetic shoes denied due to a fraudulent DME claim from across the country, is consistent with this type of harm.

The lesson from Operation Gold Rush is that detection is necessary but not sufficient. We also need 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 and are trying to prevent it.

IV. The fraud, waste, and abuse continues with DME and skin substitutes

Even after Operation Gold Rush, we continue to see actors using the same tactics described in the indictment to perpetrate DME fraud. Beneficiaries are billed for items they never requested, and legitimate orders may be delayed or denied because a fraudulent claim appears to have exhausted coverage. We are also seeing a separate, rapidly growing problem in skin substitutes, which is both fraud and wasteful and abusive utilization among otherwise legitimate providers. Supporting analyses are provided in Exhibits 1 through 3.

A. Durable medical equipment (DME)

From the perspective of an ACO that routinely monitors claims patterns, DME remains a recurring vector for beneficiary harm, ACO harm, and taxpayer loss throughout 2025. As summarized in Exhibit 1, NAACOS members identified multiple DME codes with anomalous billing spikes suggestive of potential fraud or abuse, including wound dressings (A6197), orthotics (L0486, L0651, L1852, L3916), continuous glucose monitor supplies (A4238/A4239 and related codes), and urinary catheters (A4353).

In addition to rapid growth in these codes, NAACOS analyzed Medicare data to identify a small number of DME suppliers with highly concentrated spending across the identified codes. For example, the analysis highlighted suppliers that billed billions in a short period - including Sunshine Senior Solutions LLC ($2.3B primarily in Q4 2024 and Q1 2025), ND Medical Solutions LLC ($964M beginning in Q4 2024), Almaz Med Supply Inc. ($602M concentrated in Q3/Q4 2024 with little prior activity and no 2025 billing for these codes), and Southeastern Medequip Inc. ($429M in Q2 2025).

It is important to note that anomalous spending patterns alone do not prove fraud; they are signals that warrant rapid review. But these patterns are consistent with what we saw with Operation Gold Rush and align with what front-line clinicians see when beneficiaries receive equipment they did not order, or when legitimate orders are delayed or denied because a fraudulent claim "used up" coverage eligibility.

B. Skin substitutes and skin graft products: extreme growth and waste/abuse concerns

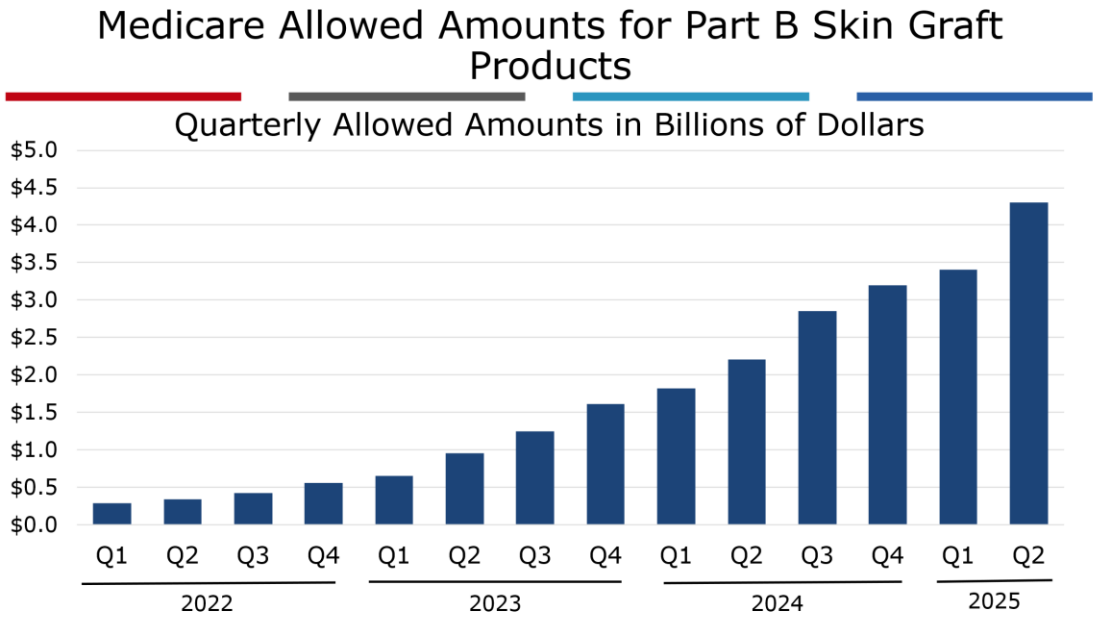
Traditional Medicare has recently experienced extreme growth in the cost and utilization of skin substitutes billed as Part B drugs (HCPCS Q4100-Q4367). Unlike the DME fraud mentioned above, much of this spending appears to be billed by enrolled clinicians and facilities that are otherwise legitimate. For that reason, this trend is better classified as wasteful spending and

abusive utilization - even when individual claims may be technically payable. As shown in Exhibits 2, analyses prepared for NAACOS show allowed amounts increasing from $1.6 billion in 2022 to $9.9 billion in 2024, with $7.7 billion in the first six months of 2025 alone.

From a clinical perspective, ACOs have reported patterns that do not align with patient need, including use of skin substitutes in patients without control of underlying conditions, use in hospice patients near end of life, continued treatment when wounds are not improving, and billing practices that raise questions about wastage and discarded units.

This rapid growth is problematic for ACOs because benchmark updates may not keep pace with sudden shifts in utilization and unit costs, creating the risk that ACOs lose shared savings - or incur losses - due to spending spikes outside their control. CMS recognized skin substitute billing impacts and made positive changes to the payment policy for 2026 and beyond that will curb this abusive behavior. However, ACOs remain responsible for spending spikes in 2025 that were largely outside their control. Exhibit 3 demonstrates the impact of this egregious spending on ACOs.

Figure 1 (Exhibit 2). Medicare allowed amounts for Part B skin graft products (quarterly)



Source: Analysis of Medicare Parts A&B Data in available through CMS Virtual Research Data Center (VRDC), October 2025.

As shown above, quarterly allowed amounts for Part B skin graft products increased sharply from 2022 through 2024 and accelerated further into 2025. Separate NAACOS analyses project

that, if the first half of 2025 trend continued, total allowed amounts are projected to reach approximately $15.4 billion in 2025 (See Exhibit 2).

V. Patient harm example: diabetic shoes denied due to fraudulent DME billing

One of our patients required therapeutic diabetic shoes - a basic, clinically appropriate intervention that helps prevent ulcers, infections, and amputations. When our team attempted to obtain coverage, we learned that Medicare records showed the patient had supposedly already received diabetic shoes from a DME supplier located across the country - something the patient did not recognize and did not request.

When we attempted to contact the supplier, the business appeared no longer operational, and publicly available information about the supplier included multiple allegations of fraudulent billing from other patients. Despite our efforts, the patient could not obtain timely resolution and ultimately paid out of pocket for medically necessary shoes. This is what "real harm" looks like: a beneficiary seeking legitimate care is denied coverage because fraudulent billing contaminated the record.

VI. ACO REACH example: 100% risk exposure to suspected DME fraud

In our current ACO arrangement with CMS's Innovation Center—ACO REACH—we are 100% at risk for total cost of care. In our most recent meeting with our actuaries, we provided claims data from six DME companies that we identified as suspected fraudulent claims for an estimated $6.3 million, with the largest concentration in the Arizona market.

For beneficiaries attributed to our ACO in the Arizona market, the projected impact from these six DME companies is more than $1,024 per beneficiary per year. For context, that is roughly three times the 2022 national per-beneficiary DME spending level of $342.

At this point, we do not know whether these claims were paid into escrow or otherwise held, nor do we know whether we will be held financially accountable for them in reconciliation. Beyond our own performance, these claims can also distort national growth factors used in benchmarking and trending for ACOs.

This uncertainty undermines confidence in the model, weakens incentives for participants to remain engaged in value-based care, and discourages new ACO formation—precisely when Medicare needs more providers willing to take risk, deliver better care, and reduce wasteful spending.

VII. Challenges for ACOs and policy recommendations

ACOs are expected to be stewards of the Medicare spending by improving quality and managing total cost of care. Yet in Traditional Medicare, ACOs and treating clinicians generally do not have the same practical tools available to Medicare Advantage plans - such as prior

authorization, pre-payment review at scale, network controls, and rapid suspension of suspect suppliers - to stop improper billing before it harms beneficiaries and taxpayers.

Instead, accountable care often operates in a pay-and-chase environment: we can identify suspect patterns, report them, and counsel patients, but we may still see the same activity continue in claims data for extended periods with limited visibility into whether action has been taken - even when ACOs are at substantial downside risk, including 100% risk in models like ACO REACH.

Based on our experience and NAACOS member input, we recommend the following policy actions:

1) Close the reporting and feedback loop with CMS, OIG, and the MACs

- Create a streamlined, standardized reporting pathway for ACOs and clinicians to submit suspected fraud, waste, and abuse, with clear data elements and an acknowledgement of receipt.
- Establish a formal feedback loop using a dedicated point of contact or case tracking system. This ensures ACOs receive status updates—from triage to resolution—and eliminates the need for informal escalations

2) Protect beneficiaries and other payers when high-confidence fraud is detected

- Require timely notification to impacted ACOs, Medicare supplemental insurers, and other secondary payers when CMS identifies high-confidence fraud. This includes alerts for claims paid into escrow, enabling these entities to half payments promptly and prevent financial loss.
- Establish fast, beneficiary-friendly record correction when DME or other high-risk items are billed in a beneficiary's name, including a simple mechanism for treating clinicians to attest that an item was not ordered and to restore eligibility for medically necessary care.

3) Strengthen DME supplier integrity

- 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 the DME MACs and UPICs time to detect and stop schemes while preserving a practical recovery path for improper payments.

4) Align ACO accountability with actual payments and recoveries and hold ACOs harmless for fraud, waste and abuse

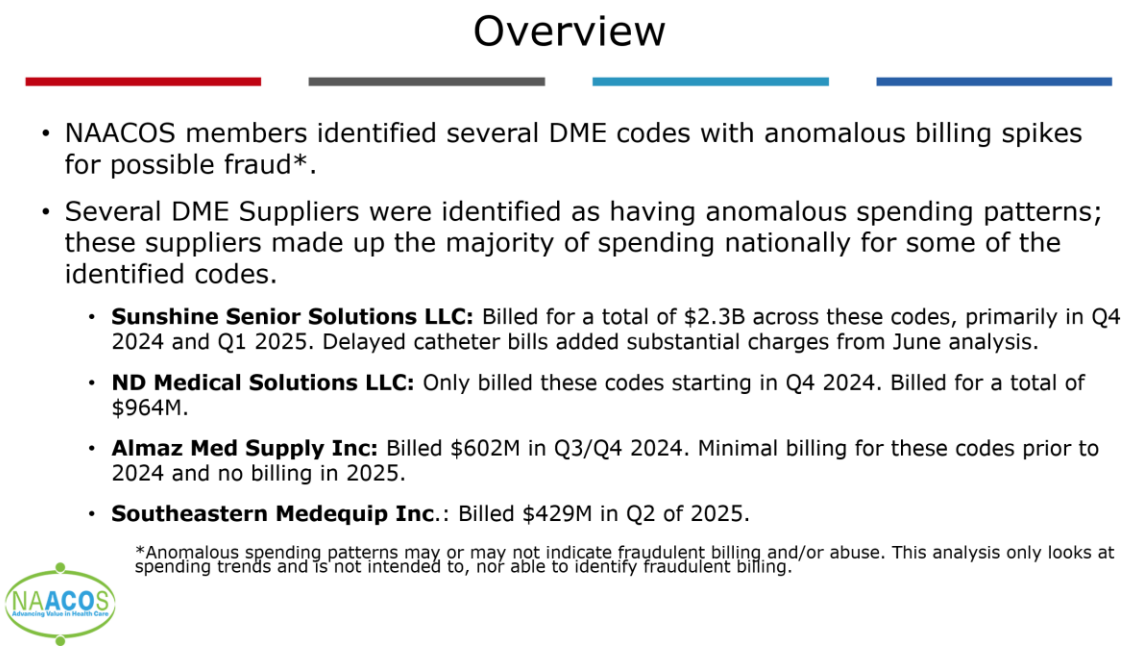
- ACOs should not be held accountable for claims that are not actually paid to suppliers. CMS and the MACs should flag claims paid into escrow, held, or later reversed, and exclude those amounts from ACO expenditures used for reconciliation and benchmarking.

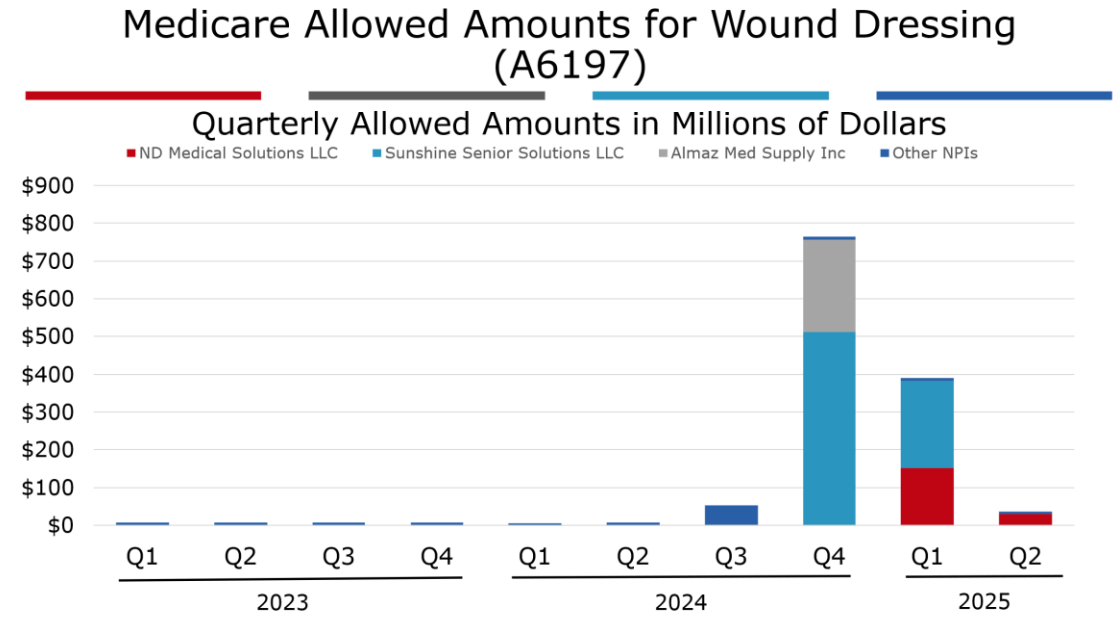
- CMS should improve its significant, anomalous and highly suspect (SAHS) billing policy to account for localized instances of fraud waste and abuse and instances when spikes in utilization and unit cost distort ACO performance and do not reflect clinical need.
- Expand reopening authorities and timelines so ACOs can be made whole when fraud is confirmed after the normal claims run out, consistent with the multi-year timeframe of DOJ and OIG investigations.

VIII. Exhibits

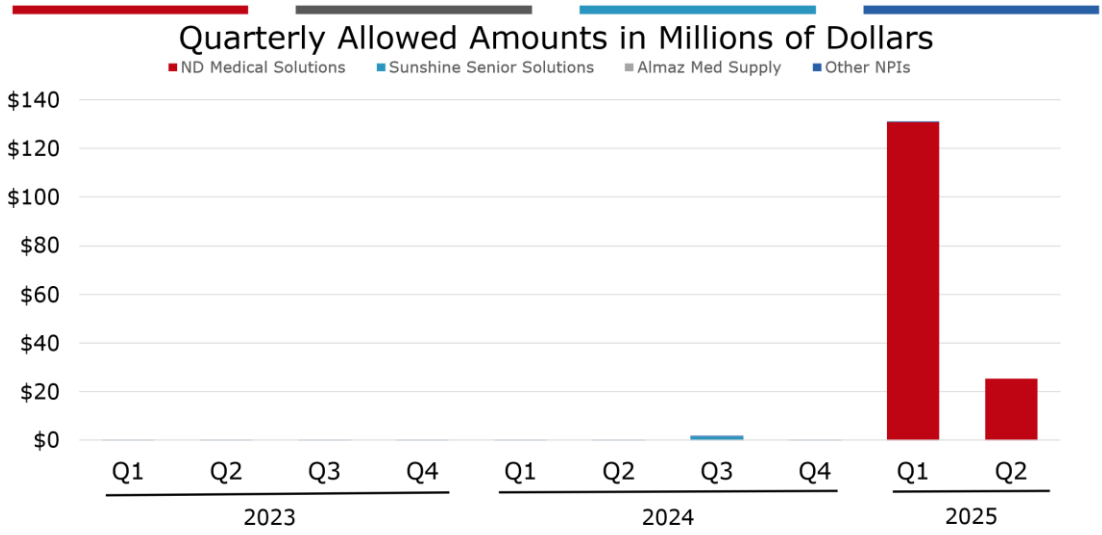
The following documents are referenced in this testimony and will be submitted as exhibits:

Exhibit 1. Suspected Fraudulent DME spending, Analysis of Medicare Parts A&B Data in available through CMS VRDC, November 2025.

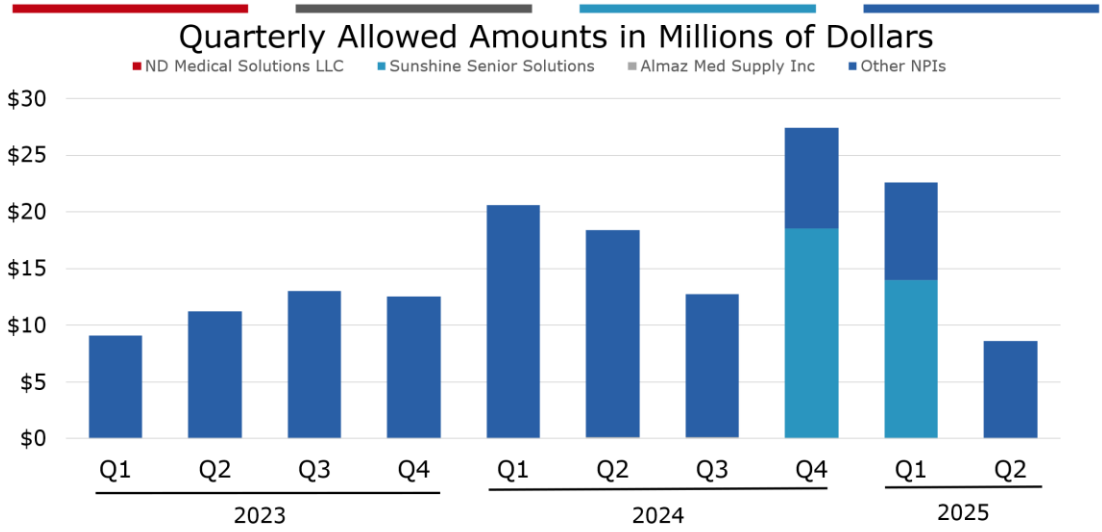




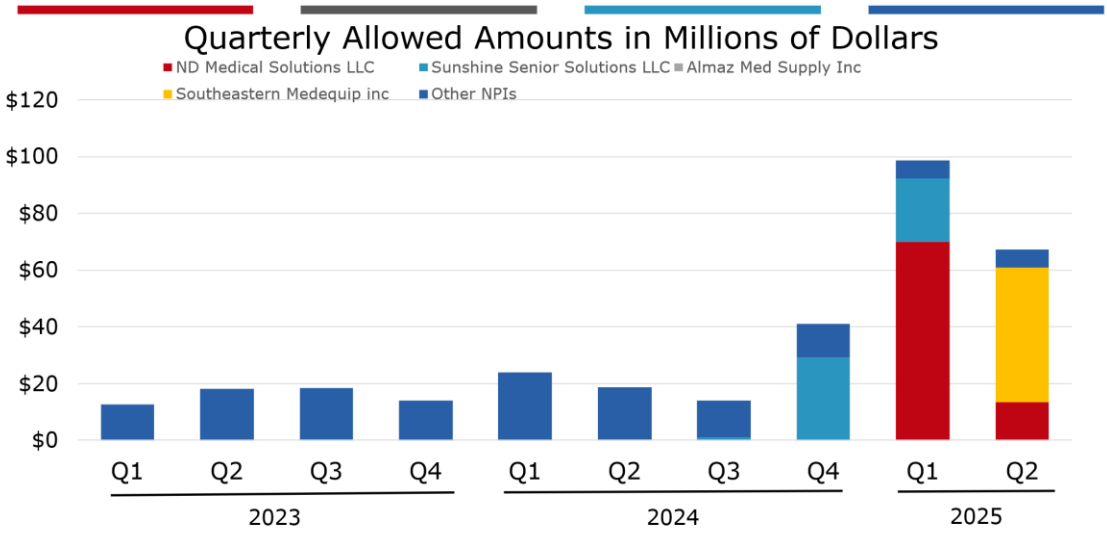
Medicare Allowed Amounts for Thoracic-lumbar-sacral Orthosis (L0486)



Medicare Allowed Amounts for Lumbar-sacral Orthosis (L0651)



Medicare Allowed Amounts for Knee Orthosis (L1852)



Medicare Allowed Amounts for Wrist Hand Orthosis (L3916)

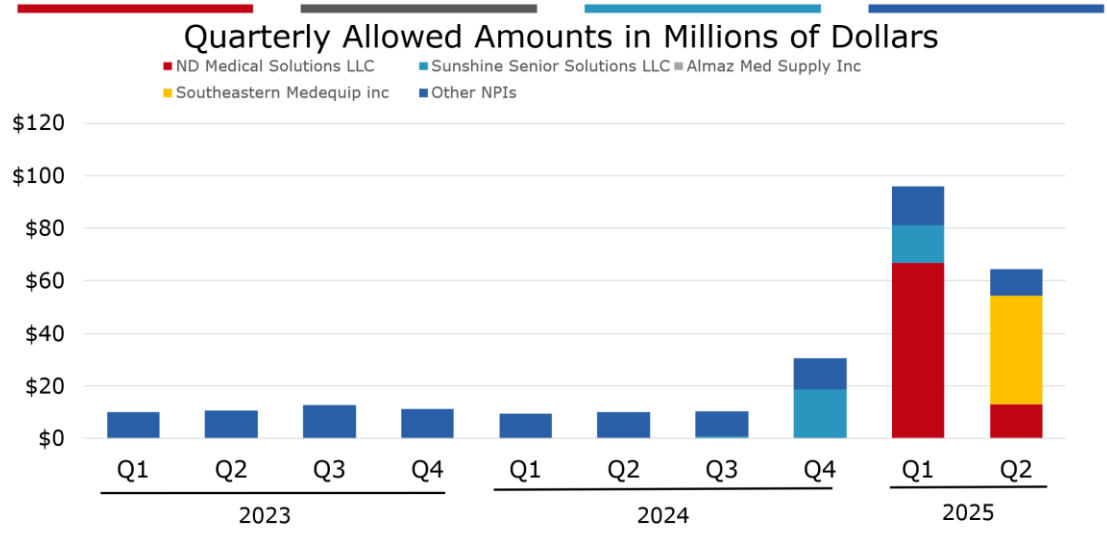
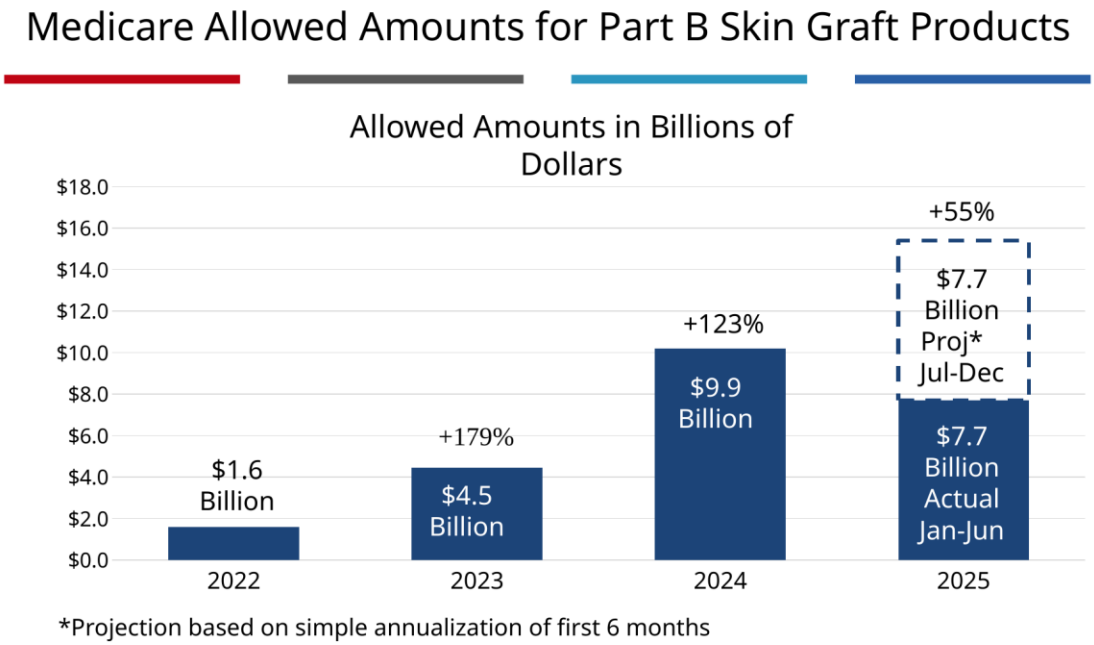


Exhibit 2. Skin substitute spending, Analysis of Medicare Parts A&B Data in available through CMS VRDC, October 2025.



Background

- Medicare Part B allowed amounts for skin graft codes (Q4100-Q4367) increased from $1.6 billion in 2022 to $9.9 billion in 2024, with $7.7 billion in the first 6 months of 2025
- These spikes in billing may adversely affect ACO shared savings if they experience more rapid growth than their regions

Exhibit 3. Data Brief: Impact of Rising Skin Substitute Costs on ACOs.

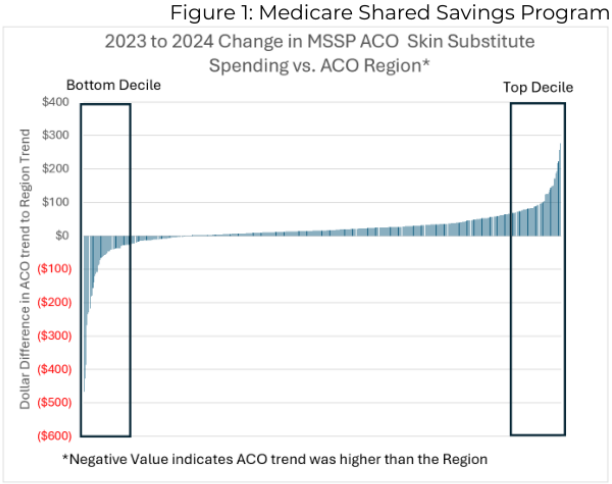
DATA BRIEF

The Impact of Rising Skin Substitute Costs on ACOs

Traditional Medicare has recently seen extreme growth in the cost and utilization of skin substitutes, increasing from $1.6 billion in 2022 to $9.9 billion in 2024. **This rapid expenditure growth is problematic for Medicare's accountable care organizations if their spending per beneficiary for skin substitutes grows more rapidly than the trend factor used to update their benchmarks.** In the final Physician Fee Schedule rule, CMS noted the impact skin substitute billing had on ACOs but failed to designate it as Significant, Anomalous, and Highly Suspect (SAHS) billing. This left ACOs responsible spending spikes beyond their control. The agency explained that skin substitute expenditures represent roughly 1 percent of total Parts A and B expenditures for ACOs on average for PY 2023. The National Association of ACOs and its data partners conducted an analysis of 2024 Medicare claims illustrates the damaging and varying effect on ACOs. This is especially problematic for ACOs serving high-needs or institutionalized seniors who are much more likely to require wound care services. With continued billing for skin substitutes expected to reach $15.4 billion in 2025, a similar impact is expected.

In **figure 1**, the distribution of the difference between MSSP ACOs' skin substitute spending growth in 2023 and 2024 is compared with their region. Some ACOs have seen increases much larger than their regions. For example, ACOs in the bottom ten percent had skin substitute spending that increased by $89 more on average than their region's spendingwith some exceeding the regional trend by more than $400.

Figure 1: Medicare Shared Savings Program



ACOs in the bottom 10 percent generally serve a more complex patient population that are more likely to need skin substitutes. As shown in **table 1**, more than 10 percent of beneficiaries in these ACOs are long-term institutionalized (LTI) while 17 percent are dually eligible for Medicaid. They also have higher risk scores. Both the top and bottom deciles are made up of smaller ACOs.

MSSP trend adjustments based on regional average spending growth would mitigate the negative financial impact of rapid growth in skin substitute expenditures for a majority of ACOs and would provide a positive financial impact for many. However, small ACOs that serve more complex populations have a much higher exposure to these expenditures and are more likely to experience reductions in shared savings due to growth in skin substitute expenditures that are not captured by regional trends.