CENTER FOR PROGRAM INTEGRITY

Crushing Fraud:

Annual Report 2025

January 1 – December 31, 2025

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

“Stop and Caught”

In 2025, CMS made efforts to transition from “pay and chase” to “stop and caught”

Historically, the **Centers for Medicare & Medicaid Services (CMS)** has focused its fraud prevention efforts on a **“pay and chase”** model where claims are paid and later investigated or audited. If during the audit or investigation the payment is deemed improper, CMS or its contractors issue an overpayment to recoup the dollars. The lag between payment and identification sometimes results in an inability to recover the full overpayment amount as funds are spent or health care providers/suppliers disappear.

Overpayments collected through post-payment reviews

$371 million

This year, CMS significantly bolstered its **“stop and caught”** method of fraud prevention that stops suspicious dollars before they go out the door. CMS operates the **Fraud Prevention System (FPS)** that utilizes hundreds of models that monitor provider/supplier outlier billing as well as automated edits that proactively deny inappropriate billing behavior.

Number of Medicare providers/suppliers investigated for potential fraud

7,701

Number of payment suspensions imposed on Medicare providers/suppliers

537

Amount on hold at the end of 2025 due to payment suspensions

$5.7 billion

Number of providers/suppliers revoked due to inappropriate behavior

5,586

Number of fraud referrals accepted by Law Enforcement for potential legal action (encompassing $3.7 billion)

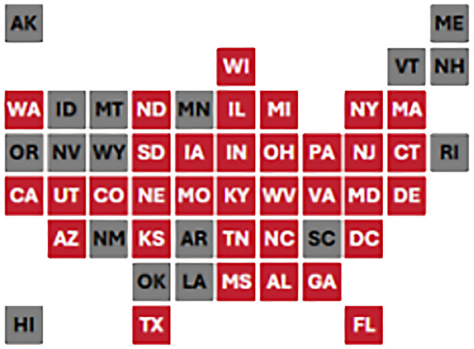
372

New Program Integrity Initiatives

In 2025, CMS launched several new initiatives to bolster its efforts to crush fraud, waste, and abuse in CMS programs. These efforts were key players in our shift from "pay and chase" to "stop and caught" fraud prevention.

Crushing Fraud Chili Cook-Off Competition

In late 2025, CMS hosted the **Crushing Fraud Chili Cook-Off Competition**, which was designed to advance CMS' understanding of industry readiness to apply explainable Artificial Intelligence and Machine Learning to **detect anomalies and trends in Medicare Fee-for-Service claims indicative of fraud, waste, and abuse**. The two-phase challenge garnered over 250 submissions in which ten finalists were selected to demonstrate their solutions at an in-person event. CMS chose **Milliman, Inc.** as our competition winner.



Submissions span states and DC **34**

IDea Challenge

In December 2025, CMS hosted the CMS **IDea Challenge**, a series of in-person, solution-oriented events designed to **generate actionable ideas to address Medicare Beneficiary Identifier (MBI) theft and misuse**. During group working sessions, attendees developed solutions to address MBI theft. CMS will consider these ideas to influence future actions to address misused MBIs.

Medical Review

In addition to FPS edits and payment suspensions, CMS regularly conducts pre-payment reviews on high-risk items and services. For example, in 2025, **CMS denied 122,658 Medicare claims for unnecessary items and services** because they failed to satisfy Medicare's preliminary approval checks that confirm medical necessity and other coverage requirements. CMS also **expanded its successful Review Choice Demonstration for Inpatient Rehabilitation Facility Services to two additional states (CA and TX)**.

Education and Action Against Providers and Suppliers

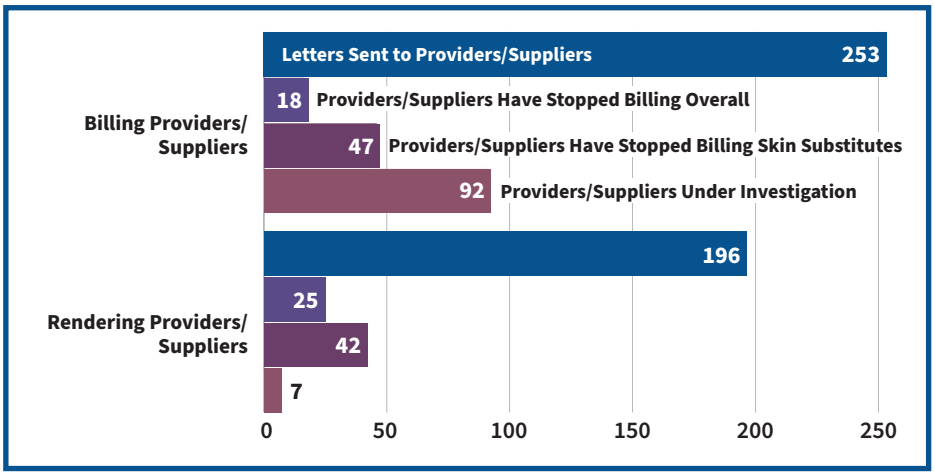
In 2025, CMS used several tools to educate or take action against suspicious providers and suppliers engaged in inappropriate billing practices.

Revocations

CMS **revoked the ability of 5,586 providers and suppliers** to bill the Medicare program due to inappropriate behavior. Revoked providers and suppliers are not permitted to bill the Medicare program for items and services.

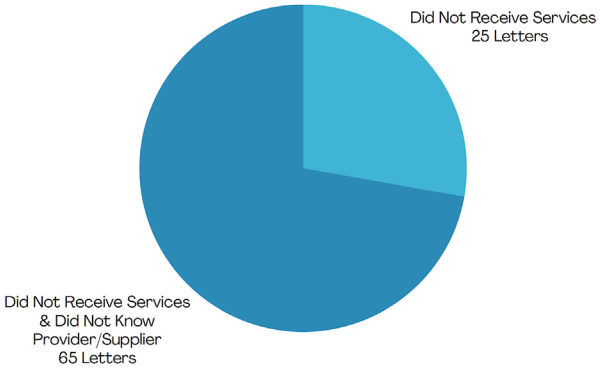
Skin Substitute Outreach

CMS launched a public outreach effort targeting outlier providers and suppliers who appeared to be **excessively billing and rendering medically unnecessary skin substitute products and services**. The letter campaign resulted in substantial decreases in suspect claims and multiple provider revocations.



Preemptive Mailers

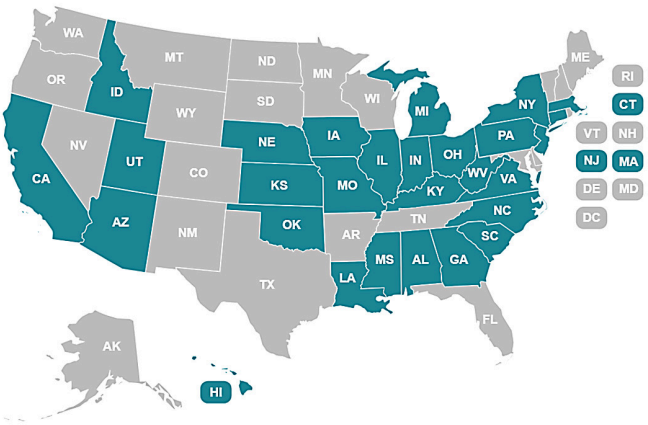
CMS issued letters to Part B and Durable Medical Equipment (DME) providers and suppliers who received a significant number of beneficiary complaints but have not yet met the threshold for formal enforcement referral. These **outreach letters sought to proactively discourage noncompliance or inappropriate billing**.



Collaborative Initiatives

State Partnerships

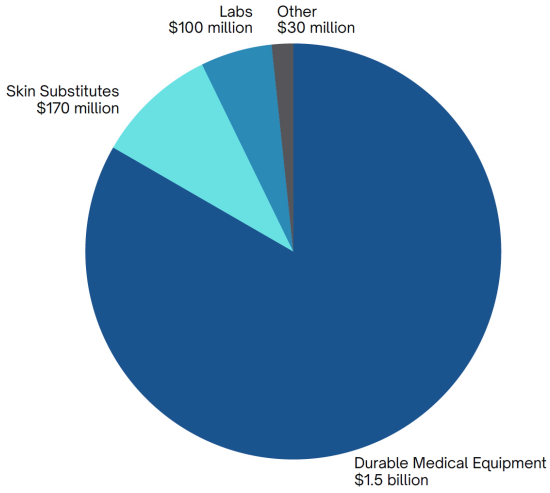
In 2025, CMS initiated a CMS-State Tax Fraud partnership with 28 states and the US Virgin Islands to **strengthen state-federal enforcement against healthcare providers and suppliers who commit healthcare and tax fraud**. CMS is collaborating with additional states and territories to initiate partnerships.



Fraud Defense Operations Center

In March 2025, CMS launched the **Fraud Defense Operations Center (FDOC)**, also known as the **Fraud War Room**, which integrates cross-functional expertise through a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement. This team **leverages rigorous, data-driven analyses to proactively detect, address, and prevent fraud, waste, and abuse in real time**.

In 2025, FDOC efforts resulted in over **$1.8 billion in Medicare payments suspended across 249 providers and suppliers**. CMS later revoked the billing privileges of 127 of these providers and suppliers.



Financial Partnerships

CMS launched a Banking Alliance Project in September 2025. This multi-agency initiative involves representatives from the Office of Inspector General, Department of Justice, CMS, and the Department of Treasury. The project has engaged major financial institutions to collaborate on crushing fraud by **alerting on large or frequent transactions that may be indicative of healthcare fraud**.