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Week 14

Medicare and Medicaid Fraud Prevention — Patient Confirmation and Direct-Pay Reform

"Stop the theft before the check clears. The patient already knows if the service happened."

1. The Problem

CMS reported approximately \$95.6 billion in improper payments across Medicare and Medicaid in FY2025. The majority are documentation errors and administrative failures — not all intentional fraud. But even the documentable fraud portion represents billions stolen annually 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. Meanwhile, patients — the one party who knows with certainty whether a service was rendered — are never asked to confirm. And providers who would accept immediate payment at a significant discount cannot access that discount because no mechanism exists to trigger it.

2. The Governing Principle

The patient is the only witness to the transaction who cannot be bribed, forged, or fabricated. Build the confirmation system around that fact. Every Medicare and Medicaid claim requires patient confirmation before payment releases. Confirmation triggers immediate payment at a direct-pay discount rate negotiated with the provider. No confirmation, no payment. The result is a system that eliminates ghost billing entirely, cuts improper payments across all categories, and reduces what the federal government pays per claim — while paying providers faster than the current 90-day claims cycle.

3. The Specific Policy

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

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. The platform does not inflate documentation errors into fraud. Both are addressed by the same mechanism: confirm before you pay.

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%	Source: CMS FY2025 Improper Payments Fact Sheet, January 15, 2026

Patient Text Confirmation System — The Core Reform

- **How it works:** when a provider submits a Medicare or Medicaid claim, CMS automatically sends the named beneficiary a text message within one hour: "[Provider name] submitted a claim for [service] on [date]. Did you receive this service? Reply YES or NO." Payment does not release until the patient replies YES. If the patient replies NO, the claim is immediately flagged and held for review. If there is no reply within 48 hours, the claim enters manual review before any payment is made.
- **Why the patient is the right confirmation source:** the patient is the only party to the transaction who cannot be fabricated. Ghost patients do not have phones. Deceased patients cannot reply. A patient who never received a service will say so. This single measure eliminates the entire category of ghost billing — providers billing for patients who do not exist, are deceased, or never appeared for the claimed service.
- **Accessibility:** beneficiaries without smartphones receive an automated voice call with the same confirmation prompt. Beneficiaries without phone access receive a paper statement with a toll-free confirmation number and a 10-day response window. No beneficiary is excluded from the confirmation process. A designated caregiver or authorized representative may confirm on behalf of a beneficiary who is incapacitated, with documented authorization on file with CMS.
- **Fraud flag protocol:** a NO reply or no-reply triggers an immediate payment hold. CMS contacts the provider for documentation. If the provider cannot produce documentation of the visit within 5 business days, the claim is denied and referred to the HHS Office of Inspector General for investigation. Three denials in a 12-month period trigger a provider audit and enrollment suspension pending review.

Direct-Pay Discount — Payment Immediately Upon Confirmation

- **Immediate payment triggers a direct-pay discount:** when a patient confirms service via text, CMS releases payment to the provider within 24 hours at the pre-negotiated direct-pay rate. Providers who participate in the direct-pay program agree to a discount of 40–60% off the standard Medicare fee schedule in exchange for immediate, guaranteed payment with no claims cycle, no prior authorization delays, and no denial and appeal process. The current Medicare payment cycle runs 14–90 days. Immediate payment at a discount is a better deal for most providers than waiting for full payment that may be reduced, delayed, or denied.
- **Participation is voluntary for providers, mandatory for CMS:** any provider that opts into the direct-pay program receives immediate payment upon patient confirmation. Providers that do not opt in receive payment under the standard schedule after confirmation. CMS is directed to negotiate direct-pay rates with all provider categories within 180 days of enactment. Target: 50% of Medicare providers enrolled in direct-pay within 2 years.

- **Net savings to Medicare:** a 40% average discount across 50% of claims reduces Medicare fee-for-service spending by approximately 20% on enrolled procedures. Applied to the \$600+ billion Medicare fee-for-service budget, full enrollment at a 40% average discount would save \$120+ billion per year. Even at 25% enrollment and a 30% average discount, annual savings exceed \$45 billion. These savings compound the drug cost savings from Week 3 and the fraud prevention savings below.
- **Patient benefit:** for patients with cost-sharing obligations, the direct-pay discount reduces their out-of-pocket cost proportionally. A procedure with a \$200 patient copay at standard rates carries a \$80–120 copay at direct-pay rates. No patient pays more under the direct-pay system than under the standard system.

Pre-Payment Provider Verification

- **Provider license verification before any payment:** every provider verified as currently licensed and in good standing before receiving payment. License status cross-referenced against state medical board databases in real time. Physical location verified for high-fraud provider categories including DME suppliers, home health agencies, and ambulance companies. Re-verification every 12 months — not just at initial enrollment.
- **Ghost provider elimination:** CMS has paid claims from providers who were deceased, had surrendered their licenses, or never existed as licensed practitioners. Real-time license verification cross-referenced against the Death Master File and state medical board suspension lists eliminates this category of fraud entirely. Estimated annual savings: \$2–5 billion.
- **High-fraud category prepayment review:** durable medical equipment, home health, ambulance transport, and compounded pharmacy claims — the four highest-fraud categories by HHS OIG audit — are subject to mandatory prepayment review for all new providers and for any provider with a billing anomaly flag. No payment releases in these categories without prepayment review for the first 24 months of enrollment.

AI-Assisted Claim Screening

- **Pattern detection before payment:** AI flags billing patterns that no human auditor would catch at scale — a provider billing identical procedures for hundreds of patients on the same day, claims for deceased patients, billing for mutually exclusive procedures, geographic impossibilities (a provider billing for a patient visit in two states on the same day), and statistical outliers in procedure frequency by specialty. Flagged claims are held for human review before payment releases.
- **Deployed to highest-risk categories first:** AI screening deployed within 180 days to the five highest-fraud billing categories. Full deployment across all Medicare and Medicaid claims within 365 days. The AI model is retrained quarterly on confirmed fraud cases to close evasion patterns as they emerge.

Medicaid Fraud Control Unit Funding

- **MFCU funding doubled from \$800 million to \$1.6 billion per year:** every dollar invested in MFCU enforcement returns \$6–8 in recoveries — confirmed by HHS OIG analysis. Doubling MFCU funding produces an estimated \$9.6–12.8 billion in annual criminal and civil recoveries. State match requirement maintained — federal increase leverages additional state investment. At \$6 return per dollar, \$800 million in new federal MFCU investment yields \$4.8 billion in additional annual recoveries.

4. Estimated Cost and Savings

Program cost: patient text confirmation system — estimated \$150–250 million per year for CMS infrastructure, staffing, and accessibility accommodations. AI screening deployment — estimated \$200–400 million per year. MFCU funding increase — \$800 million per year federal share. Total program cost: approximately \$1.2–1.5 billion per year.

Estimated annual savings: ghost billing elimination via patient confirmation — \$10–20 billion per year. Direct-pay discount at 25% enrollment, 30% average discount — \$45+ billion per year. Provider verification and prepayment review — \$5–10 billion per year. AI screening — \$5–15 billion per year. MFCU recovery increase — \$4.8 billion per year. Combined estimated savings: \$70–95 billion per year at conservative enrollment and discount assumptions. Net of program cost: \$69–94 billion per year.

These are platform estimates, not CBO-scored figures. Independent CMS actuarial review required. GAO directed to score the full Week 14 reform package within 18 months of enactment.

5. Year 1 Implementation and Measurable Result

Year 1 measurable result: patient text confirmation system operational for Medicare Fee-for-Service within 180 days; provider license verification cross-referenced with state medical boards operational within 90 days; AI claim screening deployed for the five highest-fraud categories within 180 days; direct-pay discount program open for provider enrollment within 180 days with target of 25% enrollment within 12 months; MFCU funding increase enacted and deployed within 90 days; Medicare FFS improper payment rate below 5.5% by end of Year 1 (down from 6.55% baseline); 100 providers prosecuted for fraud identified through patient NO-reply flags within Year 1. Source for baseline: CMS FY2025 Improper Payments Fact Sheet, cms.gov, January 15, 2026.