Deloitte.

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# Health Care Regulatory Compliance Hot Topics Roundtable

# This quarter’s lineup

**Deloitte & Touche LLP facilitators**

**Bailey Camp, senior consultant**
Facilitator

**Kelly Sauders, partner**
AI’s emerging role in compliance operations

**Celena Pitts, manager**
Responsible AI in clinical documentation integrity (CDI) and coding

**Joe DeSimone, senior consultant, and Vincent Iannello, consultant**
CMS FY27 proposed rules and updates

**Jake Ellithorpe, consultant, and Neela Kirankumar, analyst**
Department of Justice (DOJ) and Office of Inspector General (OIG) enforcement updates

# Reminders

There are three ways participants may ask questions and submit comments during the webinar:

1. Via the webinar question and answer (Q&A) function
2. Via the webinar chat function

**After the call, we will send out a copy of today's Health Care Regulatory Compliance Hot Topics Roundtable (HRCHT) presentation**

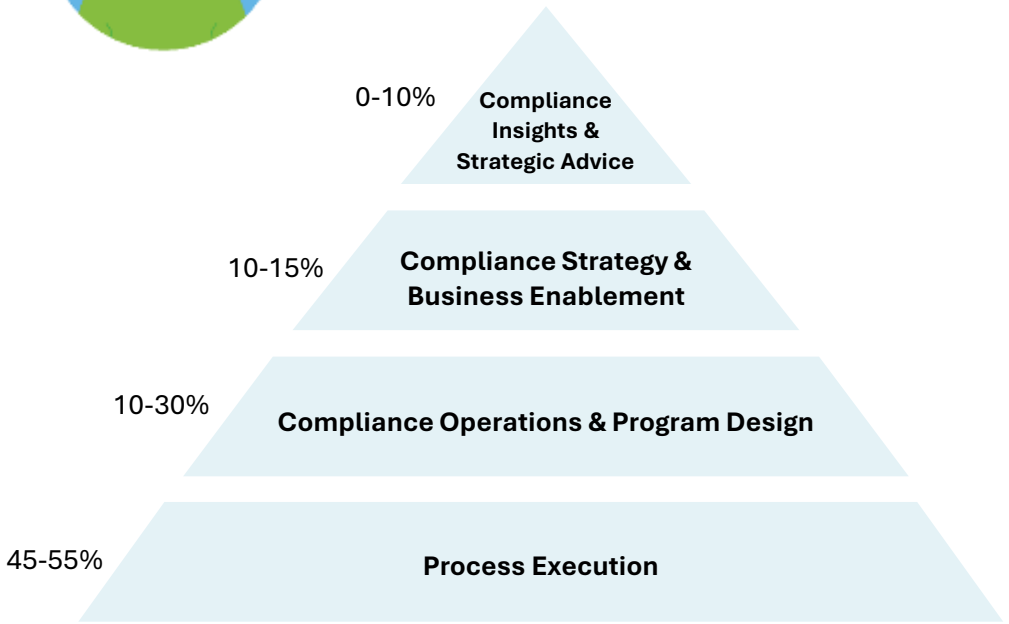
# Kelly Sauders

## AI’s emerging impact on compliance operations

# Compliance workloads will invert

As AI moves from pilot to production across health care compliance programs, the function is shifting from manual, sample-based review toward continuous, risk-prioritized oversight—reshaping how teams allocate time, talent, and assurance effort.

## TRADITIONAL DISTRIBUTION OF WORK EFFORT

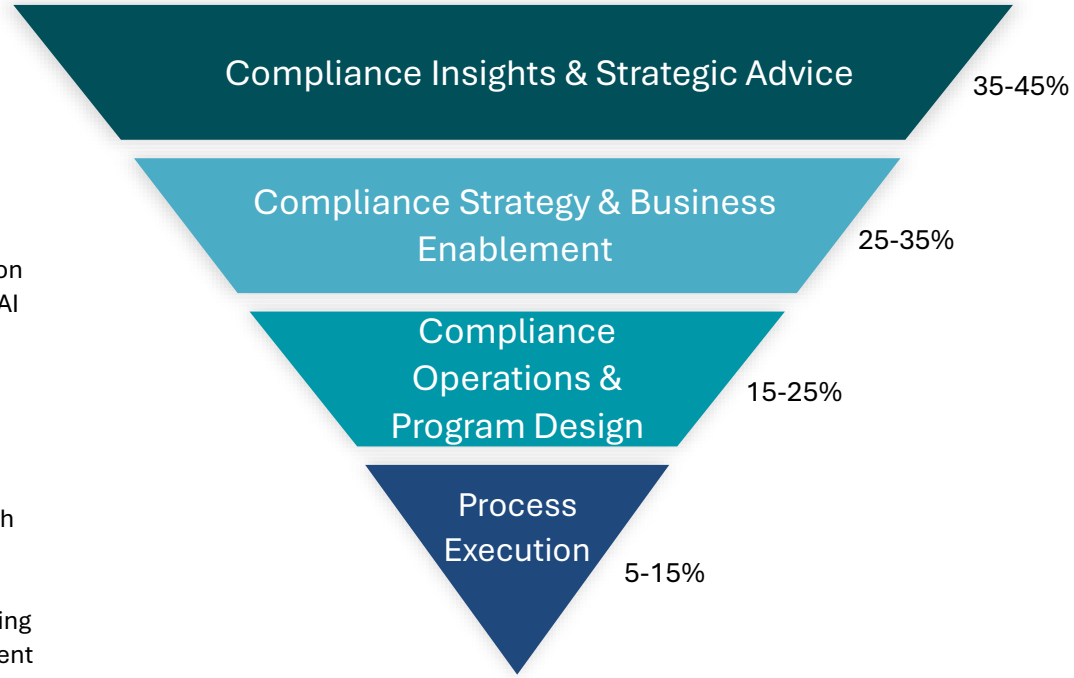



**AI-Assisted**
Primarily human-owned with moderate support from AI solutions

**AI-Augmented**
Significant collaboration between humans and AI to execute work with frequent handoffs

**AI-Powered**
Primarily AI-owned with humans managing AI outputs, monitoring performance, and driving continuous improvement

## FUTURE DISTRIBUTION OF WORK EFFORT



# Compliance* areas and activities where AI solutions can make an impact

AI and Generative AI (GenAI) are being applied across compliance programs to high-volume, evidence-intensive activities — surfacing risks earlier and freeing professionals to focus on judgment-driven work. The operational areas below highlight where adoption is gaining traction today.

## Policies, Training and Knowledge Management

- Policy Accessibility & Summarization
- Policy Drafting, Localization & Change Management
- Regulatory Scanning & Impact Assessment
- Risk & Control Recommendation
- Training Content Creation & Personalization
- Interactive Training Agents

## Risk Assessment, Mitigation & Remediation

- External Risk Horizon Scanning
- Regulatory Intelligence & Impact Assessment
- AI-driven Risk Identification & Scoring
- Automated Mitigation Plan Generation
- Control Recommendation Engine

## Continuous Monitoring & Testing

- Enhanced Data and Document Review & Summarization
- Anomaly Detection
- Real-Time Compliance Breach Scanning
- Fraud, Waste, and Abuse Detection
- Advanced e-Comms and Unstructured Data Analysis

## Investigations

- Allegation Intake & Case Triage
- Evidence Gathering & Summarization
- Fact Finding & Analysis
- Findings & Recommendations
- Matter Close-Out
- Pattern Recognition
- Policy Violation Citation Generation

## Colleague Communication & Engagement

- Real-Time Colleague Support & Guidance Agents and Communications
- Automated Alerts & Personalized Compliance Reminders
- Compliance Request Management
- Helpline/Hotline Initial Triage
- Feedback & Sentiment Analysis

## Analytics & Insights

- Cross-Functional Risk Insight Summaries
- Executive Summary Generation
- Trend and Correlation Analysis
- Predictive Analytics
- Data Set Comparison and Linkage

## Key Processes

- Regulatory Correspondence Management
- Transparency Reporting
- HCP/HCO Engagement Oversight
- HCP/KOL Management (e.g., Tiering)
- Conflict of Interest Management
- M&A Compliance and Risk Due Diligence

## Third-party Risk Management

- Third-party Risk Assessment & Scoring
- Continuous Vendor Monitoring
- Automated Due Diligence
- Contract Compliance Analysis

* does not include Privacy

# Impact within compliance areas where work can be reduced or automated

The grid below estimates the magnitude of AI-driven efficiency gains across core compliance functions, indicating where activities can be reduced, automated, or augmented.

# Compliance* capabilities that are prime opportunities for AI to disrupt

Building on the use cases and impact estimates, the capabilities below represent the highest-leverage targets for AI in health care compliance — activities where the combination of data volume, repeatability, and risk concentration makes disruption both feasible and material.

## Policies, Training and Knowledge Management

- Revision of SOPs, re-drafting / red lining of policies
- ☑ Periodic policy gap analysis
- ☒ Version controls and archiving
- Building training decks for employee training
- Assessment of employee responses and analysis of trends

## Risk Assessment, Mitigation & Remediation

- Preparing risk registers and heat map spreadsheets
- Drafting risk questionnaires
- ☑ Preparation of mitigation plans
- Follow-up for remediation tasks and communications for status
- ● Calculation of risk scores

## Continuous Monitoring & Testing

- ☑ Building plans for continuous monitoring, refreshing control test libraries
- ☑ Sample selections and data extractions
- Realtime exception tracking
- Trending of risks and remediation trackers

## Investigations

- ☒ Incident summaries and preparation of follow-up tasks
- Drafting interview notes and determining correlation of events / suspect roles
- First draft summaries of reports & analysis
- Building chronology of events

## Colleague Communication & Engagement

- Drafting compliance newsletters
- ☑ Translations for global policy / compliance communications
- ☑ Tracking of employee training acknowledgements
- ☒ Updating FAQs and employee queries
- Conducting employee surveys
- Preparation of insight presentation for board / management

## Analytics & Insights

- Assisting in data feeds to various compliance initiatives
- Building dashboards for trends, analysis and compliance insights
- ☑ Threshold based exception scanning
- ☑ Tracking data quality issues and resolution
- Ad-hoc analytics assistance

## Key Processes

- ☑ HCP Compliance interactions
- ☑ Transparency aggregate spend reporting
- Enterprise compliance risk analytics
- ABAC Due Diligence and post integration

## Third-party Risk Management

- ☒ Manual filling of intake forms
- Risk scoring of responses in questionnaires
- ☑ Gathering of vendor due diligence details (financials, adverse media, licenses)
- ☑ Training acknowledgement & reminders

☑ Autonomous resolution  Agent-assisted resolution  ☒ Elimination

* does not include Privacy

# Responsible use of AI in health care

The Joint Commission and Coalition for Health AI (CHAI) "Responsible Use of AI in Healthcare" guidance sets seven elements that health care organizations should operationalize. Each element below highlights the compliance leader's accountability

### 1 AI Policy & Governance

Enterprise AI policy and cross-functional committee; regular board reporting on AI use, outcomes, and risks.

### 2 Patient Privacy & Transparency

HIPAA-grade access and protection controls; clear mechanism to disclose AI use to patients and families.

### 3 Data Security & Data Use

Standardized vendor data use agreements; adopt RUHD-style guardrails for secondary use of health data.

### 4 Ongoing Quality Monitoring

Monitor drift, bias, and safety post-deployment; require vendor validation in your deployment context.

### 5 Voluntary Blinded AE Reporting

Confidential AI incident reporting channel linked to quality and safety operations.

### 6 Risk & Bias Assessment

Maintain a risk-classified AI tool inventory; require bias testing before deployment.

### 7 Education & Training

Role-based AI training; gate access until training completion and keep training records.

# Celena Pitts

## Responsible AI in CDI and Coding

# AI in CDI and coding: Protecting documentation integrity

AI can improve efficiency in documentation and coding workflows, but human review remains essential. AI is a support tool — not a replacement for clinical judgment, compliant query practice, or final accountability.

## What You Need to Know

1

### Documentation Integrity first

AI should support documentation that accurately reflects the patient's clinical status and care provided.

2

### AI can help identify opportunities

NLP, CAPD, and other AI tools can help surface missing documentation, prioritize reviews, and improve workflow efficiency through broader capture, reconciliation of conflicting notes, surface risk adjusted diagnoses, and increase identified revenue opportunities.

3

### Human validation is still required

CDI and coding professionals remain responsible for evaluating AI suggestions and determining whether they are clinically supported and compliant.

4

### Technology does not change the standard

AI-assisted queries and prompts should meet the same standards as any other compliant CDI activity.

***Guidance and Regulations are expected to change quickly as AI tools expand and impact patient care more***

## Recommended Practices

### Maintain Qualified Human Review

PRIORITY

AI-suggested codes and query suggestions should be reviewed by qualified personnel against supporting documentation before submission, consistent with organizational policy and workflow. AI augments, but never replaces, human final judgment.

### Perform Routine AI Output Audits

PRIORITY

Periodically compare AI-supported coding outputs with source documentation and human review results to identify patterns, improve accuracy, and strengthen controls.

### Establish AI Governance Oversight

PRIORITY

Stand up cross functional AI oversight committee including coding, CDI/HIM, compliance, IT, legal, and operational stakeholders in tool selection, performance monitoring, issue escalation, and ongoing oversight.
Manage vendor contracts for liability, data use, and validate evidence

### Train Staff on AI-Specific Risks

Provide targeted training on documentation integrity, clinical context, missed context, inappropriate suggestions, and automation bias in AI-enabled workflows

### ★ Leading Practice:

***Reference applicable compliance guidance and align vendor oversight, internal controls, and audit routines to the organization's risk profile.***

# CDI strategies in the age of AI

AI is expanding CDI capability, but the emphasis is on strengthening efficiency—not weakening—documentation integrity and compliant practices.

## Expanded Responsibility

- CDI work increasingly involves clinicians, coders, and technology teams alongside traditional CDI staff.
- Organizations should define roles clearly as AI becomes part of the workflow.
- Training should expand to all users participating in AI-enabled documentation processes.

## Ethical & Compliant Practices

- Queries should remain non-leading and grounded in relevant clinical indicators.
- Providers should retain independent clinical judgment.
- Technology-generated prompts are still subject to compliant query expectations.

## AI Governance Framework

- AI tools should operate within defined oversight and review processes.
- Organizations should monitor how technology-generated queries perform in practice.
- Governance should support defensible, auditable decisions.

***As CDI matures, the ACDIS Advisory Board has issued new guidance that aims to ensure ethical and compliant documentation practices keep pace with AI-driven efficiency gains.***

**Best Practices**

### Expand Training

Include CDI, coding, clinician, and technology stakeholders.

### Review Query Practices

Review query practices against current CDI guidance and internal policy to ensure consistency and defensibility.

### Require Governance

Do not rely on AI outputs without oversight, monitoring, escalation paths and documented audit trails.

Source: ACDIS update: New ACDIS white paper on CDI ethics out now! | ACDIS

# AI-enabled queries and provider engagement

For ACDIS and AHIMA, the key question is not whether AI is used — it is whether the resulting query practice remains compliant, clinically grounded, and appropriately governed

## WHAT CLIENTS NEED TO KNOW

**AI-assisted prompts are still queries**
CAPD and other real-time prompts should follow the same compliant query principles as traditional queries.

**Clinical indicators matter**
Queries should be supported by relevant facts in the record and should not steer providers toward a preferred answer.

**Answer choices must remain compliant**
Technology-generated options should be clinically relevant and allow for alternate explanations, including an "other" path when appropriate.

**Escalation should be disciplined**
If a technology-generated query does not produce the desired response, a manual follow-up on the same issue may be non-compliant unless new clinical indicators arise.

## WHAT YOU SHOULD DO

**Review AI-Generated Queries**
Review AI-generated queries before release or through routine auditing.

**Define Intervention Points**
Define when CDI staff, coding, compliance, or physician advisors should intervene.

**Document Governance**
Document governance, monitoring, and remediation processes.

**Train for Compliance**
Train teams on compliant query practice in AI-enabled workflows

**Key Takeaway:** The standard for compliance does not change because technology is involved. The obligation is to keep query practice accurate, non-leading, and clinically supported.

# Summary and steps to consider

AI can make CDI more efficient and proactive, but people remain accountable for documentation integrity, query compliance, and final decisions.

## THE QUESTIONS ORGANIZATIONS ARE WORKING TO ANSWER

- *Where can AI improve CDI productivity without weakening compliance?*
- *How should organizations govern AI-generated queries and prompts?*
- *How do we train teams to use AI responsibly in CDI workflows?*
- *How do we preserve defensible human judgment in increasingly automated processes?*

## HOW AI TAKES ORGANIZATIONS FURTHER

| | |
|---|---|
| **Improves prioritization** | • *AI can help surface records and documentation opportunities for review.* |
| **Supports timelier engagement** | • *AI-enabled CAPD can support earlier clarification during the documentation process.* |
| **Extends CDI capacity** | • *AI can help teams cover more cases and focus attention where clinical review adds the most value.* |

**Human in the Loop:** AI can assist with identification, prioritization, and drafting, but qualified professionals remain responsible for review, interpretation, and compliance.

# Joe DeSimone and Vincent Iannello

CMS FY27 proposed rules and updates

# Payment rate updates & quality reporting obligations

CMS proposes 2.3–2.8% net payment increases across acute, long-term care, skilled nursing, psychiatric, and rehabilitation settings — with a uniform 2-percentage-point penalty for facilities that fail to meet quality reporting or EHR requirements

| Care setting | Proposed rate update | Estimated total impact |
|---|---|---|
| **Acute Hospitals (IPPS)** | +2.4% (net) | +$1.4B |
| **Long-Term Care Hospitals (LTCH)** | +2.4% (net) | +$55M |
| **Skilled Nursing Facilities (SNF)** | +2.4% (net) | +$208M (for SNF VBF) |
| **Inpatient Psychiatric (IPF)** | +2.3% (net) | +$50M |
| **Inpatient Rehab (IRF)** | +2.4% base / +2.8% overall | +$355M |

## Key compliance obligations

### Quality data reporting

- CMS is tightening quality reporting expectations, with new mandatory eCQMs and expanded measure sets raising the bar for data accuracy and submission timeliness
- Failure to meet quality reporting requirements triggers a 2-percentage-point reduction to annual payment updates across all care settings

### EHR & digital standards

- IPPS updates CEHRT definitions aligned with ONC standards
- IPF-PAI will become first CMS program accepting FHIR API submissions (Oct 2027)
- Shift toward eCQM (electronic clinical quality measures)

### Care delivery & payment accountability

- CMS is pushing compliance deeper into operations, with tighter assessment, submission, and documentation requirements across SNF, IPF, and IRF settings
- Financial accountability is tightening, with TEAM episode risk and stricter outlier/payment oversight

Source: Proposed Rule, CMS-1849-P; CMS to Improve Care & Experience; Lower Costs for Hip, Knee, & Ankle Replacements; Proposed Rule, CMS-1843-P; Proposed Rule, CMS-1847-P; Propose Rule, CMS-1845-P

# Cross-cutting regulatory themes

## 01 Value-based care acceleration

CMS is systematically moving reimbursement from volume to outcomes. CJR-X mandates episode accountability. Mortality, readmission, and complications measures are expanding. Quality scores now directly gate reconciliation payments and payment updates across all settings.

## 02 Digital health & interoperability push

The IPF-PAI will be the first CMS quality program to accept FHIR API submissions. EHR compliance (CEHRT) is updated across IPPS. eCQMs are replacing paper-based measures. Providers not investing in interoperability infrastructure face escalating compliance risk.

## 03 Standardization of patient assessment data

CMS wants SNFs to submit MDS data for all residents receiving covered skilled care, no matter who pays. This would bring the SNF QRP in line with other post-acute care programs that already collect data on all patients.

## 04 Tighter submission deadlines

Across SNF, IRF, and IPF, data submission windows are being compressed from ~4.5 months to 45 days effective FY 2029. This requires significant operational readiness — data workflows, EHR integrations, and QA processes must be restructured.

## 05 Payment integrity & anti-gaming signals

CMS's RFI on SNF PDPM case-mix upcoding signals concern about coding manipulation. IRF payment reform RFI foreshadows a possible overhaul of the patient classification system.

## 06 Safety-net & rural provider pressure

DSH payments are declining while uninsured rates rise. Rural and low-volume hospital payment protections expire December 31, 2026 — subject to Congressional action. Safety-net and rural facilities face compounding financial and compliance pressure.

Source: Proposed Rule, CMS-1849-P; CMS to Improve Care & Experience; Lower Costs for Hip, Knee, & Ankle Replacements; Proposed Rule, CMS-1843-P; Proposed Rule, CMS-1847-P; Propose Rule, CMS-1845-P

# CJR-X: Mandatory nationwide episode-based payment model

Proposed in the FY 2027 IPPS rule, Comprehensive Care for Joint Replacement expanded Model (CJR-X) expands CMS's proven joint replacement bundled payment model to mandatory nationwide participation — holding 2,500+ hospitals accountable for 90-day episode costs across hip, knee, and ankle procedures starting October 2027

### HOSPITAL ACCOUNTABILITY

Most hospitals will be required to participate. Compliance programs must account for mandatory episode-based payment responsibility covering surgery, hospital stay, and 90-day recovery.

### CARE COORDINATION

Organizations must establish processes for proactive communication with post-acute care providers. Compliance frameworks should address care transition protocols and documentation.

### FINANCIAL RISK & OVERSIGHT

Episode-based payment creates new financial risk. Internal audit and compliance teams should assess readiness, monitor quality metrics, and avoid unnecessary re-hospitalizations and ED visits.

### IMPLEMENTATION TIMELINE

If finalized, CJR-X begins October 1, 2027. Compliance leaders should begin readiness planning now — building episode-tracking, quality-reporting, and care-coordination capabilities ahead of the mandatory start.

**CJR-X is a proposed mandatory, nationwide Medicare episode-based payment program for hip, knee, and ankle replacements. Building on the 2016–2024 CJR pilot—which reduced costs without sacrificing quality—CJR-X scales the model nationally. Readiness assessments should begin now.**

Source: Proposed Rule, CMS-1849-P; CMS to Improve Care & Experience; Lower Costs for Hip, Knee, & Ankle Replacements

# What health care organizations should be doing now

## NEAR-TERM (Oct 1, 2026 – Oct 1, 2027)

- CJR-X preparation: Begin analyzing post-discharge care patterns, physician alignment, and episode cost drivers. Establish gainsharing arrangements in advance of October 2027
- Invest in data infrastructure: Tighter submission deadlines (45 days effective FY 2029) require robust real-time MDS, claims, and clinical data workflows
- SNFs: Conduct PDPM coding audits now — CMS is scrutinizing case-mix upcoding and an RFI foreshadows future enforcement or payment recalibration
- IPFs: Develop an IPF-PAI implementation roadmap (effective Oct 1, 2027). Evaluate FHIR API capabilities and whether a CMS web app or vendor solution is more appropriate

## STRATEGIC WATCH ITEMS

- IRF Payment Reform: CMS RFI signals a potential overhaul of patient classification — IRF providers should engage actively to shape future rulemaking
- Congressional action on rural/MDH payment protections expiring Dec 31, 2026 — monitor closely
- Wage index methodology: CMS soliciting input on BLS-based alternatives across IPPS, SNF, IRF, and IPF — decisions could significantly shift geographic payment distribution
- Advance Care Planning (ACP) measures under consideration across multiple settings — begin internal policy and documentation review now

Source: Proposed Rule, CMS-1849-P; CMS to Improve Care & Experience; Lower Costs for Hip, Knee, & Ankle Replacements; Proposed Rule, CMS-1843-P; Proposed Rule, CMS-1847-P; Propose Rule, CMS-1845-P

# Jake Ellithorpe and Neela Kirankumar

## DOJ / OIG update

# CMS efforts to combat fraud, waste, & abuse (FWA)

## Overview

Paragon Health Institute hosted **CMS Administrator Dr. Mehmet Oz, Sen. Ron Johnson, and Rep. John Joyce** to discuss the scale of FWA in federal health programs — and the policy and enforcement actions underway to address it.

### Background

- Administrator Oz estimates fraud in federal health programs at approximately **$100 billion annually**, citing fraudulent hospice enrollments, fictitious home care billing networks, and an estimated **1.6 million individuals** simultaneously enrolled in both subsidized ACA plans and Medicaid
- CMS has identified concerns around Medicaid provider tax arrangements, which speakers at the event characterized as mechanisms that allow states to draw down additional federal dollars. Administrator Oz noted payments are projected to cost federal taxpayers **$5.4 trillion over 10 years** if left unchecked
- CMS has shut down **450 fraudulent hospices** in California and estimated savings at approximately **$600 million** this year. CMS also repriced skin-substitute products and estimated **$250 billion** in Medicare savings over the next decade

### Compliance considerations

- With CMS signaling pre-payment scrutiny and payment suspension as primary enforcement tools — rather than relying on post-conviction recovery — organizations should **establish billing practices, provider credentialing, and documentation** that are audit-ready before claims are submitted
- Administrator Oz called out specific fraud ecosystems in **hospice, home health, and ACA enrollment**, signaling these areas may face heightened oversight; compliance programs should consider conducting **targeted internal audits in any of these service lines**
- CMS's stated intent to expand AI-driven fraud detection means **anomalous billing patterns will be identified faster and at greater scale** — compliance leaders should **proactively benchmark their organizations' billing patterns** against peer norms and investigate outliers as part of routine compliance activity

Source: Fighting Fraud with Dr. Oz--Recapping Paragon's Event at the National Press Club

# Health care fraud – medically unnecessary DOJ

## Regulatory enforcement themes

Recent enforcement activity signals continued and intensifying government focus on health care fraud and abuse across both civil and criminal channels. Common threads include medically unnecessary services, improper referral arrangements, falsified documentation, and billing schemes that exploit federal programs at the expense of taxpayers. These actions further demonstrate that multi-agency coordination is becoming the norm in fraud investigations, and that providers failing to maintain robust compliance programs face substantial financial penalties and, in some cases, criminal prosecution.

### Arizona Cardiology Group to Pay $4.75M to Resolve Allegations of Unnecessary Vein Ablations)

- **Settlement:** Arizona based cardiology group and three physicians agreed to pay $4.75M to resolve False Claims Act violations for billing Medicare for medically unnecessary vein ablations.
- **Alleged Scale:** The conduct spanned over 5 years, generating improper reimbursements from federal health care programs.
- **Alleged Mechanics:** The physicians performed ablations on perforator veins, which require treatment only in limited circumstances, on patients who did not meet the clinical criteria for the procedure.
- **Concealment and Structuring:** To justify the procedures, the physicians allegedly falsified medical records by incorrectly documenting vein measurements, patient symptoms, and conservative therapy measures.

### Gastroenterology Practice Agrees to Pay $4.75M to Settle Allegations of Kickbacks and Unnecessary Medical Testing Services

- **Settlement:** Atlanta based Gastroenterology practice agreed to pay $4.75 million to resolve False Claims Act violations for receiving kickbacks in exchange for referrals and billing Medicare for unnecessary pathology services.
- **Alleged Scale:** The conduct spanned approximately 3 years, generating improper reimbursements from Medicare and other federal health care programs.
- **Alleged Mechanics:** The practice contracted with an outside pathology laboratory to build and operate an in-house lab, billing Medicare for technical services while exclusively referring patients back to APS for interpretation.
- **Concealment and Structuring:** Special stains were ordered through a reflex process without a pathologist first reviewing routine results or documenting medical necessity.

### Texas Doctor Sentenced to 8.5 Years in Prison for $145 Million Health Care Fraud Scheme

- **Settlement:** An orthopedic surgeon was sentenced to 102 months in prison and ordered to pay over $13 million in restitution for his role in a $145 million scheme to defraud the Department of Labor through fraudulent claims for unnecessary prescription compound creams.
- **Alleged Scale:** The scheme was conducted for about 3 years, during which the pharmacies billed over $145 million and collected more than $90 million in fraudulent payments from federal programs and a private insurer.
- **Alleged Mechanics:** The surgeon accepted bribes from pharmacy owners in exchange for prescribing medically unnecessary compound creams to injured federal workers.
- **Concealment and Structuring:** The scheme was sustained through a network of bribes and kickbacks paid to the surgeon and other doctors, creating the appearance of legitimate medical referrals.

Source: Office of Public Affairs | Arizona Cardiology Group to Pay $4.75M to Resolve Allegations of Unnecessary Vein Ablations | United States Department of Justice | Office of Public Affairs | Gastroenterology Practice Agrees to Pay $4.75M to Settle Allegations of Kickbacks and Unnecessary Medical Testing Services | United States Department of Justice | Office of Public Affairs | Texas Doctor Sentenced to 8.5 Years in Prison for $145 Million Health Care Fraud Scheme | United States Department of Justice

# Health care fraud – false claims

## Regulatory enforcement themes

Recent enforcement actions highlight sustained government scrutiny of health care fraud and abuse schemes across both criminal prosecutions and civil settlements. These matters reflect a consistent focus on false claims, kickbacks, improper physician financial relationships, medical necessity concerns, and enrollment-related misrepresentations. They also signal that proactive compliance reviews, self-disclosure, and cooperation with investigation may help mitigate, though not eliminate, potential regulatory exposure.

### Florida nursing assistant convicted in $11.4M health care fraud scheme targeting Medicare beneficiaries

- **Federal conviction:** A Florida nursing assistant and Durable Medical Equipment (DME) supplier was convicted for his role in a Medicare orthotic-brace fraud scheme
- **Alleged scale:** About $11.4M in fraudulent claims were submitted to Medicare
- **Alleged mechanics:** Illegal kickbacks and bribes were used to obtain signed doctors' orders, which supported ordering and billing for braces that beneficiaries allegedly did not request or need
- **Concealment and structuring:** The defendant allegedly concealed shared ownership with a convicted felon to obtain Medicare enrollment and structured cash withdrawals to avoid bank reporting thresholds

### Arizona surgical hospital agrees to pay $5.6M to resolve alleged False Claims Act violations

- **Federal settlement:** OASIS Hospital and related entities agreed to pay $5.6 million to resolve alleged False Claims Act violations tied to improper financial payments
- **Timeline:** The allegations occurred from 2011 to 2018. The arrangements were disclosed following a 2019 internal compliance review and independent investigation.
- **Alleged mechanics:** OASIS allegedly made improper financial contributions to a physician group through interest payments on convertible bonds, creating alleged violations under both the Anti-Kickback Statue (AKS) and the Stark Law.
- **Cooperation:** US DOJ acknowledges OASIS and related entities disclosed the arrangements to the Federal government, took remedial actions, and cooperated during the investigation.

Source: Office of Public Affairs | Florida Nursing Assistant Convicted in $11.4M Health Care Fraud Scheme Targeting Medicare Beneficiaries | United States Department of Justice | Office of Public Affairs | Arizona Surgical Hospital Agrees to Pay $5.6M to Resolve Alleged False Claims Act Violations | United States Department of Justice

# Open discussion

# Polling questions

**Which of the topics from today's agenda were you most interested in?**

*You may select multiple answers*

a) AI's emerging impact on compliance operations

b) Responsible AI in CDI and coding

c) CMS FY27 proposed rules and updates

d) OIG/DOJ updates

# Write in question

**What topics would you like to hear more about?**

*Please submit your answer via the webinar Q&A or Chat functions*

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# Thank you!

Deloitte.

*Together makes progress*