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Together makes progress

Health Care Regulatory Compliance Hot Topics Roundtable

This quarter’s lineup

Deloitte & Touche LLP facilitators

Bailey Camp, senior consultant
Facilitator

Jason Milstein, specialist leader, and Kelly Sauders, partner
Risk Adjustment & Medicare Advantage (MA) Updates

Renee LeSaux, manager
Payment and Coverage Transparency

Carsten Lachell, manager, Maxine LeSaux, manager, and Tom Comes, analyst
340B and Drug Policy Updates

Jake Ellithorpe, consultant, Vincent Iannello, consultant, and Ashley Robalino, 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

Jason Milstein and Kelly Sauders

Risk adjustment & Medicare Advantage updates

What is risk adjustment?

Risk adjustment is the process of providing health plans an incremental payment/offset based on the projected spend for a given patient – the primary input for this projection are the diagnoses received by the plan over the course of a year

Documentation drives reimbursement

- Complete and accurate diagnoses coding are key to correct payments

Sicker patients require more resources

- Risk adjustment is key to making sure funding follows the neediest patients

Inaccurate coding = inaccurate reimbursement

- Undocumented diagnoses or incorrect coding may result in lower payments

Risk adjustment payments

Modern health care payment models will pay an average rate per member per month to manage a member. **The payment for that member is then risk adjusted to account for a higher or lower illness burden than the average for the population.** This payment will not change or fluctuate based on utilization patterns: the payment is purely reflective of the member's illness burden

Medicare Advantage Health Plans receive risk adjusted payments from Centers for Medicare & Medicaid Services (CMS)

Health Plans offering products on the commercial exchange will have to pay or receive money from their regional competitors based on the risk score of their population compared to the risk score of their competitors within the same metal level. This is calculated using something called the 'Risk Transfer Formula'

Managed Medicaid Health Plan payment models vary by state, but Managed Medicaid plans are commonly risk adjusted based on a population's illness burden

Provider Organizations contracted with Federal Medicare receive risk adjusted payments from CMS

Provider Organizations contracted in value-based care arrangements with health plans will often receive risk adjusted payments from the health plan

Risk adjustment data validation (RADV)

CMS conducts audits of Medicare Advantage Organizations to confirm that payments are made based upon complete and accurate risk adjustment data submissions

Background

CMS conducts annual RADV audits to ensure risk-adjusted payment integrity and accuracy and is required to report an identified error rate. CMS selects a subset of Part C contracts for each annual RADV audit cycle. Enrollees are sampled from each selected Medicare Advantage (MA) contract to estimate payment error related to risk adjustment. Once the enrollees have been selected, the MA Organization is required to submit medical records to support all CMS-Hierarchical Condition Categories (HCCs) in the sampled beneficiaries' risk scores for the payment year. National audits determine the error payment rate for the industry as a whole, while the targeted contract audits determine payment error rate for particular plan.

Audit initiation & preparation	Retrieval	Coding	Post-audit activity
• CMS notifies Health Plan of pending audit • Health Plan receives Data Enrollee Package from CMS • Analytics provides Retrieval Team Chase List with identified medical records to procure	• Retrieval team alerts all providers of pending audit • Retrieval begins procurement process using provider engagement resources	• Coding reviews records procured to ensure validation • Coding submits medical records to CMS for approval	• Analytics team conducts financial extrapolation of member/HCC combination based on coder's rankings of submitted documentation • Health Plan conducts appeals process with CMS of any disagreed determinations

Increased risk adjustment scrutiny for Medicare Advantage Organizations

CMS announced plans to expedite completion of RADV audits for Payment Years 2018-2024 and begin annual auditing of all contracts

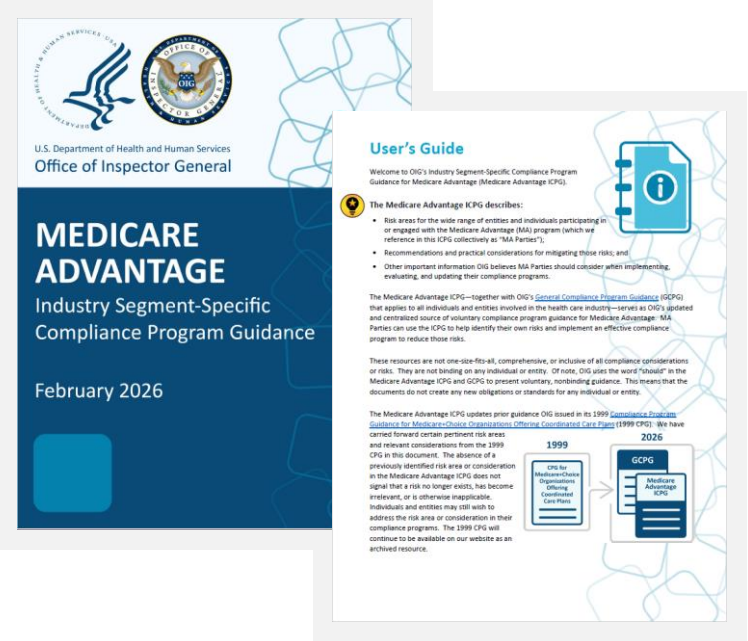
	Key components of May announcement	Recent developments
Expansion of Audit Capabilities	CMS anticipates completing remaining RADV audits for PY2018 – PY2024 by early 2026; CMS will also begin auditing all MA plans annually	• PY19 audits are ongoing, with PY20 audits starting in February • Data analytics to identify samples for PY20 through PY24 appear to be completed as CMS has reopened the system for plans to delete invalid diagnoses • CMS will initiate future RADV audits approximately every three months • CMS will accept up to two medical records per audited HCC
Improved Technology and More Coders	CMS is planning technology infrastructure improvements to increase audit throughput and flag unsupported diagnoses while expanding its medical coder team from 40 to approximately 2,000 coders	• While recent anecdotal information suggests that actual hiring has not kept pace with targets, CMS is still moving forward with its overall approach to increase audit throughput and plan to adopt AI coding in the future
Extrapolation of Results	Based on its planned improvements, CMS expects that the results will be sufficiently reliable to use its extrapolation methodology to apply its error rates to all plan payments, potentially significantly increasing required reimbursement amounts	• A federal judge recently paused CMS' implementation of its extrapolation methodology due to administrative procedure error • Department of Health & Human Services (HHS) appealed the decision • HHS and CMS will comply with the court ruling and vacate part of their extrapolation methodology

*MAOs need to **begin preparing for increasing regulatory scrutiny** of their **risk adjustment program** and **anticipate potential settlement liability** as CMS completes their audits*

Source: CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits | CMS

Medicare Advantage compliance guidance

The OIG Medicare Advantage Industry Segment Specific Compliance Program Guidance (ICPG)



OIG guidance summary

What is it: The ICPG + General Compliance Program Guidance provide voluntary guidance on top Medicare Advantage FWA risk areas and practical mitigation steps across the MA ecosystem (not just health plans)

Why it matters: It's grounded in OIG's audits, investigations, enforcement/corporate integrity agreement, and current priorities, signaling where MA oversight is focused as the program grows more complex

How to use it: It's nonbinding and not one-size-fits-all. Use the document to continually assess and strengthen compliance programs; it updates 1999 guidance and older risks may still apply even if not repeated

OIG guidance purpose

Oversight signal for providers: OIG is effectively defining where Medicare Advantage scrutiny is heading and what "good" MA-related compliance looks like—even for hospitals that aren't MA plans

Hospitals are in the MA risk chain: Hospital workflows around documentation/diagnoses (risk adjustment), claims/encounters & medical records, and utilization management (auth/denials/appeals) can directly drive MA compliance exposure.

Reduce risk and disruption: With intensifying managed care oversight and more complex contracting/vendor models, proactive compliance is framed as both a risk reducer and a business/operations investment.

Source: Medicare Advantage Industry Segment-Specific Compliance Program Guidance

Medicare Advantage compliance guidance

Building a "risk map"

The ICPG applies broadly to "MA Parties," not only MA organizations (MAOs). Hospitals should read it as a **roadmap of risks OIG associates with MA operations and partners**

Voluntary – but predictive

OIG is explicit that it is nonbinding, yet it is **built from OIG's audits, investigations, and enforcement** and thus is a strong indicator of where issues get found and pursued

OIG complements CMS requirements

OIG provides guidance that can strengthen programs and may help MA Parties.
For hospitals, this often shows up contractually as plans may push **expectations downstream**

Two high-impact MA pressure points

1. **Risk adjustment incentives:** The guidance flags systemic incentives for plans to make people appear more sick via diagnosis coding
2. **Capitated model incentives:** OIG highlights incentives to deny or delay care/payment. Hospitals should monitor for compliance in MA utilization management and payments

Complex ecosystem

OIG calls out the "constellation" of entities (vendors, brokers, Management Services Organizations, Independent Practice Associations, shared ownership). Hospitals should **expect more delegation, vendor involvement, and data handoffs** and should **strengthen oversight**

Tailored MA risk assessment

Hospital Specific MA Compliance:

- Where **MA volume is concentrated** (service lines, facilities, employed vs affiliated)
- Documentation / coding workflows that **touch MA risk adjustment**
- Contract terms that create **operational and compliance obligations**

Source: Medicare Advantage Industry Segment-Specific Compliance Program Guidance

Renee LeSaux

Payment & coverage transparency

Price transparency: Policy context

In February 2025, President Trump issued an executive order (EO) ***directing federal agencies to rapidly implement and strengthen enforcement*** *of federal health care price transparency regulations.*

The EO states that:

Patients and employers **lack clear, upfront price information.**

Individuals have **limited ability to comparison shop or obtain pricing** before a visit or procedure.

Opaque pricing allows **hospitals and insurers to operate with insufficient accountability**, leading to higher health care costs for patients, employers, and taxpayers.

Consistent with President Trump's EO, CMS **finalized updates to hospital price transparency regulations—**effective January 1, 2026—**to enhance the clarity and consistency of hospital standard charges** by requiring hospitals to public accurate, meaningful prices for items and services in a format that supports informed decisions and easier comparisons across hospitals.

CMS enforcement update

To enforce price transparency regulations, CMS issues annual civil monetary penalties (CMPs) on hospitals subject to the requirements that have violated them and remain noncompliant. Violations may include failing to post a machine-readable file listing all standard charges or not displaying shoppable services in a consumer-friendly manner.

In 2025, CMS issued CMPs to 10 hospitals for violating federal price transparency requirements:

- Arkansas Methodist Medical Center **($309,738)**
- Northlake Behavioral Health System **($257,180)**
- Lawrence Rehabilitation Hospital **($120,120)**
- Community Care Hospital **($93,214)**
- Hill Hospital of Sumter County **($84,216)**
- Bucktail Medical Center **($75,582)**
- D.W. McMillan Memorial Hospital **($71,852)**
- First Surgical Hospital **($62,01)**
- CCM Health **($55,611)**
- Southeast Regional Medical Center **($32,301)**

Finalized price transparency guidance and requirements

CMS published updated guidance and is expected to publish a new schema for machine readable files (MRFs) for immediate update and released proposals for additional changes for Calendar Year (CY) 2026

Immediate Updates

Calculating the "estimated allowed amount" and discontinuing use of nine 9s

Hospitals should discontinue encoding 999999999 (nine 9s) in the estimated allowed amount data element within the MRF and should instead encode the average dollar amount the hospital has received for an item or service, derived from electronic remittance advice transaction data using data from items or services rendered within the 12 months prior to posting the file.

Encoding payer-specific standard charge dollar amounts and contract methodologies

CMS expects that hospitals' payer-specific negotiated charges can be expressed as a dollar amount for most contracting scenarios. For items and services encoded in the MRF with a "case rate," "fee schedule," or "per diem" standard charge methodology, CMS expects hospitals to calculate and encode a payer-specific negotiated charge as a dollar amount.

Additional Updates for CY2026

- **New disclosure details of allowed amounts |** *Remove the requirement for hospitals to encode the estimated allowed amount and require hospitals, beginning January 1, 2026, to disclose the 10th percentile, median, and 90th percentile allowed amounts in MRFs*
- **Require EDI 835 electronic remittance advice transaction data for payer-specific charges |** *Use EDI 835 transaction remittance advice (ERA) transaction data to calculate and encode payer-specific charges*
- **Inclusion of National Provider Identifier in MRF |** *Require a new data element in the MRF to reflect the organization's NPI*
- **Expanded attestation requirements |** *Update the attestation language hospitals must include in the MRF and to require hospitals to encode the name of the chief executive officer, president or senior hospital official designated to oversee the encoding of true, accurate, and complete data in the MRF*
- **Enforcement and Civil Monetary Penalties |** *Reduce the amount of civil monetary penalty by 35% when a hospital agrees with CMS' determination of their noncompliance and waives the right to a hearing.*

Carsten Lachell, Maxine LeSaux, & Tom Comes

340B & drug policy updates

Medicare: Medicare drug negotiation and Part B reforms may drive significant financial and operational change across stakeholders, reshaping revenue streams and competitive market dynamics

Inflation Reduction Act: Medicare drug price negotiation

HHS Secretary is required to annually review and rank the 100 highest-cost qualifying drugs to determine which Medicare Parts B and D drugs will be selected to negotiate with manufacturers to set the **maximum fair price (MFP).**

For the Initial Price Applicability Year (IPAY) 2026, **10 Part D drugs** were negotiated, and **15 additional Part D drugs** were negotiated for IPAY 2027.

For IPAY 2028, negotiations will expand to 15 selected drugs from Part B and D and previously selected drugs will become eligible for renegotiation.

In addition to ongoing implementation of the Inflation Reduction Act (IRA), outpatient drug policy is facing heightened scrutiny, with Congress and regulators increasingly focused on cost and billing dynamics across the supply chain.

Key areas to watch include:

- **Site-neutral payment policies** that could narrow reimbursement differentials across sites of care
- Additional potential **340B program reforms** aimed at oversight and reimbursement changes
- Expanded **PBM transparency requirements** that change reporting, contracting, and pricing practices.

IPAY 2028
Medicare drug price negotiation timeline

2026

January 27 — **Selected drugs announced**
HHS published the list of 15 Part B and D drugs selected for the third cycle of Medicare Drug Price Negotiations

February 28 — **MFP negotiation begins**
HHS and manufacturer begin negotiation of MFP on February 28 or sooner if manufacturer already has an agreement in place

November 1 — **MFP negotiation concludes**
Manufacturer must reach agreement with HHS by November 1 or face penalties

November 30 — **Negotiated MFPs announced**
HHS to publicly publish any negotiated or renegotiated MFPs

2028

January 1 — **IPAY 2028 begins**
MFP effective for the calendar year

CMS finalizes Site Neutral Payment Policy for drug administration services in annual rulemaking

Background and considerations

- In the CY2026 Outpatient Prospective Payment System (OPPS) Final Rule, CMS finalized aligning **payments for drug administration services between except or "grandfathered" off-campus HOPDs and physician offices.**
- CMS will **apply the Physician Fee Schedule (PFS)-equivalent payment rate to 4 Ambulatory Payment Classifications (APCs),** covering all 61 HCPCS codes used to bill Medicare for drug administration at these except off-campus HOPDs.
- The final rule also includes an **exemption for rural sole community hospitals (SCHs).**
- The new payment rates **went into effect on January 1, 2026.**

Applicable APC codes and payment rates

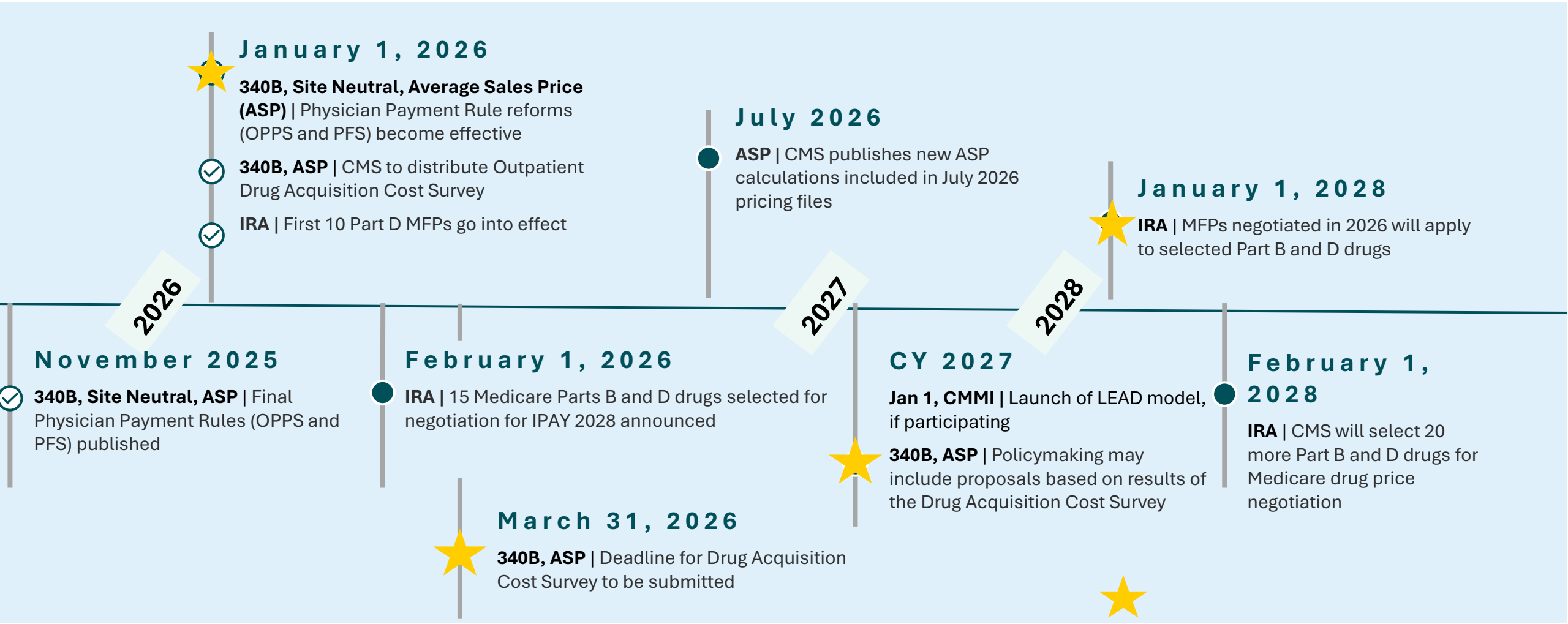
Payment rate comparison between programs

APC	CY 2026 OPPS payment rate	PFS-Equivalent payment rate
5691	$47.83	$19.13
5692	$74.57	$29.83
5693	$216.49	$86.60
5694	$341.52	$136.61

Using CY2024 outpatient claims data, CMS estimated this change will **result in a total payment reduction of $280 million in 2026,** a $210 million decrease in OPPS payments and a $70 million reduction in beneficiary copayments.

Drug policies will continue through 2028 | Compliance considerations

Below is a summary of drug policy updates that will continue through 2028. These changes increase compliance and financial risk across the organization and will require ongoing leadership oversight.



Key Takeaway: Internal Audit functions should plan for reporting, monitoring, and oversight as drug policy implementation proceeds.

Regulatory convergence: Maximum Fair Price and the 340B Program

As of January 2026, the effectuation of the MFP has altered the financial, operational, and compliance baseline for health systems. The regulatory convergence between MFP and the 340B Program fundamentally transforms a health system's 340B Program and adds financial, operational, and regulatory complexity.

Maximum Fair Price

Under the IRA, **CMS implemented negotiated MFPs for the first ten Medicare Part D drugs effective January 1, 2026.** As a result, Medicare Part D reimbursement is expected to decrease for 340B Covered Entities (CEs) and contract pharmacies, as these drugs will now be reimbursed at the lower MFP.

Old Methodology:
- *CMS payment: $120*
- *340B price: $30*
- *Spread: $90*

New Methodology:
- *CMS payment (MFP): $45*
- *340B price: $30*
- *Spread: $15*

FINANCIAL IMPLICATIONS

- Historically, 340B CEs have **benefited from the spread between the 340B ceiling price and Medicare Part D reimbursement**; MFP implementation is expected to materially narrow that spread and compress margins.
- In select scenarios (e.g., non-340B drugs), **CEs may be eligible for manufacturer MFP refunds and should monitor pharmacy and financial data** to validate eligibility and amount.

COMPLIANCE IMPLICATIONS

- Under the IRA, CEs must maintain controls to **prevent duplicate discounts, ensuring that a given claim does not receive both a 340B discount and an MFP refund.** Absent effective prevention, detection, and remediation, CEs risk receiving refunds on ineligible claims and may be subject to retrospective manufacturer recoupments, clawbacks, and related financial exposure.
- **MFP duplicate discount= 340B discount + MFP refund on same claim**

OPERATIONAL IMPLICATIONS

- MFP implementation introduces operational complexity for CEs, **requiring claim-level tracking to confirm that manufacturer MFP refunds are issued accurately and in a timely manner.** Where discrepancies are identified, CEs must be positioned to promptly dispute, appeal, and reprocess claims to secure the correct refund amount.

MFP effectuation and 340B health care provider challenges and Deloitte's recommendations

New MFP effectuation requirements create near-term financial, operational, and compliance pressures. Deloitte's recommendations focus on targeted data, controls, and operating model changes to help the CE align with these requirements.

POTENTIAL CHALLENGES AHEAD

Financial

- Medicare Part D's expected shift to MFP-based reimbursement will immediately compress margins on negotiated high-spend drugs, while the largely retrospective manufacturer refund model (buy at WAC, refund later to reach MFP) introduces cash-flow lag that ties up CE working capital in inventory longer than the upfront 340B discount model.

Compliance

- Audit scrutiny will intensify as manufacturers target MFP–340B duplicate discounts, shifting the focus from traditional 340B eligibility (e.g., patient definition) to transaction-level pricing accuracy and duplicate-discount prevention.

Operational

- Operationally, MFP refund validation is constrained by fragmented data (Part D eligibility in adjudication, acquisition/WAC vs. 340B in purchasing, MFP benchmarks on CMS) with no near-term CMS clearinghouse, shifting the burden to health systems to reconcile disparate manufacturer portals, often within tight ~14-day correction windows, making clean, near-real-time data linkage critical to avoid missed refunds.

DELOITTE'S RECOMMENDATIONS FOR CONSIDERATION

Example potential actions

- **Develop a financial model** that reconciles pharmacy and financial data to published MFPs across all negotiated drugs. Implement ongoing monitoring and periodic audits to confirm the CE receives MFP refunds when owed and in the correct amounts.
- **Implement a pre-submission claim scrub** for MFP drugs and embed it in 340B governance to prevent duplicate discounts. Update 340B policies and procedures to explicitly address MFP interaction and conduct routine mock audits focused on the 10 MFP drugs to confirm no dual discounts occurred.
- **Apply 340B-level rigor to MFP drugs** by establishing automated controls that assign and track claim status (340B vs. MFP) and compare WAC to the CMS-published MFP in near real time.

Jake Ellithorpe, Vincent Iannello, Ashley Robalino

DOJ / OIG update

FY 2025 regulatory enforcement at a glance

CMS managed $1.8 Trillion while transforming care delivery. Strategic priorities focus on access, affordability, and sustainability amid unprecedented fiscal responsibility. Additionally, false claims settlements exceeded $6.4 billion in FY 2025.

FY 2025 key facts

Medicare Fee-For-Service (FFS) improper payment impact totaled $28.83B.

Medicare Part C (Medicare Advantage) and Part D (Prescription Drugs) improper payment impacted totaled $27.9B.

CMS is investing in AI/analytics for fraud detection and improved beneficiary experience.

Record recoveries reported for more than $6.8B in False Claims Act (FCA) settlements and judgments.

1,297 qui tam (whistleblower) lawsuits were filed, which was described as the highest single-year count.

DOJ highlights continued focus and "success" in Managed Care, Prescription Drugs, and Medically Unnecessary Care.

Key takeaways

- Documentation quality is the dominant driver of improper payments across FFS, Part C, and Part D—missing, insufficient, or discrepant records are the recurring root cause.
- Prioritize high-risk drugs for targeted internal audits (mirrors CMS posture).
- Maintain retrieval readiness: fast, consistent ability to produce source records that match what was billed/submitted.

- DOJ is underscoring "medically unnecessary/potentially harmful" conduct, so clinical appropriateness and documentation quality are as important as billing mechanics.
- Whistleblower risk is structurally elevated making internal speak-up channels, non-retaliation, and rapid triage a key risk control.
- DOJ is telegraphing that credible cooperation and remediation can affect outcomes (penalties/damage multiples).

Source: FY 2025 CMS Financial Report | Office of Public Affairs | False Claims Act Settlements and Judgments Exceed $6.8B in Fiscal Year 2025 | United States Department of Justice

OIG hospital provider audit

Audit overview

HHS OIG conducted a **Medicare provider compliance audit of a Florida based hospital** to assess whether selected "high-risk" inpatient, IRF, and outpatient claims complied with Medicare coverage, coding, and billing requirements. **OIG reviewed a stratified random sample of 100 claims** from January 1, 2020 through December 31, 2021 and **identified 26 noncompliant claims, representing $272,364 in net overpayments** in the sample. Based on the sample results, **OIG extrapolated at least $12.1 million in net overpayments** for the full audit period. OIG attributed the errors primarily to the hospital not consistently following **its written policies and procedures** and recommended the hospital **refund the federal government** the extrapolated amount.

Background

- This audit was part of OIG's series of hospital compliance audits **targeting claim types previous OIG work identified as "high-risk" for noncompliance**; OIG used data mining/computer matching to **identify hospitals with a disproportionate volume** of these types of claims.
- Medicare hospital payments are a **large share of fee-for-service spend.** OIG uses these audits to **safeguard program integrity by detecting improper payments** in known error-prone risk areas and **drive corrective actions at scale.**

Compliance considerations

- Plan for **ongoing OIG focus on high-impact medical necessity and documentation** (e.g., inpatient admission/Two-Midnight, IRF criteria) **and coding/billing**, as these areas repeatedly drive adverse findings and repayment exposure.
- Reinforce importance of **maintaining relevant documentation** to support medical necessity and **aligning operational processes with developed policies and procedures.**
- Treat sample errors as **enterprise-level financial risk** given OIG's ability to extrapolate; align Compliance, Revenue Integrity, and Legal early on potential refund vs. appeal posture.

Source: Florida Based Hospital Received At Least $12.1 Million in Medicare Overpayments, A-04-23-08098

Medicare compliance updates: PEPPER & MOON

PEPPER

CMS relaunched the **Program for Evaluating Payment Patterns Electronic Report** (PEPPER) for short-term acute care hospitals, **restoring access to a valuable data tool** after a 3 year pause on the program

Background

- PEPPER is a free CMS comparative analytics report that benchmarks hospital billing patterns against national/state/peer norms to flag improper payment risks
- Program went on pause in 2023 and is expected to return in April 2026

Compliance considerations

- **Governance & accountability**: Assign an owner for PEPPER retrieval and review; document oversight and corrective actions—treat PEPPER as a core CMS compliance tool
- **Risk monitoring & integration**: Build PEPPER findings into audit plans; trend results over time to proactively mitigate audit and denial risks

MOON

CMS reauthorized **Medicare Outpatient Observation Notices** (MOON) on **February 20th** and released a new MOON form with improved readability and design with a refreshed layout intended to **improve comprehension**

Background

- MOON is a CMS-required notice for hospitals/CAHs to give Medicare/MA beneficiaries in outpatient observation >24 hours, explaining outpatient status and coverage/cost-sharing
- It requires an oral explanation, documentation of the outpatient rationale, and patient acknowledgement

Compliance considerations

- **Conversion & system readiness:** Retire old MOON versions and update EHR/templates, packets, and stock to the revised form by Apr 20, 2026
- **Execution assurance:** Refresh staff training/scripting and validate consistent delivery requirements (timing, oral explanation, patient-specific rationale)

Source: CMS relaunches PEPPER for short-term acute care hospitals | NAHRI | Beneficiary Notices Initiative (BNI) | FFS & MA MOON

Health care fraud – cases

Regulatory enforcement themes

Regulatory enforcement in health care is increasingly focused on stopping **telemedicine-enabled fraud, illegal kickbacks, and medically unnecessary** durable medical equipment (DME) billing that drains federal programs. Recent Department of Justice (DOJ) actions—backed by the Federal Bureau of Investigation (FBI) and multiple Inspectors (e.g., HHS-OIG)—show a coordinated approach that targets both **individual leaders** and the broader **marketing/telemedicine/supplier networks** that generate questionable orders and claims, with severe criminal penalties and large financial recoveries.

Oklahoma medical supply company owner indicted for $30 million health care fraud scheme

- **Federal indictment**: A chiropractor and medical-supply business operator is accused of running a DME-focused healthcare fraud scheme
- **Alleged scale**: ~$30M in claims submitted across government programs; ~$8M allegedly paid
- **Alleged mechanics**: Kickbacks to marketers/telemedicine partners for patient leads and signed orders used to bill braces/DME
- **COVID relief funds**: $133K+ in Provider Relief Fund payments allegedly misused (including non-care/personal uses)

CEO of health care software company sentenced for $1 billion fraud conspiracy

- **Case**: Two telemedicine executives pleaded guilty to a scheme involving bribes to physicians and related healthcare fraud tied to telehealth-driven ordering
- **Alleged scale**: About $64M in fraudulent claims were submitted to Medicare and TRICARE
- **Alleged mechanics**: The operation allegedly used kickbacks/bribes and lead-generation/marketing pipelines to obtain signed orders and steer prescriptions/DME through downstream partners
- **Program-integrity red flags:** Orders were allegedly issued with no bona fide patient evaluation, using beneficiary data and pre-populated forms—undermining medical necessity and documentation controls

Sources: Office of Public Affairs | Oklahoma Medical Supply Company Owner Indicted for $30M Health Care Fraud Scheme | Office of Public Affairs | CEO of Health Care Software Company Sentenced for $1B Fraud Conspiracy

Open discussion

Polling questions

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

You may select multiple answers

a) Risk Adjustment & Medicare Advantage Updates

b) Payment and Coverage Transparency Updates

c) 340B and Drug Policy 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