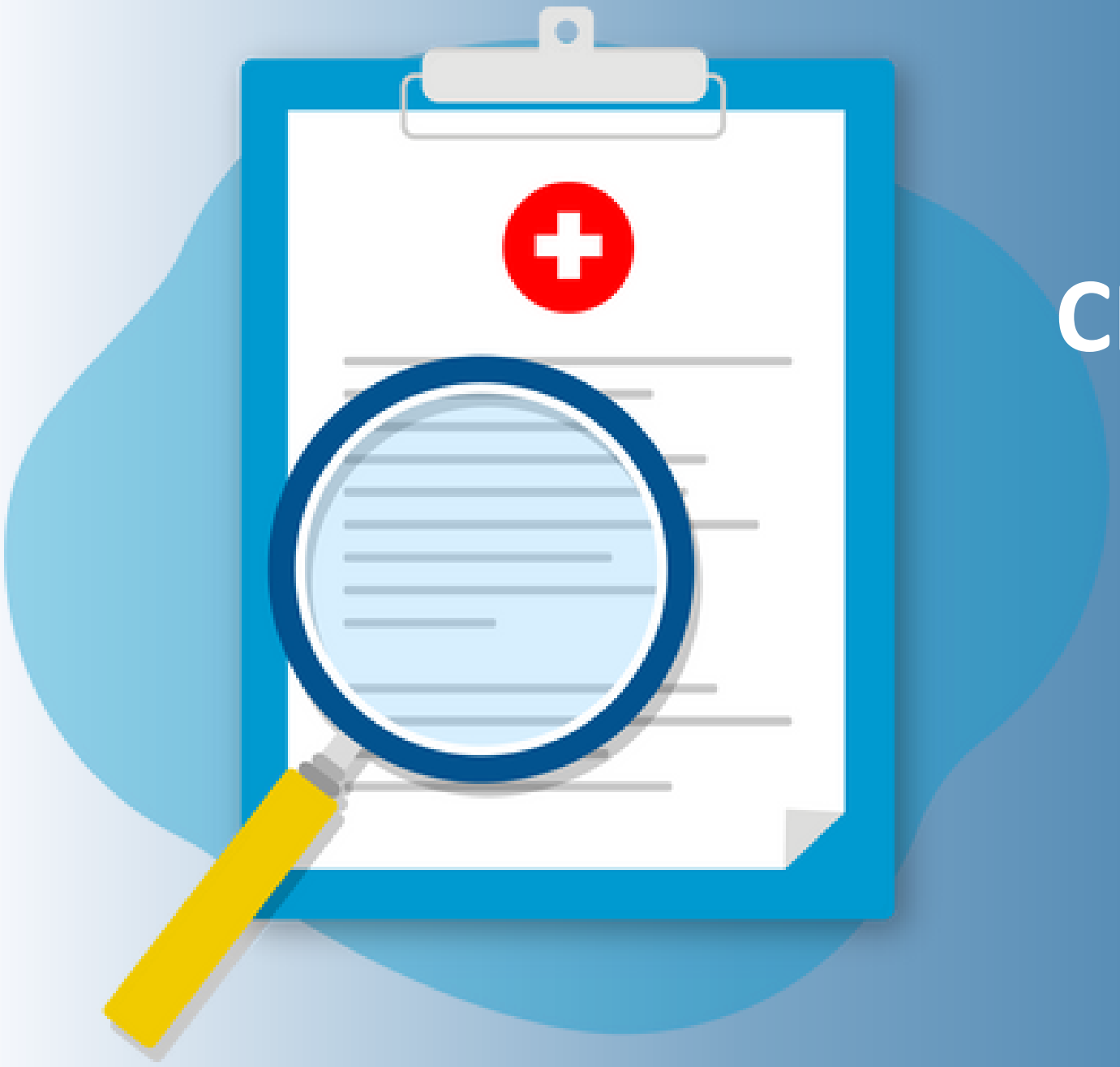

CMS Modernizations Priorities

eHealth Exchange Annual Meeting

November 18, 2025

CMS' Digital Health Ecosystem

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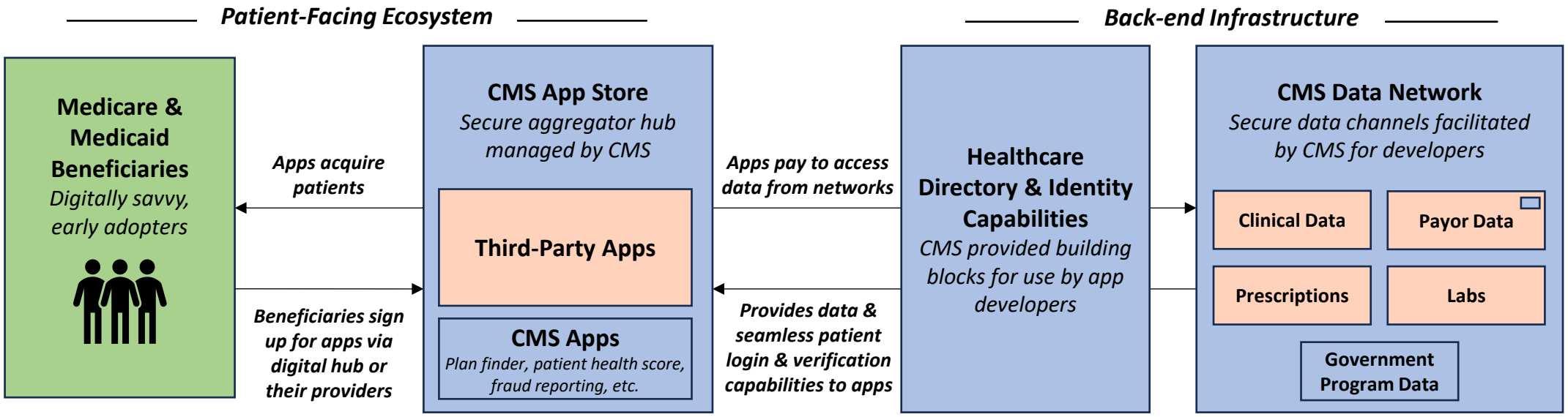
CMS Health Tech Ecosystem



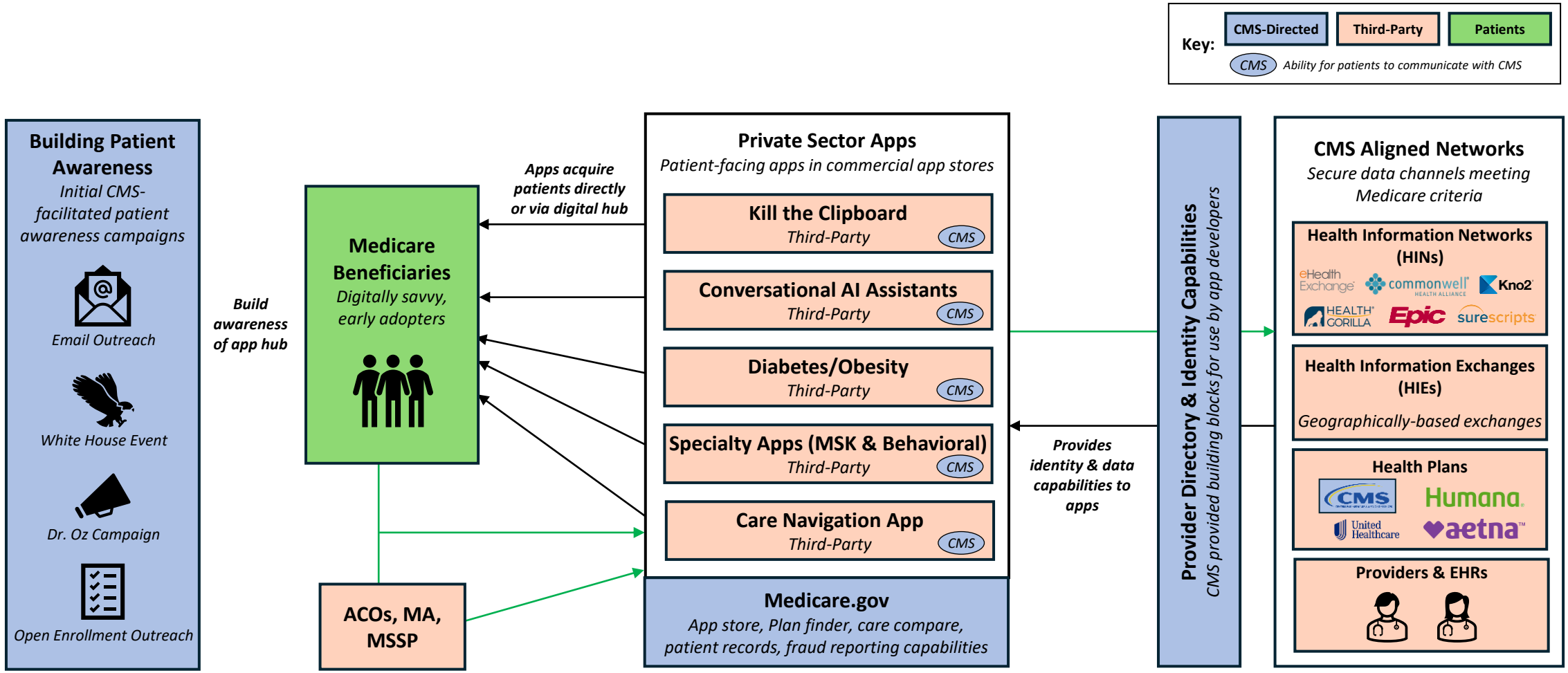
CMS to organize an "app hub" where beneficiaries can access personalized 3rd party and CMS apps. Apps will be focused on patient health record aggregation, prevention and management of chronic disease such as cardiometabolic conditions, MSK and mental health as well as effective care navigation (symptom checkers, provider scheduling and "kill the clipboard")

Apps will be able to build on the CMS data network via the national healthcare directory, and seamless patient authentication and identity verification for data access

CMS to establish criteria for industry data sources to voluntarily fulfill in order to be highlighted as a CMS Data Network participant

Key: CMS-Directed | Third-Party | Patients

CMS Health Tech Ecosystem – Stakeholder Interactions



An official website of the United States government Here's how you know

CMS.gov Centers for Medicare & Medicaid Services

About CMS Newsroom Data & Research

Medicare Medicaid/CHIP Marketplace & Private Insurance Initiatives Training & Education

Initiatives > Health Technology Ecosystem > Overview

Health Technology Ecosystem

Join CMS in Making Health Tech Great Again

Is your company interested in joining? Please email HealthTechRFI@cms.hhs.gov your company name and which category you are interested in pledging to.

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CMS Health Tech Ecosystem Categories

- CMS Aligned Networks
- Providers connecting to CMS Aligned Networks and agreeing to Kill the Clipboard
- EHRs connecting to CMS Aligned Networks and taking in Kill the Clipboard data
- Payers connect to CMS Aligned Networks
- Patient Facing Apps leveraging CMS Aligned Networks
  - Kill the Clipboard
  - Conversational AI
  - Diabetes and Obesity Prevention and Management

CMS, TEFCA, and Trusted National Interoperability

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CMS, TEFCA, and Trusted National Interoperability

- There are several important policy initiatives focused on improving interoperability. For example:
    - The 21st Century Cures Act required the Office of the National Coordinator for Health IT (ONC, now the Assistant Secretary for Technology Policy/ONC) to develop a trusted exchange framework and common agreement for exchange between health networks. The goal of TEFCA is to establish a governance, policy, and technical floor for nationwide interoperability and secure information sharing across different networks.
    - CMS recently announced a voluntary Interoperability Framework, designed as a call to action to improve data flow and put patients and providers first—by ensuring all parties have access to the health data they need.
- These initiatives reflect significant interest from the current administration in facilitating the secure flow of health data for patients, providers, and payers.
- We appreciate that eHealth Exchange has announced their support for the CMS Interoperability Framework.

Driving Innovation Through TEFCA

- While treatment and individual access has been an important priority of trusted national exchange networks, payment and operations are far less used (and not required responses under TEFCA). **As a result, trusted, national payer/provider data exchange is limited.**

- However, there are several areas where a trusted, national exchange capability could drive innovation and support CMS priorities:

    - Quality reporting – a national network could improve quality measurement infrastructure, for example, better access to clinical data to close quality gaps.

    - Fraud, waste and abuse—streamlined access to source data could fast-track approvals and minimize inappropriate 'non-affirmations,' reducing friction for prior authorization and payment review processes.

    - Individual Access Services (IAS) exchange purpose creates a broader set of entities beneficiaries can receive their data from through a single "front door"

CMS' Fight Against Fraud, Waste, and Abuse

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What's at Stake

The scope of fraud, waste, and abuse is massive, and **CMS is cracking down**. Examples of systematic abuse include:

1.8M: Medicare beneficiaries enrolled in hospice care which is a 12% increase from 2020 hospice enrollment levels.

Medicare spending on skin substitutes has had unprecedented growth rising from $256M in 2019 to over **$10B** in 2024.

$1.9B+: Improper payments related to Durable Medical Equipment (DME) in FY 2024

$14B: Individuals enrolled in multiple state Medicaid programs or both a Medicaid and Marketplace plan

$17.2B: Estimated overpayments to MAOs for unsupported medical diagnoses in PY 2022

$534M: Payments halted by CMS' War Room to providers suspected of fraud, including billing for deceased patients and non-existent care

330,000+: People fraudulently enrolled in Marketplace plans by Agents/Brokers in 2024

Make America Healthy Again

CMS Mission

Ensure our most vulnerable receive
high-value care by leading all payors and supporting providers.

Strategic Objectives

Leading Payor

Establish the CMS team as the indisputable leading payor in the country

Crush Fraud

Crush fraud and reduce inappropriate spending

Empower Beneficiaries

Empower beneficiaries with personalized, actionable health tools to support informed decision making + care navigation

Incentivize Providers

Incentivize providers to maximize focus on delivering their best, data-driven care possible

Align Spending & Value

Partner intentionally with CMS stakeholders to better align spending and value

CMS' Strategy and Actions to Crush Fraud

Advanced Detection: Rapidly assessed over 250 providers through CMS' Fraud War Room for inappropriate billing and other fraudulent behavior and successfully suspended over $500M in potentially fraudulent claims.

Robust Oversight: Expanding a probationary period for new hospices to two additional states following the revocation of 155 Medicare enrollments during the four-state pilot

Collaborative Action: Partnering with the U.S. Department of Justice to complete the largest health care fraud takedown in history involving over $14.6 billion in alleged fraud

Empowering Beneficiaries: Continuing to educate Medicare beneficiaries about emerging fraud schemes and teaching them how to help stop fraud, waste, and abuse through cms.gov/fraud

Hot Fraud Focus Areas

Robust Oversight of Hospices

March 2023 National Hospice Site Visit Project

- **~6,700 enrolled hospices were visited** to ensure the hospice provider was operational
- **~50 hospices** had their **Medicare enrollment revoked**
- Over 475 hospices had their **Medicare billing privileges deactivated**

July 2023 Hospice-Focused Probationary Period

- CMS implemented a Provisional Period of Enhanced Oversight (PPEO) on newly Medicare-enrolled hospices and hospices that underwent a change in ownership in Arizona, California, Nevada and Texas
- As of October 16, 2025, **155 hospices** had their **Medicare enrollment revoked**
- **204 providers** were revoked based on their affiliation to a fraudulent hospice provider

September 2024 Target High-Risk Hospice (THRH) Review

- Following PPEO success, CMS expanded prepayment review to existing high-risk hospices in the same four states
- As of October 16, 2025, **25 hospices** had their **Medicare enrollment revoked**

CMS plans to expand PPEO and THRF to two additional states, Georgia and Ohio, in late 2025

Hospice & DME Supplier ESVs

CMS conducted Enhanced Site Visits (ESVs) across California, Nevada, Michigan, and Florida from November 2024 through July 2025, focused on hospice and durable medical equipment (DME) suppliers. The ESV project emerged from the recognition **that Medicare's traditional site visit methodologies were insufficient to address the evolving landscape of provider enrollment fraud and abuse**. ESV represents a shift from observational assessments to **comprehensive on-site compliance reviews**.

CMS conducted 132 total visits (111 hospice, 21 DME) resulting in significant enforcement action

60% of hospice or DME ESVs resulted in a **revocation,** 36% resulted in provider education

Total Medicare and Medicaid Payments associated with revocations: **$254,905,604**

CMS' nearly universal detection rate demonstrates a highly effective target selection methodology and comprehensive nature of the review process

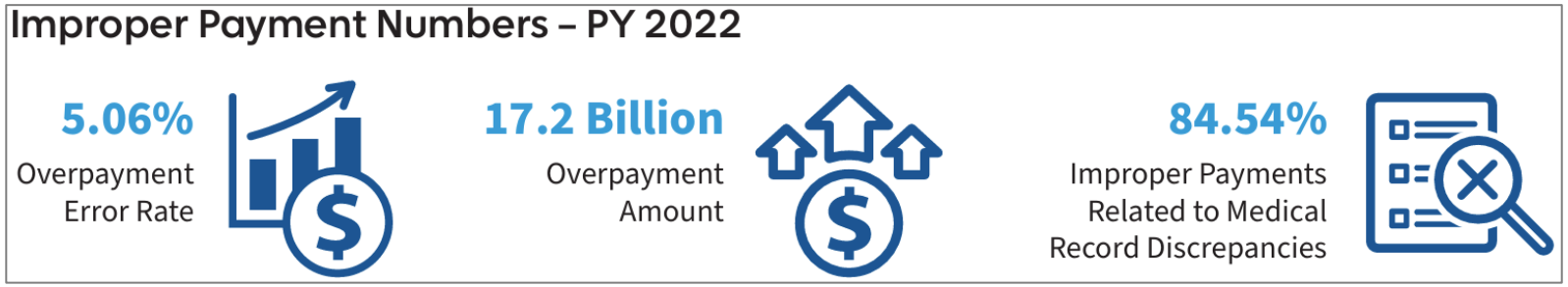
Hospice Bene Engagement & Process Improvements

Increased Beneficiary Engagement & Education	• Implemented a Rapid Response Team to promptly resolve complaints of inappropriate hospice enrollment, resulting in the reversal of over 500 hospice elections from October 2024 to date.
Improved Disenrollment Process for Fraudulent Beneficiary Hospice Election	• Published targeted beneficiary messaging to raise awareness of hospice fraud schemes, such as unsolicited visits by “door knockers.“ • Developed enhanced 1-800-MEDICARE scripts to efficiently triage beneficiary complaints of fraudulent hospice enrollment. • Streamlined the removal of fraudulent beneficiary hospice elections, reducing the processing timeline from up to six months to fewer than 12 days.
Improved Hospice Election Process	• Targeted beneficiary messaging with a pilot program beginning in Nevada. • Plans to expand to California by end of 2025.

Advancing CMS' Medicare Advantage RADV Program

The Risk Adjustment Data Validation (RADV) program is CMS' primary way of **ensuring accurate payments are made to Medicare Advantage Organizations (MAOs)**. RADV audits are critical because MAOs that report less healthy enrollees receive higher Medicare payments through a risk adjustment process. It is estimated that unsupported medical diagnoses result in overpayments to MAOs of **approximately $17 billion annually**

- In May 2025, CMS developed a plan to expand and accelerate RADV audits for payment years 2019 – 2-24 so that CMS could "catch up" to the most recent payment year possible for audit
- However, on September 25, 2025, a judge in the U.S. District Court for the Northern District of Texas vacated certain portions of CMS' 2023 RADV Final Rule. CMS is carefully evaluating the implications of this decision and determining next steps for the RADV program.



Fraud Defense Operations Center

CMS launched the Fraud Defense Operations Center (FDOC), also known as the **Fraud War Room**, to integrate cross-functional expertise to create a specialized team of data analysts, investigators, health policy experts, legal advisors, and law enforcement. **The FDOC leverages data-driven analytics to proactively detect, address, and prevent Medicare fraud, waste, and abuse in real time to safeguard beneficiaries and protect taxpayer resources**. From March 31, – October 22nd, 2025, the FDOC:

Assessed **252 providers**, over five per business day

Suspended nearly **$160 million in payments** to suspect providers billing for skin substitutes and another **$240 million** to suspect DME suppliers billing for catheters

Suspended over **$85 million in payments** to suspect laboratories

FDOC has imposed 195 Medicare payment suspensions on providers totaling $534 million

Letters to Skin Substitute Providers

CMS' continuous data monitoring has identified providers that show billing patterns that could be indicative of fraud, waste, and abuse. On August 1st, 2025, CMS mailed individualized letters to the top 5% of providers who billed for skin substitutes in 2025. The letters served as a warning to assess their billing behavior and ensure they are meeting Medicare's requirements. Preliminary results of the letter indicated that:

45% of the providers who received a letter have **stopped billing for skin substitutes**

15% of the providers have **stopped billing altogether**

40 of the outlying providers are now **under** CMS or Law Enforcement **investigation**

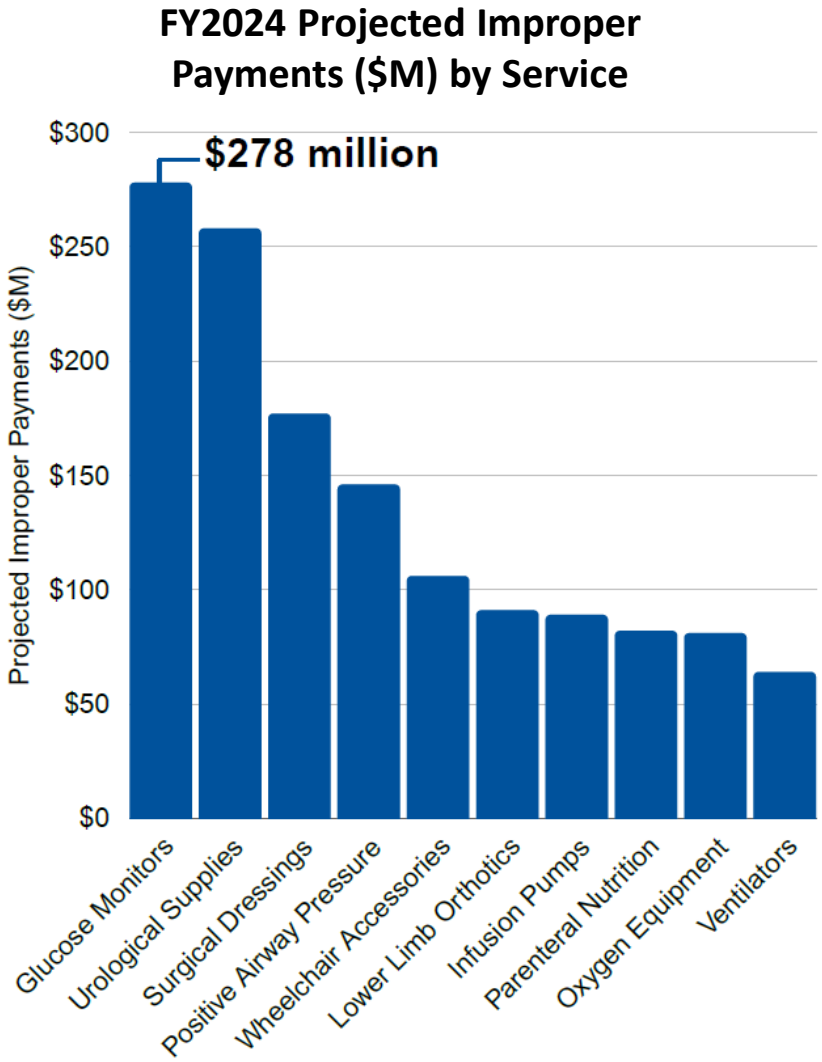
On October 9th, CMS issued a second round of letters to 196 outlier rendering providers to confirm skin substitutes have been provided to beneficiaries and the providers' identities have not been stolen

Fraud Spotlight: DMEPOS Suppliers

Medicare Part B covers medically necessary Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that are furnished by Medicare enrolled DMEPOS suppliers. Suppliers are tasked with submitting the claim and supplying the item. For some items, CMS requires prior authorization or a face-to-face encounter with a provider prior to delivery.

DMEPOS is a frequent target of fraud and has a high improper payment rate. In Fiscal Year (FY) 2024, CMS identified **$1.9 billion** (21.4%) in improper payments related to DMEPOS.[1] CMS has taken significant action to crush fraud conducted by DMEPOS suppliers.

DMEPOS Items Commonly Targeted for Fraud include: Continuous Glucose Monitors (CGMs), Orthotic Braces, Positive Airway Pressure Devices, and Surgical Dressing.



1. CMS. 2024 Medicare Fee-for-Service Supplemental Improper Payment Data

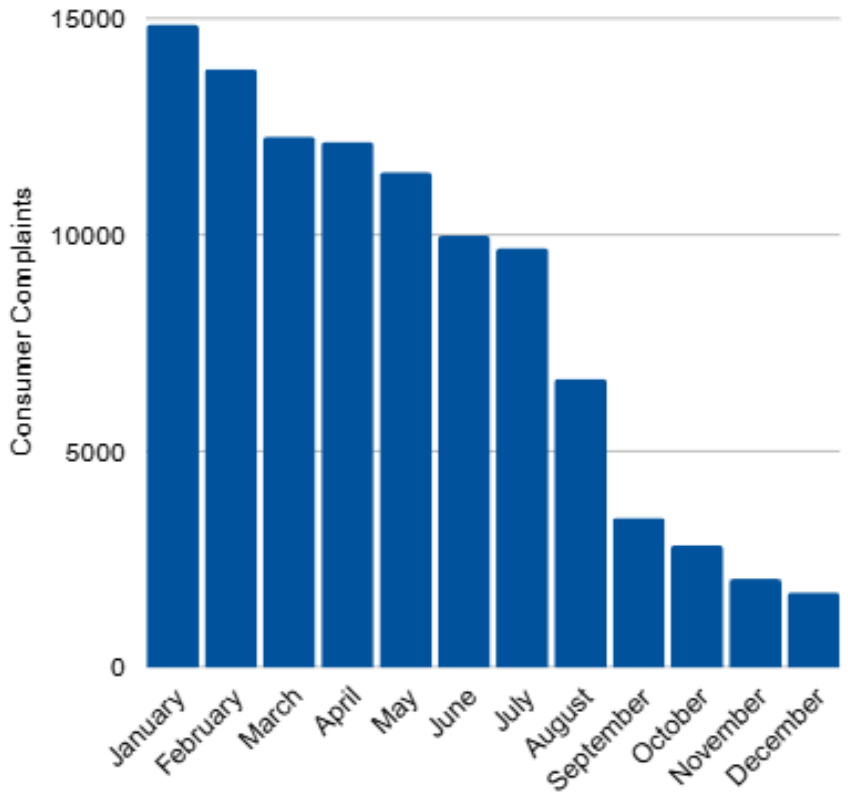
Fraud Spotlight: Agent/Broker Fraud

Licensed Agents, Brokers, and Web-Brokers operate in both the Marketplace and Medicare Advantage (MA) programs. Agents annually aid millions of enrollees in identifying and enrolling in coverage plans that best suit their individual needs.

However, some Agents have inappropriately received financial benefits or other incentives by enrolling individuals in plans that might not be best suited for them. Agents may double enroll a consumer into multiple plans, exploit Special Enrollment Periods to enroll consumers outside of Open Enrollment, falsify income attestations, or use incentives to persuade enrollees to switch to a “better” or “cheaper” plan.

In coverage year 2024, CMS received over **330,000 complaints** that consumers were enrolled in a Marketplace plan or had their plan changed without their consent. To address noncompliance, CPI and the Center for Consumer Information and Insurance Oversight (CCIIO) are implementing a regulatory compliance review process to potentially terminate noncompliant agents.

2024 Count of Consumer Complaints by Month



The Future of Crushing Fraud at CMS

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Creating a National Provider Directory

- CMS is committed to developing a **dynamic, interoperable national provider directory** as part of the Digital Healthcare Ecosystem.
- Work has begun on building a Fast Healthcare Interoperability Resources (FHIR)-based Application Programming Interface (API) to **enable apps to find provider networks, participants and relevant endpoints, while also improving data quality and mapping complex provider hierarchies**.
- CMS' goal is to create a unified, modern national provider directory serving as the **single source of truth** for provider data nationwide.
- The agency will be **launching initial functionality of the new provider directory** and expand iteratively starting later this year.
- More information is available on CMS' Health Technology Ecosystem website: **www.CMS.gov/priorities/health-technology-ecosystem**

Collaborating with Industry

Successful fraud prevention relies on coordination and information-sharing, and CMS is committed to strengthening **strong public-private partnerships** in existing formats and in new relationships.

- **Healthcare Fraud Prevention Partnership (HFPP) Enhancements**
  - The HFPP provides analysis of a **public-private dataset of professional, institutional and pharmacy claims**. This unique compilation of data allows us to detect industry-wide fraud schemes.
  - CMS has grown **the HFPP to include over 300 partners or members** across federal agencies, law enforcement, private payors, State Medicaid Agencies, and health care industry associations.

- **Public / Private Partnerships**
  - CMS is continuing to develop partnerships with Accountable Care Organizations (ACOs), Supplemental Plans, and industry compliance leaders to **further develop collaboration and outreach**

CMS' Crushing Fraud Chili Cook-Off Competition!

This August, CMS launched the **Crushing Fraud Chili Cook-Off Competition,** a market-based research challenge aimed at **harnessing explainable artificial intelligence (AI),** specifically machine learning models**,** to detect anomalies and trends in Medicare claims data to better identify fraud. The competition will take place in two phases:

Phase 1 Takeaways:

- CMS invited research proposals from all interested parties. Following the evaluation period, **10 teams were selected to advance to Phase 2** and notified on October 20th
- **237 unique organizations** from 34 states and DC submitted Phase 1 proposals, including government contractors, analytic/tech companies, and academic institutions
- Submissions included a range of novel applications of AI, including Agentic AI, anomaly detection, and time series models

Phase 2:

- Phase 2 participants will be publicly announced following the government shutdown
- Final submissions will be due December 1, 2025, at 11:59 PM ET
- **CMS anticipates announcing the challenge winner on December 15, 2025**

CMS will be releasing a **white paper with Chili Cook-Off results and lessons learned** in late 2025

Questions & Answers


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