

Written Testimony of  
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Before the United States House of Representatives Committee on Ways and Means

Hearing on “Protecting Patients and Taxpayers: Cracking Down on Medicare Fraud”

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## **Introduction**

Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to testify at this hearing on fraud, waste, and abuse in Medicare.

My name is David Klebonis. I serve as the President and Chief Operating Officer for Palm Beach Accountable Care Organization (PBACO). I am also a member of the National Association of Accountable Care Organizations (NAACOS) and participate in the Center for Medicare and Medicaid Services’ (CMS’) Healthcare Fraud Prevention Partnership.

PBACO provides independent physicians with the tools, support services, and incentives to thrive without giving up control of their practices to health systems, hospitals, and private equity. Today, PBACO partners with 15,000 clinicians across 30 states to coordinate care for more than 825,000 patients across Medicare, Medicare Advantage, and commercial value-based programs. PBACO also collaborates with like-minded hospital systems and care centers to create a seamless, integrated experience that improves outcomes and lowers costs.

Since inception in 2012, PBACO has been one of the most successful participants in the Medicare Shared Savings Program (MSSP). Collectively, our clinicians have reduced Medicare spending by more than \$936 million and consistently produced high quality scores. In Performance Year 2021, PBACO achieved a perfect quality score and was ranked first nationally among 475 MSSP ACOs in shared savings. PBACO has been ranked first in shared savings in five of the last nine performance years, specifically 2016, 2018, 2019, 2020, and 2021. Our clinical results drive that performance. In Performance Year 2024, our poor control rate for diabetes (HbA1c greater than 9) was 7.16 percent compared with the program’s benchmark of 28.04 percent (a lower score indicates higher performance). In that same year, our blood pressure control rate was 90.01 percent compared with the program’s benchmark of 66.78 percent (a higher score indicates higher performance).

As an ACO that takes on full financial and clinical accountability for our beneficiaries’ wellbeing and health outcomes, PBACO sees itself as a protector of the Medicare Trust Fund and partners to patients and their families in navigating care. Unfortunately, our ACO and participating independent practices spend far too much time identifying, tracking, and addressing fraud, waste, and abuse. In recent years, PBACO has filed hundreds of reports about suspected fraud with the CMS and the Health and Human Services (HHS) Office of the Inspector General (OIG). It is important to understand that there are different types of fraud, waste, and abuse that PBACO has uncovered.

In one case of fraud, a Medicare beneficiary was billed for high-cost wound care bandages that were never ordered, never delivered, and not medically necessary. The patient had no knowledge of the supplier and no clinical need for the product. Our team was forced to investigate, contact the patient, and submit fraud documentation. This highlights how fraudulent billing not only harms patients but also places a significant administrative burden on providers working to correct it.

This is not an isolated incident but a systematic scheme. In our network, beneficiaries have received letters referencing medical supply orders placed under the names of physicians they had never seen. In another case, the beneficiary's primary care physician confirmed there had been no encounters, referrals, nor documentation linking the patient to the ordering provider. Our ACO team's investigation determined that the provider's identity had been used without authorization. Expanding the analysis across our network, PBACO identified similar billing patterns across multiple patients, with the same supplier, the same high-reimbursement codes, and similar dates of service. Our physicians and their staff spent hours pulling claims, contacting patients, and documenting evidence – diverting time from direct patient care.

Beyond fraudulently billing for services never provided, PBACO has seen alarming trends in the provision and reimbursement of products that are clinically unnecessary, representing billions in waste and abuse as reported by the Administration's OIG.<sup>1</sup> These billing practices are often predatory, targeting patients that are facility-based and they are simply not given the choice between products such as skin substitutes that cost thousands of dollars per square centimeter versus standard dressings that cost a few dollars per unit. If Medicare is the only coverage these patients have, they then get stuck with coinsurance that represents 20 percent of the cost for these expensive products. PBACO does not encounter these challenges with our Medicare Advantage and commercial payers, as their policies typically prohibit the reimbursement of these skin substitutes which they deem to be experimental in nature, or they employ prior authorizations to control the waste and abuse.

The ACO model is built around accountability, but this accountability needs to go both ways. PBACO and its clinicians are working to help protect Medicare from unnecessary spending, but ACOs should also be protected from being financially accountable for fraud, waste, and abuse that is outside our control.

Additionally, the federal government must do more to proactively stop the bad actors who form companies solely for the purpose of fraudulently billing medical supplies.

### **ACOs are on the Frontline of Identifying Fraud, Waste, and Abuse**

ACOs are strong stewards of the Medicare program and serve as key partners to CMS in identifying fraud, waste, and abuse. Over the past two decades, the shift toward alternative payment models (APMs) has enabled providers to collaborate more effectively and invest in critical infrastructure to improve patient care.

ACOs exemplify this success. They have generated more than \$34 billion in gross Medicare savings since 2012 and \$13.5 billion in net savings to taxpayers after shared savings payments, while outperforming traditional Medicare on key quality measures, including preventive care, reduced hospitalizations, and

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<sup>1</sup> <https://oig.hhs.gov/reports/all/2025/medicare-part-b-payment-trends-for-skin-substitutes-raise-major-concerns-about-fraud-waste-and-abuse/>

fewer avoidable readmissions.<sup>2,3</sup> By routinely analyzing claims data to manage care and spending, ACOs detect anomalous billing patterns and report concerns to CMS and the HHS OIG. Furthermore, unlike traditional Medicare fee-for-service, ACOs operate under risk-based or shared-savings models that incentivize the delivery of high-quality, appropriate care while controlling costs – an approach that is essential for ensuring medically necessary services are provided and avoiding wasteful or inappropriate care for both patients and the federal government.

PBACO has identified multiple large-scale instances of fraudulent billing across durable medical equipment (DME) categories, most notably involving urinary catheters and large wound care bandages. In both cases, the patterns were consistent and deeply concerning. Medicare beneficiaries were billed for products that were never ordered by a treating provider, never delivered to the patient, and did not meet a legitimate medical need. Through ongoing claims analysis, PBACO observed rapid and disproportionate increases in utilization tied to a small number of suppliers. These suppliers often billed a narrow set of high-cost codes at extremely high volumes over short periods of time, with no corresponding clinical activity.

The scale of this activity in our network is substantial and accelerating. As of March 31, 2026, PBACO has formally submitted 289 suspected fraudulent DME companies to the Unified Program Integrity Contractor and the HHS OIG, with 13 additional companies currently in the attestation pipeline. The vast majority are concentrated in South Florida, which the FBI's Miami Field Office has described as ground zero for health care fraud. To build these cases, PBACO's team and participating practices have collected 2,972 verbal attestations and 1,705 written attestations from patients confirming they never received the billed supplies. PBACO refers vendors to law enforcement after seven patients confirm non-receipt. Since 2020, PBACO has reported more than \$112 million in paid claims representative of suspicious Part B DME billing within its network (see Appendix A, CPT Analysis). This represents nearly \$112 million in suspected fraud that has been charged to PBACO as expenditures. Based on a claims analysis from 2022 to 2025 comparing identified suspected fraud and Medicare recoupments or reversals, less than 18 percent of the suspected fraud reported by PBACO was reversed. Thus, over 82 percent of DME fraud is being charged against ACO financial benchmarks.

The DME fraud identified by PBACO reflects billing in several areas, including but not limited to, glucose monitors, urinary catheters, urostomy pouches, collagen-based and fiber gelling dressings, home ventilators, ultraviolet light therapy systems, speech generating devices, orthotic back braces, among others. Suspected fraud in these areas have also been reported by ACOs nationally.<sup>4</sup> NAACOS and the Institute for Accountable Care conducted a national review of Medicare claims data and found catheter-related spending for just two catheter codes increased from approximately \$153 million in 2021 to over \$2 billion in 2023. It is important to note that figures tied to DME exclude other waste and abuse categories such as skin grafts and genetic testing PBACO has identified, which are also paid under the Part B benefit.

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<sup>2</sup><https://www.naacos.com/medicare-aco-stats/>

<sup>3</sup><https://www.cms.gov/files/document/fact-sheet-ssp-py24-financial-quality-results.pdf>

<sup>4</sup><https://www.modernizeacos.org/wp-content/uploads/2026/03/Data-Brief-Impact-of-Rising-Skin-Substitute-Costs-on-MSSP-ACOs-v2.pdf>

These findings are not isolated. In collaboration with the ACO community, we have observed numerous fraudulent trends. In 2024 and 2025, ACOs have identified a dramatic rise in Medicare payments for skin substitutes. Spending increased from \$1.6 billion in 2022 to more than \$10 billion by the end of 2024, with NAACOS projecting \$16.4 billion in 2025.<sup>5</sup> This spending increase far exceeded clinical expectations. In one case, PBACO identified a patient associated with over \$9.8 million in Medicare-paid claims for skin substitutes. This was not driven by life-threatening clinical necessity, but by a vulnerability in payment policy.

Much of this spending was attributed to a payment policy that CMS has since corrected, yet some are attributed to known bad actors as evidenced by Department of Justice (DOJ) actions. The owners of Apex Medical LLC were sentenced to 15.5 years and 14 years in prison, respectively, for a \$1.2 billion fraud scheme, with a separate \$309 million False Claims Act settlement.<sup>6</sup> Notably, Medicare Advantage plans spent only \$192 million on skin substitutes in Q3 2024, compared with \$2.9 billion in traditional Medicare, demonstrating that managed care controls work where fee-for-service does not. Additionally, in 2025 ACOs reported broad national suspected fraud for wound dressings, orthotics, catheters, and continuous glucose monitors.

As PBACO actively identifies fraud, waste, and abuse, our ACO operations and participating physicians make great effort to understand the issue, inform the government, and educate patients. These steps include:

- **Routine claims surveillance.** Conducting monthly and ad hoc reviews of claims data to identify abnormal billing patterns, new high-volume suppliers, and rapid utilization spikes within specific codes or regions.
- **Supplier tracking and pattern analysis.** Monitoring suspect vendors over time to identify recurring behaviors, including rapid billing escalation, concentration of specific HCPCS codes, and short operational lifespans.
- **Historical baseline analysis.** Analyzing historical claims data to establish baselines and identify sudden billing spikes tied to new suppliers.
- **Patient outreach and verification.** Directly contacting beneficiaries to confirm whether services or products were requested, ordered, or received, and documenting discrepancies.
- **Physician engagement and validation.** Collaborating with treating providers to confirm whether they ordered the billed services and to validate the absence of clinical need or documentation.
- **Attestation collection.** Coordinating both verbal and written attestations from beneficiaries and providers to formally document fraudulent activity and support escalation efforts.
- **Diagnosis cross-referencing.** Cross-referencing DME claims against the patient's actual diagnoses in their medical records. For example, verifying that a patient billed for glucose monitoring supplies has a diabetes diagnosis, or that a ventilator claim corresponds to a documented respiratory condition.
- **Corporate investigation.** Investigating supplier companies through state business entity databases, examining establishment dates, recent ownership changes, and whether the same registered agent appears across multiple suspect companies. Reviewing Better Business Bureau listings and public reviews for evidence of legitimate business operations.

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<sup>5</sup> <https://www.naacos.com/wp-content/uploads/2026/03/Data-Brief-Skin-Substitute-Costs-and-Spending.pdf>

<sup>6</sup> <https://www.justice.gov/opa/pr/wound-graft-company-owners-sentenced-12b-health-care-fraud-and-agree-pay-309m-resolve-civil>

- **Escalation and reporting.** Submitting detailed reports to CMS and the HHS OIG, including supporting documentation, patient attestations, and identified billing patterns.
- **Cross-payer fraud analysis.** Participating in CMS’ Healthcare Fraud Prevention Partnership, where PBACO contributes claims data for cross-payer fraud analysis alongside more than 310 federal, state, and private-sector partners.
- **Practice education and watchlist distribution.** Educating participating practices on how to recognize suspicious billing activity, respond to patient concerns, and properly escalate potential fraud. Distributing active watchlists of suspected DME suppliers to our participating practices so physicians can proactively flag suspicious billing in their patient panels.
- **Patient education.** Educating patients on how to recognize and report suspicious DME activity, including review of Explanation of Benefits statements.
- **Cross-organizational collaboration.** Working with national organizations, such as NAACOS and other ACOs, to identify broader trends and share intelligence on emerging fraud schemes.
- **Ongoing monitoring and follow-up.** Continuously tracking flagged suppliers and claims activity to determine whether billing persists, shifts, or reappears under new entities.

These activities require significant administrative coordination and clinical involvement, often diverting time and resources away from direct patient care. They are necessary to protect beneficiaries and uphold the integrity of the Medicare program in the absence of more proactive system-level controls. While these efforts have contributed to broader enforcement actions, they also highlight a fundamental gap in the current system: fraudulent claims are often paid before they are identified, placing both patients and providers in a reactive position.

The efforts of ACOs have significantly contributed to CMS’ efforts to crush fraud. A clear example is Operation Gold Rush.<sup>7</sup> This was part of the 2025 National Health Care Fraud Takedown, which exposed a massive transnational scheme responsible for \$10.6 billion in fraudulent catheter and DME billings submitted to Medicare. According to CMS, approximately \$4.45 billion was on track to be paid, but CMS’ advanced data analytics capabilities detected anomalous billing patterns early and intervened before funds were disbursed. As a result, all but roughly \$41 million of those scheduled payments were successfully blocked, with billions held in escrow accounts that were returned to the Medicare Trust Fund. This is a real success story where fraud prevention helped stop billions of dollars in fraudulent payments. Operation Gold Rush shows how CMS is moving away from a “pay-and-chase” model toward a more proactive, data-driven approach. Advanced analytics helped CMS and law enforcement detect suspicious billing patterns early and stop improper payments before they went out the door. It is also a case study in how data produced by ACOs through analysis of utilization patterns plays a central role in safeguarding taxpayer dollars and strengthening program integrity.

### **Protect ACOs from Waste, Fraud, and Abuse**

The ACO model is established around accountability, but that accountability must be mutual. At PBACO, physicians are actively working to reduce unnecessary Medicare spending and identify inappropriate billing. They should not be held financially responsible for fraudulent activity that falls outside their control.

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<sup>7</sup> <https://www.cms.gov/newsroom/press-releases/national-health-care-fraud-takedown-results-324-defendants-charged-connection-over-14-6-billion>

In the examples of catheter fraud, the failure was not detection but rather communication and coordination. CMS was successful in stopping payments on more than 99 percent of the fraudulently billed claims. However, from the perspective of ACOs, clinicians, and patients, those claims still appeared to be paid. Based on PBACO's reading of the indictment, the DOJ required CMS to continue paying claims into escrow during the investigation. Despite PBACO's best efforts, and those of our fellow ACOs to regularly report suspicious claims to CMS and HHS OIG, PBACO did not receive timely confirmation from government officials that those reports were reviewed or addressed.

This gap has major implications for patient care and the viability of accountable care. Increased spending due to unexpected waste, fraud, and abuse threatens commitment to value-based care because ACOs would potentially have a significant reduction in shared savings or owe the government shared losses due to fraud, waste, and abuse outside of their control. Without stronger intervention from CMS, ACOs will continue to be held accountable for costs tied to suspected or confirmed fraud, even in cases where they have identified and reported the issue. This dynamic undermines the integrity of accountable care and may discourage participation in two-sided risk arrangements.

Medicare's Serious, Anomalous, and Highly Suspect (SAHS) policy is intended to correct this issue and represents an important step forward, but its current scope is too limited.

- The policy does not account for regionalized instances of fraud. PBACO identified a regionally concentrated surge in billing for large wound care bandages driven by a small number of suppliers operating within a limited geographic area. These suppliers billed high volumes of claims over a short period of time, often without any associated physician orders, clinical encounters, or confirmed delivery of the products to beneficiaries. While this pattern was clearly anomalous at the regional level and consistent with fraudulent billing behavior, it did not initially meet national thresholds for classification as SAHS. As a result, these claims continued to flow through the system and remained included in ACO expenditures.
- It is difficult to account for areas of waste and abuse within the permanent mechanisms. While CMS has taken important steps recently to protect the vast majority of ACOs from overpayment for skin substitutes, 10 percent of ACOs remain harmed and a permanent approach is needed.
- The process can be slow. CMS allows ACOs to request a reopening of payment determination as a pathway for removing fraud from their accountability, however, this puts the onus on ACOs to prove the payments are improper. The process is delayed and retrospective, requiring ACOs to bear financial losses while waiting for review. PBACO recently received a recoupment payment from CMS in the amount of \$1,188,710 on March 27, 2026. This delay means that PBACO was unable to invest those funds in physician payment and patient care for work already performed.

PBACO asks this Committee to build on that leadership and work with CMS to address the challenges with straightforward policy solutions:

- Implementing standardized reporting pathways and a consistent feedback loop, including acknowledgment of submissions and status updates. Timely notification of high-confidence fraud would allow ACOs to act more quickly to protect beneficiaries and limit improper payments.
- Removing claims that are not fully adjudicated, such as those held in escrow, from ACO financial calculations.
- Removing suspected fraudulent claims, such as claims submitted by vendors under investigation, claims from vendors referred to law enforcement, or claims for which there is no referring provider.

- Improving data sharing to help ACOs identify improper payments, including when suppliers are removed from the program.
- Adapting the SAHS policy to account for regionalized instances of fraud and abuse that results from flaws in payment policy.

Absent these changes, ACOs may continue to bear financial responsibility for improper spending they cannot control.

### **Proactively Stopping Fraud, Waste, and Abuse**

Since ACOs operate in traditional Medicare, they lack key tools available to Medicare Advantage plans, such as prior authorization, scalable pre-payment review, network controls, and the ability to rapidly suspend suspect suppliers. This limits our ability to directly prevent improper billing before it affects beneficiaries and taxpayers. The federal government must do more to proactively stop the bad actors.

High-risk areas like DME illustrate this challenge clearly, with billing patterns that often lack clear clinical justification or appropriate provider involvement. The companies PBACO have flagged share a consistent profile. They are recently established entities, often incorporated within the past 12 to 24 months. They bill a narrow set of high-reimbursement codes at extremely high volume (e.g., glucose monitoring supplies, orthotic braces, and wound care products) for a short operating window before disappearing. Many lack any physical presence, have no patient reviews, and show recent ownership or registered agent changes on state business entity filings. When PBACO cross-references claims against patients' medical records, PBACO routinely finds mismatches such as glucose monitoring devices billed for patients without a diabetes diagnosis, ventilator supplies for patients without COPD, and orthotic braces for patients who never visited the ordering provider.

PBACO, our participating practices, and the broader ACO community consistently identified the following indicators of fraud:

- Claims submitted without any associated physician order or related clinical encounter.
- Patients reporting that they never requested or received the billed products.
- Billing for medically unnecessary or clinically inappropriate items.
- Suppliers that bill a disproportionate share of national spending for certain codes.
- Suppliers that bill a narrow set of codes at high volume for a short period, typically a few quarters.
- Use of newly enrolled or short-lived supplier entities that rapidly scale billing and then disappear.
- Concentrated billing patterns within specific geographic regions or patient populations.

PBACO applauds CMS for their recent actions to mitigate DME-related risks. In particular, the six-month nationwide moratorium on new supplier enrollments effective February 27, 2026, the CRUSH Request for Information, and consideration of stronger surety bond requirements are a good first step. As policymakers consider additional program integrity strategies for high-risk providers, several targeted approaches warrant consideration:

- Provide more timely, actionable data. This would enable ACOs to identify and mitigate suspect billing earlier, improving both cost control and patient protection, as inaccurate claims can delay or prevent access to necessary care.
- Increase transparency by confirming whether services were ordered by a treating clinician, this would strengthen oversight and care coordination.

- Ensure beneficiaries receive clear notification of billed services and have a simple process to correct inaccuracies, while allowing clinicians to attest when services were not ordered.
- Expand pre-payment edits, strengthen documentation requirements, and enhance supplier enrollment and monitoring.
- Establish a clear definition of improper payments tied to known fraudulent actors.

## Conclusion

PBACO is not asking to be exempt from accountability. PBACO is asking to be deputized. The ACOs who detect fraud need to be connected to the tools and information CMS uses so they can prevent improper payments before they happen. The \$4.45 billion CMS prevented on Operation Gold Rush proves the detection loop works. Extend it.

PBACO is committed to improving quality and reducing unnecessary spending in Medicare. On behalf of PBACO and our 15,000 clinicians, I urge Congress to work with CMS to strengthen collaboration with ACOs through improved information sharing, enhanced program integrity tools, and appropriate financial protections.

## Appendix A, CPT Analysis

DME Category	Distinct HCPCS Codes	Total Units (Volume)	Total Paid Amount (\$)	Avg Paid per Unit (\$)
Wound Dressings	21	13,327	\$48,371,531	\$3,629.59
Urological Supplies	10	10,339	\$43,998,249	\$4,255.56
Orthotics & Braces	49	10,613	\$8,605,037	\$810.80
Diabetic Monitoring Supplies (CGM, testing)	5	7,874	\$5,376,556	\$682.82
Respiratory Equipment	6	2,778	\$2,903,964	\$1,045.34
Other DME	7	1,994	\$1,095,787	\$549.54
Ostomy Supplies	1	233	\$616,341	\$2,645.24
Prosthetics	1	129	\$150,956	\$1,170.20
Bone Growth Stimulators	1	284	\$113,456	\$399.49
Wheelchairs	2	40	\$62,509	\$1,562.72
Mobility Aids (canes, walkers, POVs)	5	38	\$34,497	\$907.82
Enteral Nutrition	5	108	\$18,751	\$173.62
NPWT	2	23	\$5,455	\$237.16
Walking Boots	1	3	\$1,002	\$334.05