

A report to the Chairman, Special Committee on Aging, United States Senate

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What GAO Found

GAO has designated Medicare a high-risk program due, in part, to its complexity and potential for fraud. Fraud schemes in traditional Medicare often focus on certain services, such as durable medical equipment. Fraudsters may use stolen or inappropriately obtained Medicare beneficiary identifiers to submit fraudulent claims for unneeded or never provided services.

The Centers for Medicare & Medicaid Services (CMS), which oversees Medicare, uses data analytics on claims in traditional Medicare to identify anomalous patterns indicative of emerging fraud schemes and potentially fraudulent behaviors, such as billing spikes. CMS uses these analytics to develop leads for investigations and to inform administrative actions that can prevent potentially fraudulent payments, such as suspending provider payments. For example, in 2023 and 2024, CMS suspended payments to, and later revoked the enrollment of, 15 providers involved in a scheme that allegedly billed Medicare for more than \$4 billion in urinary catheters that were never supplied. Selected private payers GAO spoke with reported using data analytics in ways similar to CMS—namely, to identify anomalous provider billing patterns to generate leads for investigations and to inform actions like payment suspensions.

CMS estimates that from fiscal years 2022 through 2024, it prevented a total of \$11.9 billion in potentially fraudulent Medicare payments by taking administrative actions on providers engaged in potential fraud.

Administrative Actions and Estimates of Potentially Fraudulent Payments Prevented by CMS, Fiscal Years 2022 through 2024

Administrative action	Prevented payments (in millions)
Prepayment claims reviews	\$27
Automated prepayment denials	\$132
Overpayment recoveries	\$652
Payment suspensions	\$2,579 ^a
Revocations and deactivations	\$7,962 ^a
Law enforcement referrals	\$554 ^b
Total	\$11,906

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-26-107799

Note: For more details, see Table 3 in GAO-26-107799.

^aProjected amount of potentially fraudulent payments prevented based on estimated cost avoidance.

^bEstimated amount in financial judgments that courts may order on behalf of Medicare.

In December 2025, CMS began sharing information about Medicare provider payment suspensions with supplemental payers—private plans and state Medicaid agencies that cover certain Medicare beneficiaries' out-of-pocket expenses. CMS did not share such information previously. This lack of information sharing led some supplemental payers to pay beneficiary cost sharing on potentially fraudulent claims. Representatives of private payers estimated that private plans may have paid tens of millions of dollars in beneficiary cost-sharing for the urinary catheter scheme. GAO's analysis found that state Medicaid agencies paid at least \$196,000 in state and federal funds for cost-sharing payments for the urinary catheter scheme in 2023 and 2024.

Why GAO Did This Study

CMS is responsible for ensuring the integrity of the Medicare program and preventing and mitigating potential fraud.

GAO was asked to review CMS's use of data analytics to prevent and reduce fraud in traditional Medicare. This report describes characteristics of common Medicare fraud schemes, CMS's use of data analytics to identify Medicare fraud, and CMS's estimates of potentially fraudulent payments it prevented; and examines the extent to which CMS shares information on payment suspensions with relevant entities.

GAO reviewed CMS documentation on its activities to prevent fraud and interviewed CMS officials and program integrity contractors that investigate Medicare fraud about common Medicare fraud schemes and their use of data analytics. GAO also analyzed CMS data on administrative actions and the extent of potentially fraudulent payments prevented for fiscal years 2022 through 2024. Data from 2024 were the most recent data available at the time of GAO's review.

For additional context on CMS's use of data analytics, GAO interviewed representatives of selected private health insurers and two organizations representing private payers about their use of data analytics. GAO also interviewed CMS officials and private payers about the sharing of information on payment suspensions with supplemental payers.

The Department of Health and Human Services provided technical comments, which GAO incorporated as appropriate.