Medicare Advantage Fraud, Waste, and Abuse Policy Options

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Contents

INTRODUCTION

By providing benefits through private plans, the Medicare Advantage (MA) program has the potential to make care delivery more efficient and to reduce costs through market competition and innovation. The MA program addresses some challenges faced by Traditional Medicare (TM). However, the MA approach of paying plans a capitated amount to deliver Medicare benefits in lieu of the government paying for care directly presents some oversight challenges and some fraud, waste, and abuse (FWA) compliance challenges and risks that differ from TM. These risks can lead to increased program costs and burden for providers, reduced access to care for enrollees, poor-quality care, and in some cases, direct harm to enrollees.

Purpose of This Study

There are many options for reducing FWA in MA, ranging from policy changes to oversight actions that target different parts of the program. However, there is no comprehensive summary of the available options and their implications for FWA that policymakers can use to develop evidence-informed strategies to prevent and reduce FWA. This study focused on issues that are most closely related to the demonstrated FWA risks with clear impacts on the MA program. Although there are also risks of FWA that are initiated by providers, suppliers, and beneficiaries, those risks are similar across MA and TM. Because of this, we instead focus on options to mitigate FWA risks that are more specific to the MA program and to the actions of MA organizations. While there have been documented instances of FWA, we are not accusing all MA organizations of FWA; we are simply noting that FWA risks exist and therefore could be exploited by bad or careless actors working within the program's existing system of regulations and incentives.

Definitions of Fraud, Waste, and Abuse

To guide this work, our study started with the definitions of FWA from the Centers for Medicare & Medicaid Services (CMS).[1] These definitions often assume a TM payment environment so we have extrapolated the current definitions to define how they apply to MA. Because fraud carries the most serious repercussions and is well-defined in statute, it is likely to be relatively uncommon. Per CMS definitions, Medicare fraud typically includes any of the following:

- "Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, or paying remuneration (e.g., kickbacks, bribes, or rebates) to induce or reward referrals for items or services reimbursed by federal health care programs
- Making prohibited referrals for certain designated health services."[2]

An example of fraud in MA is an MA organization intentionally and knowingly submitting a diagnosis for a condition a patient does not have to obtain larger payments.

Most of the issues we have identified in the MA program can be considered waste. CMS has defined waste is "the overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to the Medicare program ."[3] Waste is generally not due to criminal negligence but involves misuse of resources such as ordering excessive diagnostic tests.[4,5] CMS's definition focuses on the actions of stakeholders in the program (e.g., MA organizations and health care providers) and differs from other views of waste, which may include value judgements on government policy choices that have cost implications at the program level.[6] This study uses a definition of waste that includes actions by MA organizations and their affiliates that can contribute to waste but excludes program-level topics such as poorly defined benefits or higher spending on MA relative to traditional Medicare. Examples of waste in MA include excess spending on programs such as capturing diagnosis codes or marketing in pursuit of higher payments or more enrollments, thereby diverting resources away from health care delivery.

Medicare abuse is similar to fraud but may not involve *intentional* misrepresentation of facts to obtain payment. CMS defines abuse as including "actions that may, directly or indirectly, result in: unnecessary costs to the Medicare Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary".[7] In MA, instances of abuse may reduce costs to the MA organization and/or increase costs to Medicare. Examples include practices that prevent or delay patients from receiving covered services that are medically necessary such as overuse of prior authorization or misrepresentation of provider networks, making it difficult for enrollees to access care.

Report Structure

This report's findings are presented in nine stand-alone chapters. In each chapter, we describe the policy context for a topic and a set of associated FWA risks. We then describe mitigation

options through policy and oversight activities and the strengths and weaknesses of those options. The chapters cover the following:

- Coding Intensity
- Favorable Selection
- Star Ratings and the Quality Bonus Program
- Network Adequacy and Misrepresentation of Provider Networks
- Cost Shifting to the Veterans Health Administration
- Enrollment, Agents, and Brokers
- Prior Authorization and Other Utilization Management Approaches
- Vertical Integration
- Dual Eligible Special Needs Plan (D-SNP) Look-alikes

Methods

We examined the peer-reviewed and gray literature to identify policy options and oversight approaches to address select risks for FWA in Medicare Advantage. The selected FWA risks include coding intensity; favorable selection; Star Ratings and the Quality Bonus Program; network adequacy and misrepresentation of provider networks; cost shifting to the Veterans Health Administration; enrollment, agents, and brokers; prior authorization and other utilization management approaches; vertical integration; and Dual Eligible Special Needs Plan (D-SNP) look-alike plans. For each risk topic, we identified search terms. For example, for network adequacy and misrepresentation of provider networks we used the following terms: "Medicare Advantage" AND network AND (ghost OR misrep* OR inaccur* OR nonexistent OR incorrect OR non-existent). Using the search terms for each risk topic, we conducted searches using PubMed, Google, the Federal Register, the CMS website, and news media websites (e.g., STAT News, *The Wall Street Journal*) to locate information about policy options related to FWA in Medicare Advantage. We applied the following exclusion criteria to our search:

- Published before July 1, 2015;
- Did not discuss a new policy or oversight option;
- Was not relevant to MA;
- Was not relevant to the FWA risk topic of interest; and
- Was a duplicate of another included source.

Because our aim was to identify the most salient policy and oversight options, we designed our search strategy to reach a saturation point as quickly as possible. We reviewed search hits in the order they appeared, which was generally by relevance. For each hit, we determined whether the resource met the exclusion criteria; and if it did not, we abstracted a summary of the proposed policy or oversight option and any additional information on the stated policy goals, applicable FWA areas, cost impacts, implementation considerations, strengths, weaknesses, gaps, questions, and debates around the policy. If the article cited another primary source (e.g., a proposed rule, bill, or policy paper), we then retrieved and abstracted information from that primary source. Once we reached a point where 20 search results in a row on a given FWA risk topic did not produce any new policy or oversight options, we considered the topic to be saturated and did not review additional sources. After completing the literature review, we combined all information about each policy option, added material as needed (e.g., additional policy options not raised by any sources but proposed by the research team or reviewers, or our understanding of implementation requirements), and summarized the results for each policy or oversight option.

Findings

In this section, for each topic, we describe the FWA risk, the current policy and oversight approach, and details on additional options based on the literature review and research.

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TOPIC: STAR RATINGS AND THE QUALITY BONUS PROGRAM

Background

CMS introduced the Medicare Advantage (MA) Star Rating system as a mechanism for providing beneficiaries with information about the clinical quality, administrative capability, and patient experience one could expect as an enrollee in an MA plan.[1] The Star Rating system evaluates plans on a 1 to 5 scale based on quality, member experience, and performance.[2] Star Ratings are available on the medicare.gov Plan Finder website and enable beneficiaries to make comparisons across plans.[3]

Key Points

- High star ratings increase payments to MA plans through increased rebates and benchmark bonuses but are not always associated with better care quality or beneficiary experience.
- Incentives for MA organizations to increase star ratings, coupled with shifting cut points and lack of downside risk and potential to game measures, may produce FWA risks.
- Mitigation strategies include increased and aligned oversight of star rating operations, the application of budget neutrality, changes to the QBP measure set and weights, and quality assessments at the local level.

In 2012, the Patient Protection and Affordable Care Act established the MA Quality Bonus Program (QBP). QBP is based on the five-level Star Ratings system, and increases Medicare payments to MA plans in two distinct ways: rebates and benchmark bonuses. Capitated, per-beneficiary-per-month (PBPM) payments to MA plans are based on a comparison of a plan's estimated cost of providing Medicare-covered services (referred to as a bid) relative to the maximum amount the federal government will pay for an MA enrollee (referred to as a benchmark).[4,5] A benchmark is a percentage of estimated spending in traditional Medicare in the same county, ranging from 95% in high-cost counties to 115% in low-cost counties.[6] If a plan's bid is less than the benchmark, its PBPM payment equals its bid plus a rebate.[7] The rebate amount is directly dependent on plan quality (i.e., the plan's Star Rating) and ranges from 50% to 70% of the difference between the bid and the benchmark.[8] Contracts with 3.0 or fewer stars keep 50% of the difference between their bid and the benchmark as a rebate, contracts with 3.5 or 4.0 stars keep 60%, and contracts with 4.5 or 5.0 stars keep 70%.[9] Medicare retains the residual, or the portion of the difference between bid and benchmark not given to the plans in the form of

rebates.[10] If a plan's bid is more than or equal to the benchmark, Medicare's PBPM payment to the plan will be the benchmark amount and each enrollee will therefore pay an additional premium, equal to the amount by which the bid exceeds the benchmark.[11] Rebates must be spent on supplemental benefits, lower premiums, or reduced cost sharing for enrollees.[12] Consequently, the higher a plan's Star Rating rebate, the more revenue a plan has to increase benefits or reduce cost sharing without charging a supplemental premium to the beneficiary.[13]

In addition, the county benchmark for MA contracts with Star Ratings of 4, 4.5 or 5 is increased by 5% as a quality bonus, allowing these contracts to submit higher bids relative to these higher benchmarks and ultimately increase their rebates.[14] Benchmarks for plans with 4 or more stars operating in bonus counties, defined as urban counties with low traditional Medicare spending and historically high Medicare Advantage enrollment, are increased by 10%.[15] Revenues from higher benchmarks due to Star Rating bonuses do not need to finance extra benefits and can be allocated as profit or administrative expenses.[16] Further, five-star contracts can offer year-round enrollment instead of being limited only to Medicare's annual open enrollment period, removing a barrier to entry for potential members.[17]

To illustrate the impact of Star Ratings on payments to MA plans, consider the following example adapted from Xu et al. Three MA plans are operating in the same county. That county's benchmark is $1,000 per member per month, and each plan submitted an $800 bid. Plan A has a 3-star quality rating, Plan B has a 4-star rating, and Plan C has a 5-star rating. Plan A's quality-adjusted, risk-adjusted benchmark remains $1,000. Because plans rated below 3.5 stars receive 50% of the difference between the adjusted benchmark and the bid as a rebate, Plan A receives a $100 rebate for a total payment of $900. Four-star rated Plan B's quality-adjusted, risk-adjusted benchmark is increased by 5% to $1,050. In addition, Plan B receives 65% of the difference between the adjusted benchmark of $1,050 and the $800 bid, resulting in a $162.50 rebate and a total payment of $962.50. Lastly, Plan C's quality- and risk-adjusted benchmark is also $1,050. However, Plan C receives 70% of the difference between the adjusted benchmark of $1,050 and the $800 bid, resulting in a $175 rebate and a total payment of $975.[18] Further illustrating the financial importance of Star Rating performance, several insurers sued CMS in 2024 seeking corrections to their contracts' Star Ratings. One insurer claimed that having an overall Star Rating of 3.5 instead of 4 on a contract cost them $375 million in bonus payments for 2025.[19]

CMS measures the quality of Medicare health and drugs plans annually through the MA Star Ratings system. The system is intended to incentivize plans to provide high-quality care, as described above, and to help people to compare the available MA plans and make informed enrollment decisions. For 2025, and affecting 2026 MA Quality Bonus Payments, MA contracts that include Part D prescription drug plans (PDPs) were rated on up to 40 quality and

performance measures; MA-only contracts (without PDPs) were rated on up to 30 measures; and PDP-only contracts were rated on up to 12 measures. CMS classifies measures into six categories as follows:[20]

- Outcome measures reflect improvements in a beneficiary's health status.
- Intermediate outcome measures reflect actions to assist in improving a beneficiary's health status, such as the "Diabetes Care – Blood Sugar Controlled" measure.
- Patient experience measures reflect beneficiaries' perspectives of care received, such as getting needed care, access to appointments, and customer service.
- Access measures reflect processes and phenomena that could create barriers to receiving needed care, such as the "Plan Makes Timely Decisions about Appeals" measure.
- Process measures capture health care services provided to beneficiaries to assist in maintaining, monitoring, or improving their health status.
- Improvement measures are derived through comparisons of a contract's current and prior-year measure scores. A contract must meet certain requirements to receive a Star Rating in the improvement measures. For example, a contract must have measure scores for both years in at least half of the required measures used to calculate the Part C improvement or Part D improvement measures.

Each measure receives a numeric score (or an assigned "missing data message") that is converted into a Star Rating. Measure Star Ratings are then combined into three groups (Domain, Summary, and Overall) and each group is assigned 1 to 5 stars.[21] Examples of Part C domains include "Staying Healthy: Screenings, Tests, and Vaccines," "Managing Chronic (Long Term) Conditions," and "Member Experience with Health Plan."[22] A domain rating is the average, unweighted mean of the domain's measure stars.[23] The summary and overall ratings are calculated as weighted averages of the measure stars.[24] For the 2026 Star Ratings, CMS assigns the highest weight to improvement measures, followed by outcome and intermediate outcome measures, then patient experience/complaints and access measures, and finally, the lowest weight is assigned to process measures.[25] New measures included in the Star Ratings are given a weight of 1 for their first year of inclusion; in subsequent years the weight associated with the measure weighting category is used.[26] Notably, CMS can change both the measures included in the Star Ratings system and the weight assigned to measure categories year over year. For example, the weight of the patient experience, complaints, and access measures decreased from 4 to 2 between 2025 and 2026. Further, the Part C Kidney Health Evaluation for Patients with Diabetes measure moved into the 2026 Star Ratings as a new measure with a weight of 1.[27]

Data used to determine Star Ratings come from four source categories: (1) data collected by CMS contractors, (2) CMS administrative data, (3) health and drug plans, and (4) surveys of enrollees.[28] For each measure, CMS establishes thresholds or "cut-points" that are used to determine each contract's performance for that measure, expressed as a 1-, 2-, 3-, 4- or 5-star rating.[29] Numeric measure scores are converted into Star Ratings through a clustering method or, for Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey measures, relative distribution and significance testing. As described by CMS, "The clustering algorithm identifies the 'gaps' among the scores and creates four cut points resulting in the creation of five levels (one for each Star Rating). The scores in the same Star Rating level are as similar as possible; the scores in different Star Rating levels are as different as possible."[30] Cut points separating the five levels may change from year to year, creating shifting performance targets and distributions of scores.[31] Notably, CMS measures Star Ratings at the MA contract level to ensure an adequate sample size and retrospectively determines the cut points used to compare contract performance. MA contracts can cover large multi-state geographic areas.[32]

Potential for FWA

QBP Effectiveness and Resource Allocation

Despite major budget outlays on behalf of the federal government and significant investments by plans, some researchers found that the QBP is not associated with improvements in plan quality.[33] Meyers et al. concluded that "exposure to a higher rated Medicare Advantage contract does not appear to convey any improved enrollee reported outcomes. For both the health status measures and the patient contract experience measures, increased Star Ratings did not consistently lead to any improvements."[34] Similarly, findings suggest that increased bonuses given to MA plans with relatively high-quality performance operating in eligible counties do not improve quality and distort the distribution of Medicare funds.[35,36] Diversion of plan resources toward strategies aimed at boosting Star Ratings without commensurate quality improvement and enhanced beneficiary experience represents a risk of waste. Iterative changes by different administrations have created complexity and inconsistency, resulting in a less coherent, long-term Star Rating strategy that may not effectively support quality programs. This may have led to wasteful spending by plans to frequently change their Star Rating policy implementation approaches.

High Reward Without Downside Risk

The QBP is a reward-only program that does not limit how many plans can be highly rated by enforcing a normal distribution. As such, the program is financed through additional payments, does not impose financial penalties on low-performing contracts, and the amount paid to plans because of Star Rating performance (via increases to county benchmark amounts and rebates) is not constrained.[37,38] The financial and operational benefits of achieving relatively high Star

Ratings for MA insurers are significant. To illustrate, MA insurers received $10 billion in QBP payments in the form of additional allocated funds in 2022, representing a sizable source of revenue.[39] Federal spending on MA bonus payments tied to Star Ratings is consistently increasing. MA QBP payments totaled at least $12.7 billion in 2025, which is similar to 2023 spending, and more than four times higher than spending in 2015. Since 2015, Medicare has spent at least $87 billion on QBP payments.[40] MA organizations may be incentivized, by potential payment increases and lack of downside financial risk, to engage in activities aimed at optimizing Star Ratings, and some of these activities may carry risks of FWA. These risks may be exacerbated by CMS's decision not to implement the Excellent Health Outcomes for All reward for the 2027 Star Ratings and continue the historical reward factor,[41] making it easier for highly rated plans to maintain high ratings.

Shifting Cut Points

As described earlier, QBP performance is determined by comparing contract performance relative to other contracts, instead of comparing performance to predetermined targets.[42] CMS has indicated that this approach incentivizes continuous quality improvement, reduces misclassification of a contract's performance, and also allows cut points to adapt to significant external events that could affect overall plan performance (such as those that occurred during the COVID-19 pandemic).[43] However, MA organizations do not definitively know the definitions of success, in the form of cut points, in advance of a measurement year. Because of the outsized impact of performance that just meets a threshold,[44] MA organizations may direct resources toward predictive modeling and other techniques to determine potential measure cut points.[45] Similarly, they may be incentivized to direct outsized resources toward influencing a few marginal cases to reach a cut point associated with a significant increase in payments.

Large Contracts and Impact on Beneficiary Decision-Making

Because Star Ratings are determined at the contract level, larger, multistate contracts may obscure meaningful beneficiary information. There is a risk that beneficiaries may misinterpret Star Ratings as a localized indicator and predictor of quality, plan performance, and access to care.[46,47]

Potential to Game Star Ratings Measures

MA organizations could selectively misreport some plan-reported measures, particularly by manipulating which beneficiaries are included in the numerator or denominator of Healthcare Effectiveness Data and Information Set (HEDIS) measures. To illustrate, a validation study of the HEDIS quality readmission measure using MA encounter data found that readmission rates were statistically significantly higher in encounter data than in HEDIS data, and this difference was associated with the underreporting of index admissions in HEDIS.[48] This finding demonstrates that there is a risk for misreporting HEDIS measures.

Fragmented oversight and variation in requirements applied to different Star Rating data sources (e.g., CAHPS and the Health Outcomes Survey [HOS]) creates a risk for plans to engage in strategies to influence the data that are reported, particularly enrollee survey data results. For example, insurers may attempt to influence enrollee selection for and responses to the CAHPS survey instrument via Do Not Survey lists, pre-CAHPS communication, and preconditioning strategies to influence survey results while circumventing oversight rules.[49,50,51] Coding intensity practices could also help MA organizations game certain measures (see also the section on coding intensity). For example, diagnosing additional marginal cases of diabetes could positively influence performance on the measure of blood sugar control among enrollees with diabetes.

Mitigation Approaches

Increase and align oversight of Star Rating operations. Different components of the Star Ratings system are subject to varying requirements and oversight methodologies, which leads to inconsistencies that may create opportunities for FWA. All health plans submit HEDIS data to the National Committee for Quality Assurance (NCQA) and must undergo a HEDIS Compliance Audit, which may only be performed by licensed organizations and certified auditors.[52] CMS uses a designation assigned by the HEDIS auditor to determine ratings. An audit designation of "biased rate" is assigned to a measure when "the individual measure score is materially biased (e.g., the auditor informs the contract that the data cannot be reported to the NCQA or to CMS)."[53] When the HEDIS auditor designates a "biased rate" to a HEDIS measure, the contract receives 1 star for the measure and the measure score is set to "CMS identified issues with this plan's data."[54] If the HEDIS summary-level data value varies substantially from the value in the patient-level data, the measure is reduced to a rating of 1 star.[55] Although this is likely a significant disincentive, additional civil monetary penalties for plans that receive "biased rate" designations from the HEDIS auditor could also be considered.

CMS-approved Health Outcomes Survey (HOS) vendors must adhere to requirements in the *Medicare Health Outcomes Survey (HOS) Quality Assurance Guidelines and Technical Specifications*.[56] CAHPS survey vendors and MA plans must adhere to requirements in the *Medicare Advantage & Prescription Drug Plan (MA & PDP) CAHPS® Survey Quality Assurance Protocols & Technical Specifications Version 16.0.*[57] Both sets of requirements include prohibitions on activities to influence or incentivize positive survey responses. For example, health plans are permitted to conduct focus groups during MA & PDP CAHPS Survey administration but "the MA & PDP CAHPS Survey Project Team strongly discourages health plans from asking any questions contained in the MA & PDP CAHPS Survey."[58] Contracts or their agents are strongly discouraged from fielding other surveys of enrollees 4 weeks prior to, during, and 4 weeks after the 2026 Medicare CAHPS Survey administration.[59] NCQA prohibits survey vendors, MA organizations, and their agents from asking HOS-related questions of

members 8 weeks prior to and during the HOS administration.[60] In contrast, the HOS Quality Assurance Guidelines do not address use of focus groups. Aligning requirements relating to communication with MA members about surveys and increasing oversight of such requirements may reduce the FWA risk opportunities for MA organizations to inappropriately influence enrollee survey responses.

Requirements and oversight activities related to the ability of plans to influence the enrollee sample drawn for surveying by CMS also could be improved. For example, MA organizations may provide their "Do Not Survey" list to supplement their MA & PDP CAHPS survey vendor's list.[61] If an enrollee named in the survey vendor's or MA organization's "Do Not Survey" list appears in the sample drawn by CMS and data collection has not been initiated, the enrollee can be removed from the sample and excluded from the survey.[62] If an enrollee named in the survey vendor's or MA organization's "Do Not Survey" list appears in the sample drawn by CMS and data collection has been initiated, the vendors are instructed to assign the enrollee a Final Disposition Code of "32 – Refusal." Enrollees who refuse participation in future surveys may be added to a survey vendor's "Do Not Survey" list.[63] Increased examination and oversight of MA organizations' Do Not Survey lists could reduce any incentive they may have to motivate enrollees who they expect to give low ratings to join such lists.

Apply budget neutrality to the QBP program. Savings to the government is often highlighted as the primary benefit of transforming the QBP into a budget-neutral program; doing so could save the federal government an estimated $6 to $10 billion annually.[64] This option could be structured in such a way that it would also result in smaller quality-adjusted rebates, thereby reducing incentives to engage in fraudulent, abusive, or wasteful actions to increase Star Ratings. However, applying budget neutrality presents significant implementation challenges as it requires changes to statute and would likely be opposed by MA organizations. A variant of this option is to eliminate entirely benchmark increases tied to Star Rating performance. However, this option would also reduce incentives to invest in activities and infrastructure that may lead to better consumer experience and higher quality care.

Assess quality at the local level. Assigning Star Ratings based on performance relative to other contracts in local markets (i.e., evaluating quality at the local market level and/or plan level instead of the contract level) may reduce opportunities for waste and abuse through contract consolidation and lead to more accurate information about MA quality.[65,66,67] When beneficiaries currently view a contract's Star Rating, they can't readily identify how many plans comprise the contract, how many service areas are covered, or what share of a contract's enrollment each plan represents.[68] For example, Employer Group Waiver Plans (EGWPs) and Dual Eligible Special Needs Plans (D-SNPs) are included in a contract's overall rating.[69] EGWPs are retiree health insurance plans originating from a waiver provision in the Medicare statute

promoting employer group plans.[70] It has been observed that "contracts with larger shares of EGWP enrollment have higher average Star Ratings," which may be attributed to demographic characteristics of EGWP enrollees, such as income.[71] Similarly, D-SNPs can have quite different benefits than other plans under a given contract, suggesting that the contract-level Star Ratings may not generalize to D-SNPs. The option of assessing quality at a local or plan level preserves the potential for financial bonuses while changing data submission and measure calculation methodology and therefore may be more palatable to MA organizations. However, this approach may not be feasible given that there are no standardized geographic regions in MA, and many existing measures could not be calculated at the plan level due to small sample sizes. Any change to the level at which measures are calculated would preserve many of the existing incentives for gaming Star Ratings measures. A related option could be adding to the Star Ratings a more limited scorecard containing some plan-level measures that are feasible with smaller samples, thereby providing additional transparency to beneficiaries without having an impact on Star Ratings bonuses.[72]

Change or reweight the measure set. Changing the impact of certain measure types used to assign Star Ratings may reduce the risk of waste and gaming by reorienting the incentive structure faced by plans when deciding how to allocate resources and by providing beneficiaries with a more accurate picture of plan performance. However, preferred approaches differ. One avenue prioritizes administrative effectiveness measures that may protect beneficiaries against substandard plans and aid in decision-making such as "rates of prior authorization and claim denials, network adequacy and access to care, and reported negative experiences with plans."[73,74] As an implementation consideration, this option acknowledges the lack of association between higher Star Ratings and enhanced clinical quality.

Other variants of this option include removing and/or de-emphasizing (by reducing assigned weights) measures that may be inflated due to upcoding practices, retiring topped-out measures, and removing certain process measures. For example, the Alliance of Community Health Plans (ACHP) recommends prioritizing patient experience and health outcome measures in computing Star Ratings and immediately retiring 10 of 17 current process measures, arguing that most insurers are adept at conducting administrative tasks and therefore score well.[75] ACHP identified the following five process measures for immediate retirement, indicating that the "majority of plans are clustered together on process measures, showing no meaningful difference between plans and distorting consumers' ability to distinguish high and low performers:" (1) Care for Older Adults – One Pain Assessment in a Year, (2) Accuracy of Prices on Medicare Plan Finder, (3) Kidney Disease Monitoring for Consumers who Needed Medical Attention for Nephropathy, (4) Care for Older Adults - One Medication Review in a Year, and (5) Medication Therapy Management Comprehensive Review.[76] Removal of these measures could improve the ability of Star Ratings to distinguish among plans and reduce waste associated with

reporting these measures; however, it would also reduce the amount of information available to beneficiaries for decision-making.

Over the years, CMS has added and removed Star Rating measures and used its discretion to increase Star Ratings required for bonuses, signaling the feasibility of this approach as a FWA mitigation option.[77] Notably, CMS's priorities regarding the characteristics of an ideal Star Ratings measure set are evolving. CMS has recently sought to "simplify and refocus the measure set on clinical care, outcomes, and patient experience of care measures where performance is not topped out and where there is more variation in performance across contracts" by removing several measures focused on operational and administrative performance, process of care, and patient experience of care.[78] More specifically, the administrative process measures confirmed for removal are related to review and timeliness of appeals, call center operations, enrollee complaints about their health plan, customer service and rating of health care quality, and member choice to leave a plan.[79] Similar to the ACHP proposal, this change could reduce waste associated with reporting these measures but it would do so at the cost of reducing information available to beneficiaries.

One option to sever ties between administrative, plan operations measures and process measure performance and potentially wasteful or fraudulent financial incentives, as described by Fowler et al., is to "move those measures outside of the Star Ratings program altogether without sacrificing oversight" by introducing a CMS-created "MA Transparency Scorecard, a complementary tool that would increase visibility into plan behavior without creating new financial incentives."[80] The authors note that this option "aligns with CMS's goals of reducing administrative burden in Star Ratings while maintaining visibility into important plan operations."[81] That is, it could reduce waste while retaining or improving the quality and accessibility of information beneficiaries can use for decision-making.

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TOPIC: NETWORK ADEQUACY AND MISREPRESENTATION OF PROVIDER NETWORKS

Background

A major difference between Traditional Medicare (TM) and Medicare Advantage (MA) is the use of provider networks as part of MA plans' financial and quality performance strategies. Most MA organizations have contractual arrangements with selected "in-network" providers and facilities to provide care for their enrollees and charge specified cost-sharing amounts. If enrollees seek care out of network, they generally face higher out-of-pocket costs up to the full cost of care. To ensure that MA enrollees have adequate access to all Part A and B covered services, MA plans are required to meet certain standards for provider network adequacy (e.g., having contracts with enough providers in geographic locations accessible to most enrollees)[1] and provider directories (e.g., publication, interoperability, and update requirements).[2,3] The Centers for Medicare & Medicaid Services (CMS) advises beneficiaries to check whether their providers are in network before enrolling in a plan and before scheduling appointments.[4] Whether providers are in network is a key factor driving beneficiary selection of MA plans,[5] and difficulty accessing, or not receiving, needed health care is associated with enrollees' decisions to switch to TM.[6] Disputes between providers and MA organizations are increasingly common and can result in providers withdrawing from plans,[7] and, in turn, increasing the risk of insufficient provider networks.

Key Points

- MA plans are required to meet certain provider network adequacy standards and provider directory requirements.
- Risks of FWA include intentionally misrepresenting provider networks via inaccurate provider directories and submitting inaccurate data to CMS for network adequacy reviews.
- Mitigation strategies include improving oversight of network adequacy, ensuring provider directory accuracy, creating a national provider directory, verifying that providers are actively treating patients, requiring reimbursement for costs incurred due to inaccurate directories, improving information available to beneficiaries, allowing special election periods following network changes or directory inaccuracies, and aligning network adequacy and provider directory oversight.

Potential for FWA

Fraud and abuse risks may arise if MA organizations *intentionally* misrepresent their provider networks by publishing inaccurate provider directories or by inaccurately conveying their network composition when submitting data to CMS for network adequacy reviews. Provider directories containing inaccurate contact or practice information, significant numbers of providers that do not have a current contract with the plan to provide services to plan enrollees, and/or providers who do not exist are referred to as "ghost networks."[8] Inaccurate representation of certain provider types' availability or in-network status, especially providers of frequently utilized or expensive services (e.g., behavioral health) may force enrollees to seek more expensive out-of-network care. Such misrepresentation may be unintentional due to the challenges of managing dynamic data (both provider networks and providers' telephone and address details can change mid-year). In other cases, such inaccuracies can be intentional neglect of network data due to maintenance costs or even intentional misrepresentation of certain provider information to reduce utilization or meet network adequacy standards. These inaccuracies may also nudge enrollees who develop conditions associated with high spending and utilization to disenroll from the plan if they have difficulty obtaining needed care from in-network providers (see also the chapter on favorable selection).

Mitigation Approaches

Improve oversight of network adequacy. CMS could improve oversight of network adequacy by reviewing networks more frequently than every 3 years, auditing submissions for accuracy, and imposing stronger penalties. CMS currently conducts network adequacy reviews as part of the application process for issuers to offer new plans and every 3 years for existing plans.[9] For these reviews, MA organizations submit provider network data, and CMS assesses networks against established provider network adequacy standards (e.g., minimum number of providers and time and distance from a proportion of beneficiaries in the applicable county) for certain types of providers and facilities.[10] MA organizations can also request exceptions to network adequacy standards in some situations, such as if there are no available providers within the minimum required time and distance.[11]

In addition, CMS could explore options to make network adequacy standards simpler and more transparent, such as by assessing network adequacy at the plan rather than the contract level, tightening the requirements to approve exception requests, reducing the options for "credits" (e.g., for plans offering telehealth services), and publishing information about the use of exceptions and credits along with other network adequacy metrics and results. For example, when a plan's members are eligible for a special enrollment period due to significant network changes, CMS could share that information publicly, along with its assessment as to whether the plan remains compliant with network adequacy standards after the change.[12] CMS also

could improve communication with state insurance commissioners and state health insurance assistance programs when special enrollment periods are available.[13] CMS development of simpler standards and increased transparency could help enrollees understand where or why a plan's network may be more limited and reduce the risk of MA organizations submitting fraudulent network data.

Ensure provider directory accuracy. Implementing changes to ensure the accuracy of provider directories has the potential to produce significant improvements in directory accuracy and to reduce the risk of misleading beneficiaries in their decisions about MA enrollment and provider selection. CMS requires MA plans to publish provider directories showing the names, addresses, phone numbers, specialties, and cultural and linguistic capabilities of their contracted providers. MA plans must update directories within 30 days of receiving or making changes to provider information.[14,15] However, there is no current requirement for regular verification of provider directory information and directory requirements are enforced inconsistently. In addition, the last published directory audit was conducted between November 2017 and July 2018.[16] As of 2028, and consistent with requirements for other health insurance products under the federal No Surprises Act and other recent proposals,[17,18,19,20] MA plans will be required to verify provider directory information every 90 days, update the information if necessary, note in the directory that information may not be up to date if it could not be verified, and remove a provider from the directory within 5 business days after determining that the provider is no longer in network.[21] CMS will have discretion to allow for directory verification less frequently for hospitals and other facilities, but verification must be done at least once every 12 months.[22] These requirements for proactive updates should help with directory accuracy. The new law also expands the types of information that directories must include for each provider, including whether the provider is accepting new patients.[23] This is important because it will reduce the risk of misleading beneficiaries who may be looking for new providers as part of their enrollment decision.

Additional proposals to improve the accuracy and oversight of provider directories (for MA and other programs)[24,25,26,27,28] have included the following:

- The imposition of financial penalties by CMS for inaccurate directories or incentives for accurate directories such as adding a directory accuracy metric to Star Ratings or leveraging better plan data;
- CMS publication of select metrics (such as directory accuracy scores) from the audits or reports;
- Regular audits of provider directory accuracy, either by CMS, MA organizations, or independent auditors contracted by MA organizations;

- Regulations or guidance describing audit methodology, including items such as:
  - Calculating the proportion of directory listings with inaccurate information,
  - Calculating the proportion of enrollees using out-of-network providers for covered services,
  - Reviewing the resources the plan offers to help enrollees find in-network providers that are accepting new patients, and
  - Collecting documentation to verify that directory updates are conducted as required.
- Studies by the U.S. Government Accountability Office (GAO) of the implementation and impact of directory accuracy initiatives and evaluations and audits by the Department of Health and Human Services Office of the Inspector General.

Directory audits could play an important role in enhancing consumer protection and in reducing the risk of fraud and abuse due to intentionally inaccurate directories. However, implementing such audits could be costly for both CMS and MA organizations and would likely require additional funding for CMS. Directory inaccuracies due to underlying problems with the data would continue to be a problem, but over time, it is possible that pressure from audits would result in greater efforts to improve accuracy.

For plans offered in 2028 and beyond, MA organizations will be required to submit to CMS reports containing results of their analysis of plan directory accuracy.[29] Analyses must contain an accuracy score, which CMS will post publicly and which MA organizations will be required to post on their directories as of plan year 2029.[30] The law also requires the GAO to study and report on the issue, and for CMS to host a stakeholder meeting and publish guidance for MA organizations and providers to support improvements in directory accuracy and burden reduction.[31]

Create a national provider directory. A national provider directory could serve as a powerful tool for improving the accurate representation of provider networks.[32] Although such a directory would not be perfect, it would help to reduce inadvertent inaccuracies in provider directories (both for MA and other health insurance products) because issuers could refer to the directory when building networks and updating provider information.[33] CMS could use it as a "gold standard" when validating plans' data. In addition, reducing the number of unintentional inaccuracies would enable CMS to focus on the inaccuracies that are more likely to be intentional. A national provider directory could also streamline the process used by providers and plans to update directories, thereby reducing the burden on both MA organizations and providers.[34] CMS has been considering a national provider directory since at least 2018,[35] requested information on a national provider directory in 2022,[36] introduced a pilot in Oklahoma to inform potential future development of a national directory,[37] and has

announced plans to build a national directory.[38] Although there is broad support for this proposal, there are also concerns about its cost, technical difficulty, timeliness, and other implementation challenges.[39]

Related proposals include standardizing how health plans collect information from providers,[40] creating standards for data quality and interoperability of provider directories,[41] identifying ways for plans to differentiate between locations where providers regularly practice versus those where they are contracted to practice but are not regularly practicing,[42] building on existing data sets, and initially focusing federal efforts on creating a limited national data set that prioritizes accurate provider location information.[43]

Verify that providers are actively treating patients. Beginning in 2025, when MA plans include nurse practitioners, physician assistants, or clinical nurse specialists in their network submissions to meet new outpatient behavioral health requirements, CMS requires these plans to verify that these providers have delivered or will deliver relevant services to at least 20 patients within a recent 12-month period.[44] CMS could introduce similar requirements for other specialties to ensure that providers listed in network submissions can provide applicable services to plan enrollees. To fulfill the 2025 verification requirements, MA organizations can use information such as health care provider claims, prescription drug claims, or electronic health records demonstrating services delivered by the applicable provider.[45] This provision is aimed at ensuring that the mid-level providers in network submissions have the necessary skills, training, and expertise to deliver outpatient behavioral health services and to prevent ghost networks for this specialty.[46] The requirement also will reduce the risk of plans intentionally padding their networks with providers that cannot deliver the required services. Due to the compliance costs associated with enacting similar requirements for other specialties, this approach could be tested initially with the specialties that enrollees report having the most difficulty finding an in-network provider. Priority specialties could be identified from complaints or by adding targeted questions to the MA and Prescription Drug Plan Consumer Assessment of Healthcare Providers and Systems survey. Alternatively, CMS could introduce provider activity verification as a remediation requirement for MA plans that are found through audits to have high rates of directory inaccuracies.

Require reimbursement for costs incurred due to inaccurate directories. Beginning in 2028, MA plans will be liable for costs incurred due to inaccurate directories. When enrollees receive care from a nonparticipating provider or facility due to inaccuracies in provider directories, those enrollees will be entitled to in-network cost sharing, and plans will be required to notify enrollees of these protections.[47] This aligns with similar requirements in the No Surprises Act (part of the Consolidated Appropriations Act of 2021)[48] that apply to other health insurance products. MA regulations currently require that plans "arrange for and cover any medically

necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs."[49] This change could further incentivize MA organizations to ensure that provider directories are accurate and to help CMS narrow attention to remaining inaccuracies as potentially intentional misrepresentation of provider networks.

Improve information available to beneficiaries. The risks of fraud and abuse due to misleading or inaccurate provider directories could be reduced by empowering beneficiaries with better information. CMS proposed in 2024, and finalized in 2025, changes that would allow MA provider directories to be integrated into the Medicare Plan Finder[50] tool.[51,52] This policy is being implemented in 2026, and in the interim, CMS incorporated provider directory information from a third-party provider into Medicare Plan Finder for most plans for the 2026 open enrollment.[53] For plans that were included and provide their data, this system enabled prospective enrollees to search for plans based on provider name, and CMS expected directory files to be submitted weekly.[54] Under the new rule, MA organizations will be required to attest, at least annually, that directory information is accurate,[55] and, as discussed earlier, directory verification requirements will increase further as of 2028.[56] The frequently updated information and search capability should help beneficiaries make informed enrollment decisions and avoid abuse by actors that might try to steer beneficiaries into plans that do not include their regular providers. However, it is unclear whether the improved accessibility of the directory information and attestation requirements will drive improvements in accuracy. Indeed, early rollout during 2026 open enrollment has confirmed that accuracy remains a challenge with this approach.[57]

Allow special enrollment periods following network changes or directory inaccuracies. Recognizing the potential for inaccuracies in Medicare Plan Finder directory data, CMS announced that individuals will be eligible to switch to a different plan or to TM under a special election period if they enroll in an MA plan for 2026 after using Medicare Plan Finder provider directory information and discover within 3 months that their preferred provider was not actually in the MA plan's provider network.[58] Assuming beneficiaries are aware of this provision, it may incentivize MA organizations to ensure that their directory data are correct and reduce the impact on beneficiaries if they are misled by inaccurate information during plan selection. CMS extension of the provision beyond the 2026 plan year, for longer than 3 months, and to all directory information published by MA organizations, rather than just that presented in Medicare Plan Finder, could increase the incentive for MA organizations to ensure their directory information is accurate.

CMS allows special election periods for various other reasons, including when beneficiaries are affected by a significant change in their MA plan's provider network.[59] Significant changes

might include hospital systems or large medical groups leaving the network, but smaller changes, such as individual providers relocating or ceasing to practice, occur frequently and also have an impact on beneficiaries. CMS therefore requires MA organizations to notify enrollees when one of their providers is terminated from the plan's network, and enrollees can subsequently request a special election period.[60,61] CMS proposed strengthening this rule by requiring MA organizations to notify enrollees of their eligibility for a special election period when a provider is terminated, but did not finalize this provision for 2027.[62,63] Although these special election periods and notification requirements should help beneficiaries make informed choices based on provider network changes, they are unlikely to have much impact on the misrepresentation of provider networks, and improved notification requirements could increase transparency.

Align network adequacy and provider directory oversight. Regulation and oversight of provider network adequacy is independent of regulation and oversight of provider directories. This confers a risk that MA organizations could include providers in their network data submissions to CMS to meet network adequacy requirements while excluding some providers from published directories. To prevent misalignment between approved networks and enrollee information about available in-network providers, directories could be evaluated for alignment with network adequacy standards, or CMS could require use of MA plans' published directories (instead of a separate provider network data set) for network adequacy reviews. These strategies would require changes to regulations and CMS processes for assessing network adequacy. In 2024, CMS proposed requiring MA organizations to attest that directory information submitted to CMS is consistent with plans' network adequacy data submissions.[64,65] CMS did not finalize this proposal, determining that it was appropriate to distinguish network adequacy from provider directory accuracy and noting that MA organizations are already required to attest that they have adequate networks.[66]

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TOPIC: COST SHIFTING TO THE VETERANS AFFAIRS (VA)

Background

People can have health insurance coverage from multiple payers, including Medicare, Medicaid, employers, the U.S. Department of Veterans Affairs (VA), and TRICARE.[1,2] For example, in 2022, more than 1.3 million veterans were enrolled in private Medicare Advantage (MA) health plans but also qualified for VA benefits.[3] The coordination of benefits is a process that determines which insurance is responsible for paying for specific services and in what order. For example, if someone has coverage through both a large employer group health plan and Medicare, the employer-sponsored plan is the primary payer and pays first for any covered services while Medicare is the secondary payer and covers any remaining eligible costs.[4] The Centers for Medicare & Medicaid Services (CMS) has the infrastructure to coordinate benefits and ensure that Medicare does not pay when another insurer is the primary payer. However, there is no coordination of benefits between Medicare and the VA.[5]

Key Points

- MA enrollees who also have health benefits through the VA can receive care that is paid for by either system; the VA spent an estimated $22.7 billion in 2023 on care for veterans who were enrolled in MA plans.
- This scenario creates waste when Medicare pays a capitated rate for MA plans to provide all services for their enrollees but the VA also pays for health care services. MA organizations may abuse overlap by steering enrollees to maximize VA utilization, thereby shifting costs to the VA.
- Mitigation strategies include improving data sharing, allowing VA to seek reimbursement from MA plans for services it delivered to MA enrollees, revising capitation rates paid to MA plans for veterans, creating a Special Needs Plan (SNP) for beneficiaries eligible for Medicare and VA benefits, and regulating the use of rebate dollars.

Potential for Fraud, Waste, and Abuse (FWA)

To reduce costs, MA plans may identify ways to shift costs to other parties, including providers, beneficiaries, and other payers. For veterans enrolled in Traditional Medicare (TM), the VA typically will pay only for covered services delivered by VA providers, while Medicare will pay for covered services rendered by non-VA providers. However, when veterans are enrolled in MA health plans, the government pays a fixed per-person, per-month, or capitated, amount for veterans even if they receive all or most of their services through the VA. In this case, the

federal government is making duplicate payments for health coverage for these beneficiaries. A 2023 U.S. Department of Health and Human Services Office of Inspector General (OIG) report found that between 2017 and 2021, TM and the VA paid approximately $128 million in duplicate payments.[6] The scope of the problem is potentially much greater for MA, with another study estimating that in 2020 alone, Medicare paid MA plans $1.3 billion for VA enrollees who received no care from their MA plan; this number would be much higher if it included waste due to payments to MA plans for enrolled veterans who receive a mix of services from both MA and the VA.[7] In addition, the VA spent an estimated $22.7 billion in 2023 on care for veterans who were enrolled in MA plans, a 77% increase since 2019 over a period when the number of veterans with VA coverage who were also enrolled in an MA plan increased by 28%.[8] CMS adjusts county-level capitated rates based on the relative TM costs for beneficiaries who are eligible for benefits through the VA, the Department of War (DoW) (formerly the Department of Defense), and the Uniformed Services Family Health Plan, but it does not account for actual service utilization among MA enrollees using VA or DoW benefits and it increases payments to plans in counties with large numbers of veterans and lower traditional Medicare spending on veterans.[9,10] MA plans may also selectively market to and enroll beneficiaries who qualify for and utilize VA services because their utilization of MA benefits will be relatively low (see also the Favorable Selection section), and may steer beneficiaries to maximize their use of VA services, thereby shifting costs to the VA.

While precedence rules are clearer for most other payers, there is still some risk that MA plans may shift costs to other payers. For example, state Medicaid agencies will pay the monthly premium for beneficiaries who are dually eligible for Medicaid and Medicare and enrolled in an MA plan.[11] For some categories of Medicaid coverage, states will also cover MA copayments.[12] Because enrollees in these plans do not pay premiums or cost sharing, they derive no direct benefit from a reduction in premiums or copayments. When organizations offering MA plans bid below the applicable county benchmark, they receive a portion of the difference between the bid and the benchmark through a rebate that they can use to reduce beneficiary premiums and cost sharing or to offer supplemental benefits like dental and vision coverage. MA plans have an incentive to use rebates on supplemental benefits that will appeal to beneficiaries and to retain higher beneficiary premiums and cost sharing, thereby shifting costs to the Medicaid programs paying the premium and possible copayments for beneficiaries enrolled in both programs. Similarly, TRICARE For Life (TFL) provides Medicare-wraparound coverage for veterans by paying deductibles and coinsurance for services covered by Medicare and TRICARE for beneficiaries who are enrolled in both.[13] This reduces or eliminates out-of-pocket costs for the enrollee. Therefore, MA plans may have an incentive to increase out-of-pocket costs because they do not directly affect enrollees and instead use rebates to provide supplemental

benefits that are attractive to beneficiaries. This cost shifting increases total health care costs for the government and could be considered waste or abuse.

There are also some instances where MA plans may shift costs to enrollees or to providers. For example, "ghost networks,"[14] which refers to inaccurate representation of certain providers' availability or status as an in-network provider, especially providers of frequently utilized or expensive services (e.g., behavioral health), may force enrollees to seek more expensive out-of-network care than the MA plan would otherwise have covered, thereby shifting costs to enrollees. (See Network Adequacy and Misrepresentation of Provider Networks section). There are also instances where MA organizations may shift costs to providers by requiring providers to cover a portion of the costs for the plan's advertised supplemental benefits through a Division of Financial Responsibility clause in provider contracts.[15]

Mitigation Approaches

Improve Data Sharing. OIG concluded that duplicate payments between the VA and TM were caused by a lack of CMS oversight.[16] One policy option that OIG recommended was for CMS to integrate VA data and establish a process to identify and address FWA.[17] Although this strategy was targeted toward duplicate payments with TM, it could also help CMS to understand and address FWA associated with MA. CMS commented that it is working with the VA to establish a comprehensive, ongoing data sharing agreement.[18] CMS also stated that once the data sharing agreement is implemented, it will work toward an interagency process to integrate VA enrollment, claims, and payment data into CMS data.[19] These data could be used for both TM and MA. As of July 2025, a data matching agreement was established between the VA and CMS.[20] Improved data sharing could identify some instances of providers or suppliers submitting duplicative claims to MA plans and the VA and would be critical in implementing other payment reform options.

Allow the VA to seek reimbursement from MA plans for services it delivered to MA enrollees. MA plans could be designated as the primary payer and the VA as the secondary payer (or vice versa).[21,22,23,24] A similar system currently exists for Medicare and Medicaid where Medicare is the primary payer and Medicaid is the secondary payer.[25] For example, if MA were the primary payer, the VA could seek reimbursement from MA plans when it delivers or pays for services that are also covered by MA plans.[26,27,28,29]

This policy option would reduce confusion about which payer a provider should bill and which program pays for services and it could reduce duplicative payments between payers. A weakness of this approach is that, although it would reduce waste from duplicative government spending, it would achieve this by shifting costs away from VA (discretionary spending), with minimal impact on MA (mandatory) spending if MA plans were to become the primary payer.

Total Medicare spending on VA-eligible veterans enrolled in MA would remain higher than it would be if they were covered by TM. Another limitation is that this approach could create uncertainty about which entity is responsible for managing and coordinating a veteran's care, as both the VA and MA plans each operates their own distinct provider networks and may cover similar services.[30] This concern could be mitigated through clear guidance about the use of prior authorization, VA facilities, and provider networks, such as requiring MA plans to treat all VA facilities as in-network providers and not charge any patient cost sharing for use of those services.

To implement VA reimbursement from MA plans, data sharing and coordination processes would be critical to ensure that CMS can identify services delivered or paid for by the VA for MA enrollees and notify the VA to seek payment from the appropriate MA plan. In addition, as outlined in the proposed GUARD Veterans' Health Care Act, Congress would need to make changes to the current statutes that limit the VA's ability to collect reimbursements.[31,32]

Revise the capitation rates paid to MA plans for veterans. Although CMS adjusts county-level rates, it does not account for actual service utilization among MA enrollees who are also eligible for benefits through the VA or DoW.[33,34] The benchmark adjustments do not account for the fact that enrollees may receive a majority of their care through the VA and they exacerbate the problem by creating higher benchmarks where spending on veterans is likely to be lower. For example, a study using 2021 data found that beneficiaries enrolled in both high-veteran MA plans and VA were more likely to have surgical care paid for by the VA than by the MA plan.[35] Payments to MA plans for veterans who receive all or most of their services from the VA represent significant waste.[36] An option to address this risk is for CMS to revise the capitation rates paid to MA plans for veterans who receive all (or some) of their care through the VA, either prospectively or retrospectively.[37,38,39,40] By revising the capitation rates to reflect actual use of services, payments to MA plans would be more accurate and reduce possible wasteful or duplicative payments to MA plans and VA.[41] Current, detailed data on MA beneficiary use of VA services and on MA plan spending on VA-eligible enrollee care would be necessary to determine the feasibility and implications of this option.

One weakness of revising capitation rates is that it may disincentivize MA plans from enrolling veterans, because they will become less profitable.[42,43] Capitation rates could be set to ensure that VA-covered beneficiaries are no less profitable for MA plans than other beneficiaries on average. Significant variation in MA utilization among VA-covered beneficiaries could also make it difficult to set rates appropriately and incentivize favorable selection among VA-covered beneficiaries. Such changes also could further incentivize MA plans to encourage veterans to maximize use of VA-funded services to try to manage spending within the capitation rate. In

addition, changes in capitated rates would need to be designed carefully to address additional complexities such as veterans' TRICARE eligibility.[44]

Create a Special Needs Plan (SNP) for beneficiaries who are eligible for Medicare and VA. If the law were changed to allow the VA to collect reimbursement for care delivered to MA enrollees, Congress could also authorize CMS to design a SNP option for MA enrollees with VA coverage. A SNP is an MA coordinated plan that is designed to provide care for certain enrollees, such as those with chronic conditions.[45] For example, dual eligible SNPs (D-SNPs) are a type of MA plan designed for people who qualify for both Medicare and Medicaid.[46] Fully integrated D-SNPs are required to coordinate and integrate services and payments across both programs. A similar fully integrated plan could reduce care fragmentation and promote more efficient government spending by avoiding duplicative utilization across the two systems and minimizing cost shifting. There are currently no requirements for MA plans to coordinate benefits with the VA, even when they claim to do so. Weaknesses may be similar to D-SNPs where MA plans may offer look-alikes or "mirror" plans, which primarily enroll dually eligible individuals but are not D-SNPs.[47] Look-alike plans are not subject to the same regulatory requirements, such as care coordination, which may create a risk for fraud and abuse if plans mislead beneficiaries about the coverage offered under these plans. They may present risks of waste if lack of coordination contributes to duplication of services or payments (see D-SNP Look-alikes section). CMS and the VA would need to collaborate to address implementation challenges, including coordinating appeals processes, designing appropriate coordination for veterans with different levels of VA benefits, and managing VA and MA provider networks without unduly limiting beneficiary choice.

Regulate the use of rebate dollars. Another policy option would be for CMS or Congress to regulate how MA organizations spend rebates. MA plans receive rebates from CMS when they bid below the benchmark for providing Medicare-covered services to their enrollees. When other payers, like Medicaid or the VA, cover beneficiaries' premiums and cost sharing, MA organizations still receive rebate dollars from CMS. CMS or Congress could consider whether rebates should be used first to reduce beneficiary premiums and cost sharing for Part A and Part B services before offering supplemental benefits in plans designed for beneficiaries who are also eligible for VA, Medicaid, or TFL. If rebates were required to reduce the beneficiary payments that the other payer would usually cover, this could reduce cost shifting to other payers and reduce waste by reducing total government health care spending, although it would not reduce MA spending. MA plans would face complexities in implementing this approach as copayments may differ for beneficiaries within a given plan depending on their level of eligibility for Medicaid or VA benefits. It also would not address the risk of cost shifting to other payers—such as Medicaid, VA, or TFL—for beneficiaries who are eligible for Medicare and another health insurance program but are not enrolled in a plan designed for dually eligible

beneficiaries. A variant of this option would be to give secondary payers the ability to recoup premium and cost-sharing costs from MA plans if they offer supplemental benefits. For example, when a Medicaid payer receives a copayment bill from a provider for a covered service delivered to an MA enrollee, the Medicaid payer could demand payment from the MA plan if the plan offers supplemental benefits. This would be consistent with the intent that Medicare, as the primary payer, is responsible for all Part A and B services, and could incentivize MA plans to focus on reducing costs for those services. However, it could also reduce supplemental benefit offerings, which can be attractive to beneficiaries and a valuable tool for MA plans to enroll and retain beneficiaries. To implement this option for VA-covered beneficiaries, Congress would also need to determine that Medicare is the primary payer over the VA as discussed above.

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TOPIC: ENROLLMENT, AGENTS, AND BROKERS

Background

If sufficient protections are in place, agents, brokers, and other authorized entities can serve as trusted information sources to inform Medicare beneficiaries about enrollment options, including joining a Medicare Advantage (MA) plan.[1,2] For example, CMS requires agents and brokers to act in beneficiaries' best interest and to ensure that MA plan enrollment is voluntary, informed, and documented. [3] In addition, CMS emphasizes that beneficiaries should receive clear, accessible information about plan options.[4] If a beneficiary is enrolled in an MA plan without proper notice or receives misleading marketing materials by an agent, broker, or other authorized entity, then that beneficiary becomes eligible for a special enrollment period to switch plans.[5]

Key Points

- Agents and brokers are an important source of information for TM and MA beneficiaries. They can receive commissions and administrative payments from MA organizations and third-party marketing organizations for MA plan enrollments.
- The incentive structure for agents and brokers, along with other information gaps, contributes to the FWA risks of uninformed or unvoluntary enrollment.
- Mitigation strategies include limiting payments to agents and brokers, implementing oversight mechanisms to ensure actors uphold best practices, prohibiting suppression technology, improving oversight of MA marketing, improving beneficiary information, and implementing an opt-in policy for employer and union retirement MA benefits.

Agent and broker compensation is much higher for MA enrollment than for Traditional Medicare (TM) enrollment. In 2025, for MA plan enrollments, agents and brokers could receive compensation from MA organizations of $626 to $780 per beneficiary for initial enrollments and $313 to $390 for renewals, depending on the state they operate in.[6,7] Agents and brokers receive no compensation for beneficiaries who enroll in TM; however, they can receive a maximum of $109 in compensation for initial enrollment and $55 for renewal enrollment in Medigap and stand-alone Part D plans that beneficiaries often purchase to supplement their Part A and Part B TM benefits.[8,9] This payment differential creates an incentive for agents and brokers to encourage beneficiaries to enroll in MA over the Medigap and stand-alone Part D plans they can offer to complement TM coverage.

Most agents and brokers work with or for third-party marketing organizations (TPMOs).[10] MA organizations contract with TPMOs and pay commissions to agents and brokers for enrolling beneficiaries in their plans. Currently, there are no limits on payments to TPMOs and "administrative payments" to agents and brokers for non-enrollment activities, such as agent and broker training, certification, and technology support.[11,12]

Potential for FWA

Fraud, waste, or abuse situations relating to enrollment may arise when beneficiaries are (1) enrolled in MA plans without their knowledge or consent, or (2) misled by marketing or other information that influenced enrollment decisions. The incentive structure for agents and brokers contributes to FWA risks. Independent agents and brokers receive higher commissions from MA organizations for initial MA enrollments compared to reenrollments, which incentivizes agents and brokers to identify beneficiaries who are not currently enrolled in MA plans. In addition, agents and brokers who are employed by TPMOs may not be subject to the same commission structure as those that contract directly with MA organizations, and thus, for example, could receive incentives only for new enrollments and not for renewals.[13]

CMS strictly regulates maximum commission amounts, as stated previously. However, actual payments vary by MA organization and even across plans offered by a given MA organization. Agents and brokers do not represent all plans and may be paid more for enrollments in some plans over others, which may incentivize agents and brokers to promote some plans over others and potentially contribute to abuse. MA organizations can sidestep financial caps on agent and broker compensation by adding "administrative payments."[14] A 2025 U.S. Senate Committee on Finance report found typical administrative payments for agents and brokers ranged from $150 to $250 but can exceed $1,000 per enrollee.[15] In addition, agents and brokers may receive bonuses via MA insurers for meeting enrollment benchmarks.[16]

Enrollment compensation and administrative payments may influence what information on MA plans is shared by agents and brokers or which plans they choose to present as options to potential enrollees, which can contribute to abuse.[17,18] Prior research found that agents and brokers may steer beneficiaries into MA plans, especially larger MA plans, to earn higher payments.[19,20] In addition, in 2025, the U.S. Department of Justice joined a lawsuit alleging that MA insurers knowingly paid brokers to enroll individuals into specific plans.[21] The lawsuit alleges that insurers and brokers concealed payments by claiming they were related to marketing and administrative services.[22]

The 2025 Senate Committee on Finance report found a lack of transparency in lead generation, which refers to the process of identifying and attracting potential beneficiaries who may be interested in enrolling in MA plans for the purpose of selling information to TPMOs or other

advertising entities.[23] Lead generators are independent from MA organizations but they can partner with MA organizations to provide leads.[24] Beneficiaries targeted by lead generators can be overwhelmed with unauthorized contacts that may misrepresent plan benefits, omit pertinent plan information, and cause beneficiary confusion about the plan in which they are enrolling.[25] If agents and brokers selectively target beneficiaries who have low utilization relative to expected MA payment rates, it could contribute to FWA related to favorable selection (see the Favorable Selection chapter). Agents and brokers can receive relatively generous bonus payments from MA organizations for conducting health risk assessments of potential enrollees,[26] exacerbating the risk of favorable selection. In addition, the committee report highlighted the experiences of beneficiaries with dementia who were targeted with multiple marketing calls that may have caused them to unenroll and reenroll in MA plans,[27] which could be considered enrollment fraud. Finally, TPMOs sometimes use offshore call centers, which exacerbate risks because it may be more difficult for CMS to monitor these call centers for deceptive marketing practices.[28]

Information gaps can also present a risk. Currently, individuals who are 65 years of age and who receive Social Security payments are automatically enrolled in Medicare Part A and may be unaware of all their coverage options, such as TM for Parts A and B plus a Part D plan and an optional Medigap plan versus MA.[29] Meanwhile, beneficiaries are exposed to much more marketing material about MA than about TM. Lack of understanding of health plan information presents opportunities for bad actors to mislead beneficiaries about plan trade-offs, increasing the potential for fraud or abuse.

Special rules for employer and union MA plans can create risks for uninformed enrollment. Employers and unions that offer retirement health benefits can contract with MA organizations to provide group MA plans.[30,31] Employers may offer MA plans to retirees to reduce employer administrative burdens and costs as some plans would cover retiree dental and vision plans.[32] Employers and unions must provide advance notice of the possible MA plan enrollment and a way for their members to opt out of participating.[33] CMS can waive or modify MA requirements for employer-sponsored MA plans such as not having to submit data for Medicare Plan Finder and having different open enrollment periods from TM.[34] Individuals who do not opt out can be enrolled automatically in their employer or union MA plan, rendering them ineligible for TM,[35] and potentially unaware of the implications of their plan membership.

Mitigation Approaches

Limit payments to agents and brokers. CMS could regulate payments to agents and brokers to reduce adverse incentives. For 2025, CMS set new guardrails for MA plan compensation to agents and brokers to prevent steering and reinforced the prohibition against financially incentivizing agents, brokers, and TPMOs to recommend and possibly enroll beneficiaries in MA

plans that are not in their best interest.[36,37] The rule combined administrative payments with enrollment-based compensation payments and eliminated separate administrative payments (thereby increasing compensation for new enrollments by $100), and required that all MA organizations that choose to engage agents and brokers pay the same enrollment-based compensation,[38] a policy similar to that proposed by the Senate Finance Committee.[39] These provisions in the rule were not implemented due to a lawsuit filed by trade associations representing agents and brokers who claimed that CMS failed to assess how the rule would harm their business model.[40] In addition to appealing the ruling or reintroducing a similar policy, CMS could consider other options to regulate payments to agents and brokers, such as setting administrative payment limits to reduce their use as financial incentives for higher enrollment in certain MA plans.[41,42,43]

Another policy option that limits payments to agents and brokers is strengthening regulations concerning enrollment benchmark bonuses for agents and brokers. A complete ban on enrollment benchmark bonuses for agents and brokers is unlikely to be palatable and would be difficult to enforce. However, limiting the size of the bonuses that agents or brokers can receive may curb the risk of inappropriate steering created by enrollment benchmark bonuses.[44]

Implement oversight mechanisms to ensure actors uphold best practices. Several policy options could reinforce best practices, as defined in existing legislation, regulations, and guidance, and increase accountability among agents and brokers.[45,46] To support compliance with best practices, CMS could monitor disenrollment trends and the numbers of beneficiaries receiving special enrollment periods due to marketing issues by MA plans or by agents and brokers.[47,48] This could include collecting data on which agents and brokers facilitated each enrollment. CMS could then identify agents and brokers with disproportionately high disenrollment and use this information to seek insights from affected beneficiaries and conduct targeted audits of MA plans.[49,50] For contract year 2026, CMS discussed plans to monitor disenrollment patterns but it is not clear whether CMS plans to publish this information.[51] CMS has the authority to penalize MA organizations if they (or their employees or contractors) enroll a beneficiary solely for the purpose of a commission or without a beneficiary's consent, or misrepresent information or fail to comply with marketing requirements.[52] Penalties can include fines, suspension of enrollment, and termination of MA contracts when agents, brokers, or MA organizations violate current best practices.[53] Congress could update penalties for MA organizations and consider granting CMS additional authority to issue penalties directly to any agent, broker, or company that is noncompliant.[54] Enforcing compliance and publishing accountability measures may disincentivize steering beneficiaries to plans that do not suit their needs.

As of 2026, MA plan Star Ratings include the measure "Members Choosing to Leave the Plan." CMS proposed removing this measure for 2029 Star Ratings and retaining the information as a display measure, which means it will be publicly reported but will not be used to calculate Star Ratings (see the chapter on Star Ratings and the Quality Bonus Program). [55] CMS has since confirmed that the Disenrollment Reasons Survey, which is the source of data for "Members Choosing to Leave the Plan" and other display measures of reasons for leaving, is no longer being conducted, and that it therefore will not publish these measures on the display page for 2027 and subsequent years.[56] Retaining the survey and potentially revising the disenrollment measure—for example, to track rapid disenrollments—could help incentivize MA organizations to ensure agents and brokers are following best practices. If the survey were retained, CMS could also continue to publish the reasons for disenrollment as display measures,[57] which, combined with the rates of members choosing to leave the plan, would provide additional accountability.

Prohibit suppression technology. CMS could prohibit the use of suppression technology, contracts that require use of suppression lists, and TPMO software provisions to MA plans that limit information brokers and agents can see.[58] TPMOs often offer contracted agents and brokers software to search plan options and enroll beneficiaries in MA plans.[59] The 2025 Senate Finance Committee report found that current technology, paid for by MA organizations through contracts with TPMOs, can be manipulated to limit results and essentially "suppress" some MA plans.[60] The technology discourages agents and brokers from informing beneficiaries about all available options.[61]

Improve oversight of MA marketing. Regulating aggressive as well as false and misleading marketing tactics could reduce uninformed or involuntary MA enrollment. The Senate Finance Committee reported on evidence indicating that beneficiaries are targeted by TPMOs with aggressive marketing tactics and misleading information.[62] As a result, beneficiaries may be confused about plan information and feel pressured to enroll in MA plans that do not meet their health care needs.[63] The committee also found incidents of beneficiaries being enrolled in plans without their consent after responding to an MA plan advertisement.[64] The committee's report called on CMS and Congress to pursue multiple corrective actions, including ***strengthening regulations for, and conducting regular reviews of, MA marketing materials***.[65] Starting in 2025, CMS restricted use of the Medicare name, the CMS logo, and of quoting or reproducing information issued by the federal government in marketing for MA that may mislead or confuse beneficiaries.[66] The intent of these marketing limitations was to increase transparency and reduce beneficiary confusion.[67,68,69] States can also regulate marketing. One state has additional requirements for MA plans that include a notice to be displayed prominently for beneficiaries that reads, "This policy or certificate may not cover all your medical expenses."[70]

Starting in 2023, CMS allowed for special enrollment periods for beneficiaries who received inaccurate material or relied on incorrect information provided by employers, group health plans, or others that affected their enrollment in Medicare Part A or B.[71] CMS could consider a similar ***special enrollment period*** for beneficiaries who relied on inaccurate or incorrect information from agents or brokers when enrolling in an MA plan. This could add another incentive for agents and brokers to provide accurate information and also protect beneficiaries, assuming they know the special enrollment period is an option.

The Senate Finance Committee's report called on Congress to grant CMS the authority to ***regulate lead generators***.[72] With authority to oversee lead generators, CMS could ensure that partnerships between MA organizations and lead generation companies are approved and in good standing.[73] Further, CMS could potentially ban offshore call centers that are harder to monitor.[74] In contract year 2025, CMS finalized a rule prohibiting TPMOs from sharing personal beneficiary data, or leads, with other TPMOs unless express written consent from the beneficiary was obtained,[75] which could help reduce aggressive marketing to those beneficiaries who do not consent.

In a 2025 request for information, CMS indicated that it is considering several ways to improve oversight of MA marketing.[76] It sought information on ways to hold MA organizations accountable when TPMOs provide inaccurate, misleading, and confusing information and on options that could reduce risks associated with agents and brokers such as updating training and testing requirements and improving how they interact with beneficiaries. CMS also requested information on how to use data effectively to monitor MA organizations, TPMOs, and other downstream entities for compliance with marketing and enrollment requirements. Improved oversight could help reduce fraud, waste, and abuse risks associated with enrollment marketing.

Improve beneficiary information. Another possible policy option is for CMS to ***regulate and standardize the language used to describe MA plan processes and benefits***. The Senate Finance Committee has repeatedly recommended that CMS provide model language to clearly explain beneficiary out-of-pocket costs, network limitations, and extra benefits.[77,78] CMS also could move to standardize definitions and require MA plans to use consistent language during enrollment.[79,80] Another possible solution to misleading marketing is for CMS to create and provide coverage information to beneficiaries, including about TM.[81,82,83,84] This could help reduce information gaps and allow beneficiaries to make informed choices between TM and MA as well as among MA plans.

To improve beneficiary experiences with using Medicare Plan Finder, CMS could consider using an ***artificial intelligence (AI)-based tool*** that could help beneficiaries compare plans accurately

and give more personalized suggestions.[85] Look-alike tools closely mirroring Medicare Plan Finder, which may be operated by agents and brokers, exist and are easily located through search engine queries. Our team found that these tools only provided information on select plans, so they are not as comprehensive as Medicare Plan Finder but may be preferred by beneficiaries due to additional features. For consumers to be effective shoppers, they need to be able to access, review, and understand unbiased information about TM, MA plans, and other options in their area, including from independent sources such as CMS and State Health Insurance Assistance Programs (SHIPs).[86,87] Plan information that is more accessible would also help beneficiaries make more informed decisions about shopping for a new MA plan rather than defaulting to their existing plans.[88,89] CMS has requested information on how it might use AI and other technology to enhance decision support tools,[90] suggesting that changes may be forthcoming. To implement an AI-based tool, the language used to describe health plans would need to be standardized and CMS may need to collect and release more MA plan characteristics.[91]

Implement an opt-in policy for employer and union retirement MA benefits. One option for addressing unwanted enrollment in an employer or union MA plan is to ***switch from an opt-out policy to an opt-in policy***.[92] With an opt-in policy, beneficiaries would be assured an active role in their choice of health insurance and reduce the risk of involuntary MA enrollment.[93] However, an opt-in policy likely would require MA organizations to invest more in education and marketing for those who are eligible for an employer or union MA plan, including directing them to information on the implications of opting out at different times. In addition, employers may not want an opt-in policy as they would have fewer covered people in their retiree pool, exposing them to more high-risk outliers and increasing their risk of adverse selection.

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TOPIC: PRIOR AUTHORIZATION AND OTHER UTILIZATION MANAGEMENT APPROACHES

Background

Medicare pays Medicare Advantage (MA) plans a risk-adjusted, capitated payment for each month that a beneficiary is enrolled.[1] The MA organization agrees to authorize and pay for all medically necessary benefits covered by Traditional Medicare (TM).[2,3] MA organizations employ utilization management strategies to ensure that health care services are medically necessary and meet TM coverage requirements to help manage spending and to identify instances of fraud, waste, or abuse (FWA) by providers. MA organizations often require prior authorization for certain services, which means that a health care provider must get approval from the MA plan before delivering a covered service to an enrolled beneficiary.[4]

Key Points

- MA organizations use utilization management methods, such as prior authorization for certain services prior to delivery, to manage costs and identify instances of fraud, waste, or abuse by providers.
- The use of prior authorization or other utilization management strategies to delay care delivery and payment to providers inappropriately can be considered abusive; incentives may exist for MA organizations to deny or delay care to improve financial performance.
- Mitigation strategies include enhancing oversight, audits, and report information; creating federal standard guidance for utilization management strategies; banning all use of utilization management; continuing to ban the reopening of approved authorizations; and reducing delays due to prior authorization.

Potential for FWA

MA organizations' use of prior authorizations and claim denials and other utilization management strategies is likely effective at mitigating provider FWA, but these strategies can pose risks to beneficiaries. A 2022 report from the U.S. Department of Health and Human Services Office of Inspector General (OIG) found that, among requests denied by MA organizations, 13% of prior authorization requests and 18% of payment requests were for services that met Medicare coverage rules and MA billing rules.[5] Denying medically necessary care based on Medicare coverage determinations can be considered abusive.[6] Although some denial decisions are ultimately reversed, initial denials delay medically necessary care, result in some patients abandoning prescribed treatments or missing a window of beneficiary readiness for treatment, and can burden providers with administrative costs, creating waste by diverting resources away from clinical care. Prior authorization processes that delay care can also be abusive to the extent that the delays mean care is not delivered in

accordance with professionally recognized standards. In addition, there is a risk that prior authorization, claim denials, and delays may be applied inconsistently, which could disproportionately increase barriers to care among some subgroups of patients or providers.[7,8]

There is a potential incentive for MA organizations to inappropriately delay access to services and delay payment to improve financial performance.[9] MA organizations can invest the money they hold between the time they collect monthly capitation payments and beneficiary premiums and the timing of payment to providers, known as insurance float.[10] The MA organizations benefit from the returns on those investments, and, because the proceeds are excluded from the calculation of income in medical loss ratios, there may be an additional incentive for MA organizations to deny or delay payments to increase investment income.[11] The use of prior authorization or other utilization management strategies to delay care delivery and payment to providers inappropriately can be considered abusive.

Mitigation Approaches

Enhance oversight, audits, and report information to beneficiaries. Currently, CMS uses different mechanisms (i.e., program audits, enforcement actions, and Star Ratings) to oversee MA organizations' denial and appeal processes, identify inappropriate denials, and incentivize MA organizations to improve performance.[12] CMS also requires MA organizations to conduct oversight of utilization management. For example, as of January 2024, CMS required all MA organizations to establish a Utilization Management Committee to review and approve all prior authorization and other utilization management policies at least annually to ensure consistency with TM coverage decisions and guidelines.[13] In its 2027 final rule, CMS removed some requirements for MA organizations' utilization management committees;[14] it is unclear whether the changes will have any impact on fraud, waste, or abuse.

Utilization management strategies are not measured directly in Star Ratings but can indirectly appear in some measures. For example, if prior authorization denials lead to delays or gaps in care, patients may miss preventive services or medication adherence that is measured in the current quality indicators. In addition, if patients face many barriers to care due to utilization management policies, it could be reflected in Star Rating measures of disenrollment rates, member satisfaction, or complaints.[15] CMS has decided to remove the measures relating to appeals, complaints, and disenrollment from the Star Ratings calculations as of 2029.[16] The rationale included high performance on appeals and complaints measures, and that for the disenrollment measure, MA organizations expressed dissatisfaction with its calculation and claimed it is hard for beneficiaries to interpret.[17] There is some risk that removal of these Star Rating measures could reduce MA organizations' accountability for inappropriate denials; however, CMS does intend to continue monitoring or displaying some of these measures.[18]

One policy option is for CMS to require ***MA organizations to report more details about authorization denials*** like physician specialties, the service that was denied, the reasons for denials, and possibly the ownership interest between the provider and MA organization.[19,20,21] As of March 31, 2026, MA organizations must report publicly each year on their use of prior authorization, including the average time between the submission of a request and a determination; the percentage of requests approved, denied, and approved after appeals; and the items and services that require prior authorization.[22,23,24] Transparent reporting requirements can reduce the risks of abuse and can show whether provider ownership is associated with higher approval rates, suggesting possible waste. Another option is to report MA plans' denial rates and utilization management practices directly on Medicare Plan Finder, so it is easier for beneficiaries to access the information to compare plans.[25] An enforcement consideration for CMS is to direct MA organizations to examine their processes for manual review and system programming and correct vulnerabilities that result in inappropriate denials based on the data.[26] CMS could consider increasing oversight of MA plans with extremely high initial denial rates, overturn rates for denials, or low appeal rates.[27,28,29] CMS could use its civil monetary penalty authority to fine MA organizations for having too high a rate of prior authorization denials, reversals, or audit violations.

Another policy option is for CMS or MA organizations to ***publicly report prior authorization criteria***.[30] In the 2024 CMS final rule, CMS did not propose public reporting or provide comment on the topic but did encourage MA organizations to provide beneficiaries and providers with coverage or clinical criteria information relevant to individual prior authorization decisions.[31] Some states have started to require insurers to publicly post their prior authorization policies, clinical criteria, and documentation requirements for patients to access.[32] Making the criteria accessible to the public may increase transparency and deter fraudulent or abusive behavior like inconsistent use of prior authorization.

CMS could also ***include behavioral health services in audits of MA prior authorization*** usage.[33] A 2025 U.S. GAO report found that eight out of the nine MA organizations reviewed required prior authorization for behavioral health services and that CMS does not target these services in its oversight of prior authorization.[34] The prior authorization process and possible delays for behavioral health care services may result in missing a window of patient readiness for treatment, meaning patients may miss out on care consistent with professionally recognized standards.[35] In addition, behavioral health practices are particularly short staffed, so the prior authorization process may be more onerous and create more waste, for example, if it has to be done manually.[36] By scrutinizing use of prior authorization in behavioral health services, CMS can ensure that coverage criteria are consistent with TM and identify whether any MA organizations are not compliant with Medicare standards, thereby potentially identifying cases of abuse.[37] Similar to previous policy options, reporting prior authorization usage could deter

wasteful or abusive behaviors. MA organizations would need guidance on how to code and submit behavioral health service data to CMS, which may require more time and resources on the MA organization side.

Another policy option would be to ***include audit violation findings in the Star Rating measures*** with direct effect on quality ratings. As of 2019, CMS audit findings and enforcement activities of MA utilization management tools do not affect MA Star Ratings.[38] Instead, MA plans with audit violations have an indicator on Medicare Plan Finder that links to a list of violations.[39] Beneficiaries can use Star Ratings to evaluate and choose their health plans and plans' payments can be higher if they receive higher Star Ratings.[40] Including audit violations in MA plans' quality rating and subsequent payments would reduce the incentive for MA organizations to use utilization management inappropriately, promote transparency and accountability, and align financial rewards with quality metrics. Not all measures are appropriate for use in Star Ratings; if that were the case for an audit violation measure, other methods of public display could be considered.

For all oversight options mentioned, CMS would need more resources to monitor and audit MA plans in a more intensive and timely manner to deter improper behavior.

Create federal standard guidance for utilization management strategies. To mitigate fraud, waste, or abuse risks from improper use of utilization management tools, CMS or Congress could ***issue guidance about the appropriate use of AI***, including standards on human involvement in particular.[41,42] In the 2024 CMS final rule, CMS clarified the clinical criteria guidelines that MA organizations should use in medical necessity reviews.[43,44] These criteria are used by MA organizations to determine whether a specific health service should be approved or reimbursable.[45] Some MA organizations use AI or other algorithms to assist in these decisions. However, a 2022 OIG report found that most incorrect payment and prior authorization denials sampled were due to human error or system processing errors.[46] If AI models or algorithms are trained on historical data that include these errors, they risk perpetuating flawed decision-making. Currently, three ongoing court cases allege that MA organizations inappropriately relied on AI to make coverage decisions, disregarding clinical determinations by providers.[47,48,49] Some states have started to reinforce that human oversight is needed, require insurers to disclose the use of AI, and prohibit the use of AI systems to issue adverse determinations without human review.[50] A standard guideline can increase transparency and help CMS detect possible abuse propagated by AI.

Another policy option is for CMS to ***provide guidance to beneficiaries and providers about the appeals process and their appeal rights***.[51] Currently, less than 10% of adverse determinations are appealed.[52] This policy change may increase the volume of appeals initially but reduce the

volume over the long term because plans would have to weigh the costs of dealing with appeals versus the potential savings from denying care in borderline cases. CMS would need to consider how to disseminate this information to beneficiaries.

Ban all use of utilization management. An extreme policy option that has been proposed is to ban all use of prior authorization, utilization management strategies, and medical necessity reviews by MA organizations.[53,54] In response to public comments that called for a ban of all prior authorization use, CMS stated that it does not believe it has the authority to issue a sweeping prohibition of prior authorization and that the payment structure between the MA plan and provider for value-based care is a private matter.[55] To end the use of prior authorization, Congress could provide authority for independent physician-led nonprofit organizations to conduct prior authorization reviews.[56] This approach would remove the payers' profits from the decision-making process but would be costly to implement, based on experience with a similar Professional Standards Review Organization program that operated for around a decade starting in the 1970s.[57] Another approach to end prior authorization would be to reduce payments to providers modestly, recognizing that they would have greater professional autonomy and reduced administrative costs in the absence of prior authorization.[58] For any health care program, removing prior authorization would be difficult to implement, could increase premiums, and may reduce any cost savings that occur as a result of provider avoidance of the prior authorization process.[59] It is also unlikely to be feasible in MA given the range of different approaches to paying providers. The elimination of utilization management tools could reduce opportunities for vague-decision making that may hide fraud by MA organizations. However, banning all utilization management strategies would increase the risk of FWA by providers and remove a powerful tool that MA organizations can use to manage costs by reducing low-value or unnecessary care. In addition, MA organizations and providers would need clear, standard guidance on what items and services must be covered. Payment arrangements that move providers away from fee-for-service reimbursement and thereby reduce the incentive to deliver unnecessary services may be a more feasible approach to reducing the need for prior authorization in MA.[60]

Continue to ban the reopening of previously approved authorizations. By banning these reopenings, CMS reduced the ability of MA organizations to manipulate payment timing for financial gain by generating investment income and to shift the costs of previously approved care to providers and beneficiaries. CMS recently finalized a proposed rule that would restrict MA organizations' ability to reopen and possibly adjust a previously approved inpatient hospital admission authorization.[61,62] CMS stated that the goal of this provision is to ensure that MA organizations honor the approved prior authorization.[63] Previously, hospitals had to absorb the cost of inpatient admissions if MA organizations reversed previous decisions that deemed the admissions to be medically necessary and reimbursable.[64] Hospitals could also seek payments

from patients to cover the costs of the retrospective denial.[65] The introduction of this rule should help to reduce abuse risks associated with reversing decisions.

Reduce delays due to prior authorization. In June 2025, a group of health insurers with plans in MA and other markets pledged to implement six policies aimed at streamlining, simplifying, and reducing prior authorization.[66,67,68] Participating organizations promised to implement standardized prior authorization submission processes (already required for MA as of 2027),[69] reduce the scope of services for which prior authorization is required, honor existing prior authorizations for 90 days after a patient's change in insurance (already required for MA),[70] provide clear explanations of prior authorization decisions and guidance on appeals (required for MA starting January 1, 2026),[71] approve 80% of electronic prior authorizations in real time by 2027, and continue medical review of all denied requests.[72] These changes, if implemented consistently, could reduce delays in access to care and payments to providers and reduce waste related to providers' resources to handle prior authorization. The voluntary approach has some implementation benefits such as reducing lead time and cost of government spending on developing regulations. However, it also has risks, such as a lack of clarity regarding how CMS will measure and evaluate compliance, the possibility that the nonbinding pledge will fail to sustain changes long term, and the possibility that nonparticipating insurers may not change their behavior. The federal government has indicated that regulation remains a possibility if issuers do not comply with the pledge.[73]

Per the CMS 2024 final rule, and consistent with the pledge, starting in 2027, MA organizations are required to adopt and maintain Health Level 7® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) application programming interfaces (APIs) that aim to improve the exchange of information electronically and streamline the prior authorization process.[74] MA plans, patients, and providers will have access to patient data to increase transparency and reduce the burden of prior authorization and thereby reduce the waste of diverted clinical resources.[75] CMS could ***codify the adoption of a standard electronic prior authorization process*** to ensure long-term implementation and consistency for all involved.[76,77] By codifying the process, it becomes permanent and legally binding for the future. Permanent enforcement ensures long-term adherence and prevents MA organizations from reverting to less transparent practices that may conceal abuse.

Starting in 2026, CMS will require MA organizations to respond to standard prior authorization requests within 7 calendar days and urgent prior authorization requests within 72 hours.[78] CMS or states could implement policies to ***further reduce prior authorization timelines***.[79,80] For example, some states have prior authorization laws that cover MA and other payers and require responses to standard prior authorization requests within 3–5 working days.[81,82,83,84] One state's law requires a request to be automatically approved if an insurer misses the

deadline.[85] One organization suggests that the federal standard should be 72 hours for standard requests and 24 hours for urgent services.[86] With the adoption of an electronic prior authorization process in 2027, the process of sending and receiving needed documentation should be quicker and more efficient.[87] By reducing prior authorization timelines, there would be fewer delays in care, which would decrease the risk of abuse by MA organizations. [88,89]

Alternative policies could require MA organizations to automatically approve a service when the provider has a history of prior authorization approval of 90% or higher for that service, or ***"gold card" laws or policies***.[90,91,92,93] Gold card policies can be implemented at either the state or federal level or voluntarily by MA organizations.[94,95,96,97,98] They can streamline the prior authorization process for providers that usually get approved, reducing waste related to provider resources. With fewer delays and denials of necessary care, there is less risk of abuse by MA organization as their ability to increase investment income by delaying payment is lessened. In addition, this would allow MA organizations to focus on and investigate requests that may be more likely to involve provider FWA. Some implementation considerations include the timeline for notifying providers , how long providers need to be in good standing to receive gold-card status, and how providers could appeal if they lose gold-card status.[99,100,101,102] There are also considerations related to whether services should be included in the gold-card program or exempted from prior authorization altogether, such as in the case of low-cost, high-value services.

Regulate payment methods for prior authorization denials. Prior authorization vendors offer technology solutions to both payers and providers to support prior authorization processes. Although they may improve efficiency and timeliness, thereby reducing waste in processing requests and delays in decision-making, such technology can also create risks of fraud or abuse if they are calibrated to deny too many requests. A particular risk occurs if vendors are paid based on their volume of denials, as this creates an incentive to deny as many requests as possible, even if some requests should have been approved based on Medicare coverage criteria. One option to reduce this risk is to prohibit payment arrangements that involve vendors being paid based on their volume of denials. This option could reduce the volume of inappropriate denials.

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TOPIC: PAYER-PROVIDER VERTICAL INTEGRATION

Background

Key Points

- Vertical integration between payers and providers in Medicare Advantage may improve coordination and data sharing.
- Vertical integration can also create risks of fraud, waste, and abuse (FWA) through gaming medical loss ratio (MLR) limits, inflating patient risk scores, and steering patients within the integrated organization.
- Mitigation strategies include improving data transparency, updating MLR requirements, creating federal guidance on beneficial integration, increasing enforcement of antitrust laws, and updating or implementing Corporate Practice of Medicine (CPOM) laws.

Vertical integration in health care refers to the consolidation of different parts of the health care delivery system under a single corporate umbrella.[1,2] Although integration in health care can encompass a range of structural and functional models, this chapter focuses specifically on vertical integration between payers and providers within Medicare Advantage (MA). This is sometimes referred to as a "payvider" model because one company owns both the payer, or insurance, and the provider, or care delivery, sides of health care.[3,4] It can occur when a health insurance issuer acquires providers or when a health system creates its own insurance product. Vertically integrated payer-provider arrangements (which generally participate in MA as well as other markets) aim to improve coordination, reduce fragmentation, and enhance patient outcomes, and they often support value-based care.[5,6] In addition, vertical integration can simplify patient navigation if it can reduce duplicative care management and logistics activities and facilitate more seamless data and information sharing.[7,8] Vertical integration between MA plans and hospitals has increased over time, with 2,190 hospitals integrated with MA plans and 230 MA plans integrated with hospitals or hospital systems as of 2024.[9] Vertical integration of MA plans with other types of providers is also widespread; UnitedHealth Group is reported to have 90,000 physicians (10% of the US physician workforce) and 40,000 advanced practice clinicians who are employees or affiliates.[10] However, there is a lack of transparency and data on ownership and pricing for MA vertical integration, and regulations generally assume providers and payers are separate entities.

Potential for Fraud, Waste, and Abuse (FWA)

Despite some potential benefits, there are three ways vertical integration may increase the risk of FWA. First, vertically integrated organizations may shift profits to provider subsidiaries to ***game the medical loss ratio (MLR) limits*** that apply to MA plans and avoid government oversight.[11,12,13] The current MLR threshold is 85%, which means that MA plans must spend at least 85% of their revenue on patient care and quality improvement.[14] If an MA plan fails to meet the MLR threshold for 3 or more consecutive years, the Centers for Medicare & Medicaid Services (CMS) can require the plan to repay the difference or it can issue sanctions, like prohibiting new enrollment.[15,16] Vertically integrated MA plans could game the system by paying higher prices to their own providers relative to others in the same market and by increasing the amount categorized as medical spending, thereby artificially inflating their MLR.[17,18,19] By making higher internal payments, MA plans can mask profits and increase spending without improving quality or delivering more care, which may contribute to FWA in MA.[20] MA plans can then exploit their market power by increasing premiums to cover the apparently higher medical costs.[21] There are similar concerns about MLR limits driving vertical integration and higher provider payments in Marketplace plans where there are similar MLR limits.[22]

Second, vertically integrated entities can ***inflate patient risk scores*** because they may have more influence over providers' coding practices. This can be achieved by implementing coding protocols, embedding prompts in medical record systems, incentivizing aggressive documentation, or conducting retrospective chart reviews to identify every possible condition that can increase a beneficiary's risk score and associated payments from Medicare (see Coding Intensity section).[23] For example, two years after physicians were employed by corporate primary care practices, which often have risk-based or ownership arrangements with MA organizations, their patients' risk scores increased by 25% without additional evidence of increased health care utilization.[24] Vertically integrated MA organizations' greater level of control over medical charts also offers more opportunity to align charts with encounter data, thereby reducing the chance that MA risk adjustment data validation audits will identify unsupported diagnoses and weakening the audits as a tool for combatting inappropriate coding.

One payment arrangement that can accelerate inflation of patient risk scores is sub-capitation, a subset of global capitation where MA plans pay a provider group a set fee upfront, and the provider group then pays its own physicians on a capitated basis.[25] This arrangement is typically structured as a percentage of premium, meaning that as coding intensity increases, Medicare's payment (or premium) to the plan increases, and with it the provider's revenue also increases. The provider may have an incentive to increase coding intensity because it also increases the

sub-capitated payment. Although upcoding is a concern in any sub-capitation arrangement, the risks are greater if the MA organization owns the provider organization because it also carries the risks of MLR gaming and price inflation due to the fact that the entire sub-capitation payment to a contracted provider for clinical services is considered patient care even if it contributes profits to the provider arm of the MA organization.[26]

Third, vertically integrated MA plans may generate "captive revenue" by ***steering their beneficiaries toward their affiliated health care providers,*** or by providers steering their patients to the integrated MA plan. This steering may introduce concerns about conflicts of interest and legal risks related to the federal Anti-Kickback Statute and the Stark Law on physician self-referrals.[27,28,29] Similar to practices that can occur within large provider systems and other limited provider networks, steering within vertically integrated MA plans can restrict patient choice and access and potentially drive up health care costs, producing waste.[30] In addition, steering within vertically integrated plans can adversely affect competition, both for unaffiliated providers that may receive fewer (or more costly) referrals, lower rates, and potentially other unfavorable contract terms, and for rival payers that may face higher provider costs.[31] Risks may increase if competitor information held by a business unit is shared with other parts of the vertically integrated organization, or if sharing of critical patient data outside the organization is blocked.[32,33]

Mitigation Approaches

Improve Data Transparency. There is a lack of understanding concerning the way that vertically integrated MA plans operate, including internal payment data and the scale and impact that vertical integration may have on MLRs. Currently, as part of their bids MA plans directly report to CMS on their arrangements with related parties, including services provided by related parties and how prices for those services compare to costs in the absence of related parties.[34] A policy option for addressing this issue is ***requiring vertically integrated MA plans to disclose and publicly report*** detailed information on any department or subsidiary that provides medical services or products as well as information on payments to providers. [35,36,37,38,39,40,41] Payment information could include transfer prices, which are the internal prices that MA plans pay their affiliated providers, and non-claims or incentive-based payments to affiliated providers. Members of Congress attempted to pass legislation that would require reporting to the Secretary of Health and Human Services as well as some public reporting on ownership, transfer prices, incentive-based payments, and loss recoupment by corporations that own health systems.[42,43] A transparent reporting requirement policy option could be implemented at the federal or state level.[44,45] If applied to MA plans, enhanced transparency could reveal potential conflicts of interest and help antitrust enforcement agencies track patterns of anticompetitive behavior or instances of MLR manipulations to reduce fraud and abuse in

MA.[46] Information on contracts between vertically integrated providers and rival payers could also provide better data on the anticompetitive impacts of vertical integration.[47] Streamlined reporting requirements for small transactions would help enforcement agencies track patterns where multiple small acquisitions contribute to vertical integration.[48]

Update MLR requirements. One policy option is for ***CMS to establish benchmarks for reasonable transfer prices***.[49,50] CMS could use prices from Traditional Medicare (TM) fee schedules as transfer prices, or CMS and MA plans could prospectively develop advance pricing agreements that establish approved methods and pricing for transfer prices.[51] This could occur through an application process whereby MA plans propose their transfer pricing approach and include financial records on how they priced health care procedures in the past.[52] CMS could then review and negotiate with the MA plan about its approach.[53] Any approach that requires MA organizations to use a particular price structure for provider payments is likely to require Congressional action to amend the non-interference clause in the Social Security Act that prohibits CMS from requiring a particular price structure.[54] There are several weaknesses with this option, including difficulties in identifying owned entities, determining appropriate profit margins, and breaking out prices when MA organizations use many different approaches to paying providers, such as salaried employees, capitation, and fee-for-service contracts. Price negotiations between CMS and MA organizations for all contracts also would be very resource intensive. In addition, it is not certain that this option would reduce waste because prices may be set too high, and such an approach could also reduce MA plans' ability to pay higher rates based on quality.

Another policy option is for ***CMS to implement a separate sub-capitated MLR reporting requirement.*** MA plans can pay affiliated providers through sub-capitation or other non-claims payments that essentially transfer some of the insurance risk and profit to the provider. Under MA's current MLR rules, payments to affiliated providers count as medical spending even if the parent company realizes profits from its affiliated provider organization.[55] Similar to the previous option, the disclosure of pricing and mandatory reporting could reduce the ability of vertically integrated MA plans to artificially inflate their MLRs through sub-capitated payments. However, it is not certain that this option alone would reduce waste because the incentives for coding intensity would remain, and it may increase the incentive for engaging in overutilization.

Congress could ***raise the MLR for all MA plans*** to ensure that public funds are spent on care rather than on other activities.[56] A related option could involve raising the MLR standards just for vertically integrated MA plans. However, it is unlikely that higher MLRs would reduce waste or abuse specifically associated with vertically integrated plans, because higher MLRs would increase the incentives to code intensively to maximize payments and engage in unnecessary or overpriced utilization.[57]

Congress also could require that ***MLR standards be expressed as a dollar value per beneficiary*** rather than as a percentage of MA organization revenue. For example, currently, an MA plan receiving a per-beneficiary per-month (PBPM) payment of $1,200 for beneficiaries with an average risk score of 1.0 would have an MLR of $1,020, meaning the plan can spend up to $180 PBPM on non-medical costs/profits. If the same MA plan has beneficiaries with an average risk score of 1.2, the payment would be $1,440 and MLR would be $1,224, meaning that the plan can spend up to $216 PBPM on non-medical costs. Similarly, the average allowance for non-medical costs is much higher in absolute value for plans operating in counties with higher benchmarks or for plans with higher Star Ratings. For example, where the rate is $1,500 PBPM and beneficiaries have an average risk score of 1.0, the MLR is $1,275 and the plan can spend up to $225 on non-medical costs. Expressing the MLR requirement as a dollar value (e.g., an average non-medical cost limit of $180 PBPM) would reduce the profitability of intensive coding. However, it may not reduce the incentive for vertical integration because additional profits beyond the limit could still be hidden if realized by the provider arm of the organization. For this policy to be implemented, CMS, Congress, or other government entities would need to set the initial amount and determine how to adjust for inflation and regional cost differences.

Create federal guidance on beneficial integration. To reduce the fraud, waste, and abuse risks from vertical payer-provider integration, CMS, Congress, the Department of Justice (DOJ), and the Federal Trade Commission (FTC) could ***define the characteristics of beneficial integration***.[58,59] This could include issuing formal guidelines that distinguish high-value consolidation or integration from arrangements that may undermine competition or the quality of care.[60,61] Congress could allocate resources to analyze existing vertically integrated relationships to determine what characteristics of integration are associated with improved outcomes, and agencies could develop best practice guidelines.[62] The agencies could then evaluate new integration proposals against the guidelines, monitor adherence to the guidelines, and potentially enforce noncompliance. A related option would be to offer payment incentives to encourage consolidated organizations to adopt and follow the guidelines.[63] One weakness of this policy option is that it could incentivize consolidated organizations to follow the recommended guideline at the expense of other innovations to improve clinical practice.[64] It also could be costly to implement, and the extent to which it would reduce FWA is unknown.

Increase enforcement of antitrust laws. In December 2023, the DOJ and FTC updated their merger guidelines to include stronger standards for merger review, which included serial acquisitions and patterns of consolidation that can create market power or reduce competition.[65,66] In May 2024, the DOJ created a Task Force on Health Care Monopolies and Collusion, signaling increased interest in addressing competition in health care markets.[67,68] Options for enforcement actions could include breaking up large integrated systems,[69] or requiring vertically integrated organizations to divest either their insurance or provider

entities.[70] However, such breakups would be technically difficult to achieve, and likely to face significant opposition.

To strengthen enforcement, ***Congress could direct more resources to supporting antitrust enforcement and give more authority to antitrust regulators***.[71,72,73,74] For example, Congress could change the law to enable the FTC to enforce prohibitions against anticompetitive conduct by not-for-profit firms, which carry the same vertical integration risks as for-profit health care firms; alter the standard for competitive harm; and change the criteria for presuming that a merger or conduct is illegal.[75] Antitrust laws also can be enforced at the state level. Several states have established requirements and enforcement agencies dedicated to health care transactions.[76,77,78,79] These state-level requirements range from giving notice to needing approval from the state before a consolidation transaction.[80] It is unclear whether state efforts to enforce antitrust laws have successfully decreased fraud and abuse in MA.[81]

A more aggressive policy option is ***banning payer-provider vertical integration practices***.[82,83,84] Some experts advocate for a vertical consolidation policy that would prohibit insurers and pharmacy benefit managers from owning pharmacies and also prohibit insurers from owning medical providers.[85,86] The policy would be modeled after the now-repealed Glass-Steagall Act that prohibited banks from being both commercial and investment banks because of possible conflicts of interest.[87,88] A health care consolidation policy would formally challenge vertical integration in the health care sector and recognize the conflict and risk associated with a single entity being both a provider and a payer.[89] This also has parallels in the Stark Law, which prohibits physicians from referring patients to providers in which they have a financial interest.[90] The proposed Patients Over Profits Act and the Break Up Big Medicine Act would make it unlawful for any person or entity to simultaneously own or control a health insurance issuer and a service provider.[91,92,93] Restricting ownership structures could reduce anticompetitive behavior and conflicts of interest.[94] However, there would be significant implementation challenges because of the high degree of vertical integration in the market currently, which affects all health insurance markets, not just MA. In addition, Congress would have to amend the Medicare law within the Social Security Act to implement prohibitions against ownership structures.[95]

Update or implement corporate practice of medicine (CPOM) laws to reduce risks associated with vertical integration.[96,97,98] CPOM laws generally block unlicensed individuals and lay corporations from owning, employing, or controlling physician and medical practices.[99] As a workaround to CPOM laws, many corporate entities have a professional corporation (PC) or a management services organization (MSO) model.[100,101] CPOM laws require PCs to be mostly owned by a physician, and the PC controls clinical decisions. MSOs help medical practices with administrative services.[102] In an extreme version of the PC-MSO model, the MSO contracts with

a physician who has a financial interest in the MSO.[103] The contract narrowly defines clinical decisions that the physician would have a say in while the MSO controls all other business and administrative decisions.[104] By enforcing physician control, CPOM laws may reduce the risk of upcoding or unnecessary procedures and conflicts of interest between insurers and their provider networks that can contribute to FWA in MA.

Several states have attempted to pass updated CPOM laws.[105,106,107,108] For example, Oregon attempted to place guardrails around the PC-MSO model specifically.[109,110] The proposed bill listed activities that PCs would have ultimate control over, such as coding practices, staffing, and patient time, and provided examples of prohibited partnerships that give control to MSOs, such as stock transfer restriction agreements and dual ownerships.[111,112] The updated law would give the state the authority to block health care transactions that violate CPOM laws but it would not provide resources to monitor, investigate, or bring action to enforce compliance with existing partnerships.[113]

Another policy option that can be implemented at the state or federal level is ***prohibiting certain contract provisions between providers and payers*** that could increase the risk of FWA.[114] Prohibited contract provisions might include noncompete agreements, gag clauses or other mechanisms that prevent sharing information with patients about provider cost and quality, and a physician's ability to control shares of their practice.[115,116] By protecting physician control, contracting laws may reduce the risk of upcoding and unnecessary procedures as well as conflicts of interest between insurer and provider networks that contribute to fraud, waste, and abuse in MA.

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TOPIC: DUAL ELIGIBLE SPECIAL NEEDS PLAN (D-SNP) LOOK-ALIKES

Background

D-SNPs are a type of MA plan designed for individuals who qualify for both Medicare and Medicaid.[1] These plans operate under a CMS-approved Model of Care, which requires the coordination and integration of services across both programs.[2] D-SNPs are also required to establish contracts with state Medicaid agencies that define responsibilities for benefit coordination and alignment.[3] CMS has implemented D-SNP integration policies with the aim of coordinating Medicare and Medicaid services, reducing cost-shifting incentives between Medicare and Medicaid, and facilitating a seamless experience for enrollees.[4]

Key Points

- D-SNPs plans are designed for individuals who are dually eligible for Medicare and Medicaid. They operate under a CMS-approved Model of Care requiring coordination and integration of services across both programs and are subject to specific regulatory requirements, including formal contracts with state Medicaid agencies.
- D-SNP look-alike plans are standard MA plans and present risks of FWA if they mislead beneficiaries about the integrated coverage offered or if MA organizations are avoiding the costs of complying with D-SNP requirements designed to protect beneficiaries and payers.
- Mitigation options include limiting dual eligible enrollment in non-D-SNP plans, increasing integration requirements for look-alike plans, limiting enrollment of dually eligible beneficiaries to D-SNPs, and limiting deceitful marketing strategies by look-alike plans.

Potential for FWA

Some standard MA plans, referred to as D-SNP look-alikes or "mirror" plans, primarily enroll dual-eligible individuals but are not officially recognized as D-SNPs.[5] Look-alike plans are not subject to the same regulatory requirements as D-SNPs, such as care coordination or formal contracts with state Medicaid agencies. Look-alike plans may present risks of FWA if plans mislead beneficiaries about the integrated coverage offered or if MA organizations are gaming the system by avoiding the costs of complying with D-SNP requirements designed to protect beneficiaries and payers from unnecessary, duplicative, or missed services that can occur in the absence of integrated care.

Chronic Condition Special Needs Plans (C-SNPs) that primarily enroll dually eligible beneficiaries are similarly exempt from some of the coordination requirements that apply to D-SNPs but also are exempt from look-alike termination policies if they enroll a high proportion of dually eligible beneficiaries.[6] Both the number of C-SNP plans and C-SNP enrollment among dually eligible beneficiaries have increased significantly in recent years.[7,8] Dually eligible beneficiaries also comprise around 90% of enrollees in Institutional Special Needs Plans (I-SNPs), but I-SNP plan offerings and enrollment patterns have remained more consistent in recent years.[9] I-SNPs are for beneficiaries needing long-term care in facilities like nursing homes for more than 90 days.[10] There is a risk that MA organizations could mislead dually eligible beneficiaries about integration of coverage offered under C-SNPs or I-SNPs or promote these plans to avoid the costs of complying with CMS and state requirements that apply only to D-SNPs.[11,12]

Mitigation Approaches

Limit dual eligible enrollment in non-D-SNP plans. CMS will not renew or enter into a contract with an MA plan if its projected total enrollment is 70% or more dually eligible beneficiaries unless the plan is a designated and approved D-SNP. (C-SNPs and I-SNPs are exempt from this requirement.) This threshold decreased to 60% in 2026.[13] To help MA organizations meet this threshold, CMS has allowed look-alike plans to transition members into a true D-SNP or MA plan with $0 cost sharing by the same sponsor. One policy option is to lower the threshold even further—for example, to 50%.[14,15] This would still exceed the proportion of beneficiaries who are dually eligible nationally (16% in 2025).[16] As an alternative, the threshold could be indexed to the proportion of beneficiaries who are dually eligible at a county level to account for geographic differences in dual eligibility. CMS could also apply the threshold to C-SNPs and I-SNPs, only count beneficiaries with full dual benefits toward the threshold, or exempt plans in states with no D-SNPs.[17,18] Lowering the dual eligible enrollment threshold makes it harder for majority-dual plans to pose as D-SNPs while not adhering to all D-SNP requirements. However, lowering the dual eligible enrollment threshold would result in plan terminations that could disrupt beneficiary access to care.

Increase integration requirements for C-SNPs and I-SNPs. Given the high enrollment of dual eligible beneficiaries in C-SNPs and I-SNPs, policies to increase integration requirements for these plans could be less disruptive than prohibiting them from having high dual enrollment. For example, CMS could require C-SNPs and I-SNPs with 60% or more dually eligible enrollees to contract with state Medicaid agencies to ensure benefit integration, or CMS could introduce care coordination requirements for C-SNPs and I-SNPs consistent with requirements for D-SNPs.[19] These approaches could reduce waste and abuse by minimizing duplicative services and the potential for cost shifting.

Automatically enroll dually eligible beneficiaries in D-SNPs. Another option is for states to automatically enroll beneficiaries who are dually eligible in a D-SNP.[20] As demonstrated in the Financial Alignment Initiative, this could increase enrollment and retention in integrated plans.[21] However, automatic enrollment or locking enrollees in to a D-SNP restricts beneficiary choice and can disrupt continuity of care and create unmet need.[22] Automatic enrollment also may not be appropriate given mixed evidence regarding whether D-SNPs produce better outcomes for enrollees.[23] In addition, this policy option may only be viable in counties where there are multiple D-SNPs,[24] and it would be difficult to determine which plan to assign if there are multiple options in a county.

A variant of this option is to nudge dually eligible beneficiaries toward D-SNPs via Medicare Plan Finder and other sources of information. For example, if visitors to Medicare Plan Finder indicate that they are eligible for Medicaid, the filters are set automatically to show only D-SNPs if any are available in that area. To make it more difficult to mislead beneficiaries, CMS could require similar choice architecture in other information sources such as agents, brokers, and industry versions of Medicare Plan Finder. Just as beneficiaries can adjust the filters on Medicare Plan Finder if they wish to consider other options, they could also ask agents and brokers for additional options if this option were implemented. As noted earlier, D-SNPs may not be the best choice for all beneficiaries given that it is unclear whether D-SNPs provide better outcomes or reduce spending relative to other MA plans or TM.

Limit deceitful marketing strategies by look-alike plans. A 2022 study of MA marketing practices found that dually eligible beneficiaries, who are allowed to switch plans more often than other MA beneficiaries, were being targeted disproportionately with aggressive marketing tactics.[25] In the years following the publication of this report, CMS prohibited look-alike plans from claiming their plans are for dually eligible individuals in their marketing efforts.[26,27]In addition, starting in contract year 2024, CMS restricted the marketing of plans that mislead using the Medicare name, the CMS logo, or information issued by the federal government.[28] The intent of these marketing limitations is to increase transparency and reduce confusion for dually eligible beneficiaries.[29] Limiting deceitful marketing strategies by look-alike plans makes it harder for majority-dual plans to pose as D-SNPs. It is not yet clear if these policy changes have been effective. Another policy option is to implement other recommendations from the Senate Finance Committee's report such as the use of regular proactive oversight of MA marketing materials to ensure compliance with CMS rules.[30]

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