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.

References

[1] Centers for Medicare & Medicaid Services. (2021 January). *Medicare fraud & abuse: Prevent, detect, report* (MLN Booklet). U.S. Department of Health & Human Services. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf

[2] *Ibid.*

[3] Centers for Medicare & Medicaid Services. (2013). *Medicare managed care manual* (Chap. 21, Compliance program guidelines) (Rev. 110). https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf

[4] *Ibid.*

[5] Centers for Medicare & Medicaid Services. (2021). *Medicare fraud & abuse: Prevent, detect, report*. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/fraud-abuse-mln4649244.pdf

[6] Freed, M., Cubanski, J., & Neuman, T. (2025 March 31). *Medicare program integrity and efforts to root out improper payments, fraud, waste, and abuse*. KFF. https://www.kff.org/medicare/medicare-program-integrity-and-efforts-to-root-out-improper-payments-fraud-waste-and-abuse/

[7] Centers for Medicare & Medicaid Services. *Medicare managed care manual* (Chap. 21, Compliance program guidelines) (Rev. 110).