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.

References

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[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

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TOPIC: CODING INTENSITY AND FAVORABLE SELECTION

Background

Risk adjustment is designed to ensure that Medicare Advantage (MA) plans receive sufficient payment for beneficiaries regardless of differences in health status. The Centers for Medicare & Medicaid Services (CMS) risk adjusts MA plan payments to account for variations in cost based on enrollee health status and demographic factors. This ensures that, on average, plans are paid less for healthier beneficiaries and more for sicker beneficiaries relative to what they would be paid for beneficiaries with an average health risk profile. "Coding intensity" refers to the extent to which

Key Points

- Risk adjustment is necessary to ensure that payments to MA plans account for the higher health care costs for sicker beneficiaries. Despite risk adjustment, favorable selection remains when plans disproportionately enroll or retain beneficiaries whose costs are low relative to the payments received.
- Fraud, waste, and abuse (FWA) risks arise when MA organizations use inappropriate coding intensity strategies to make enrollees appear sicker and thereby increase their payments from Medicare. Risks also arise when MA organizations use inappropriate strategies to enroll or retain lower-cost beneficiaries or discourage enrollment or encourage disenrollment among higher-cost beneficiaries.
- Policy-based mitigation strategies include:
  - eliminating chart review diagnoses from risk adjustment,
  - eliminating health risk assessment (HRA)-only diagnoses from risk adjustment,
  - using 2 years of diagnosis data for risk adjustment,
  - refining the coding intensity adjustment factor,
  - refining or redesigning the risk adjustment approach,
  - introducing a reinsurance policy,
  - limiting contractual arrangements that incentivize providers to capture more diagnosis codes,
  - introducing competitive bidding,
  - setting benchmarks administratively,
  - limiting MA marketing tactics,
  - introducing multiyear MA plans,
  - auto-enrolling beneficiaries in MA plans, and
  - requiring broader provider networks.
- Oversight-based mitigation strategies include:
  - increasing the number of and improving the timeliness of risk adjustment data validation (RADV) audits,
  - extrapolating results from RADV audits,
  - targeting audits and monitoring based on HRAs and chart reviews,
  - financing audits through MA plan user fees,
  - increasing financial or enrollment penalties,
  - improving calculation of coding intensity for RADV purposes,
  - focusing audits on the plans most likely to have high rates of improper payments,
  - introducing prepayment reviews, and
  - improving oversight of favorable selection.

conditions are diagnosed and the severity of the conditions diagnosed. MA plans with higher coding intensity receive higher risk-adjusted payments for a given beneficiary.

The original intent of risk adjusting MA plan payments was to reduce the incentive for MA organizations to enroll healthier-than-average beneficiaries and avoid the sickest beneficiaries, a phenomenon known as "favorable selection." Despite risk adjustment, favorable selection can still occur within a cohort—for example, the selection of beneficiaries who use fewer services than other individuals with similar risk scores and demographics. This means that favorable selection can happen at any risk score level if actual spending is lower than predicted spending. When favorable selection occurs in MA, it can create adverse selection, or enrollment of beneficiaries who are more costly than average in Traditional Medicare (TM). This favorable selection into MA and adverse selection into TM results in lower costs for MA plans and distorts risk adjustment calibration and benchmarks that are based on TM spending, particularly in counties with high MA penetration, and further increases payments to MA plans.[1]

The design of the risk adjustment model and the rules related to data that can be included in risk adjustment should help to ensure fair and accurate payment. The Secretary of Health and Human Services (HHS) has broad discretion to determine how to adjust for health status, with some specifics defined in legislation (e.g., with requirements to consider the number of conditions, the level of dual eligible benefits, as well as substance use disorder, mental health, and chronic kidney disease).[2] The current risk adjustment model uses data from TM beneficiaries to estimate costs associated with each risk factor (e.g., an age group or a diagnosis), which are converted to relative weights and used to adjust MA payments relative to the average predicted cost for a TM beneficiary.[3] CMS uses the diagnosis data that MA organizations submit to the Encounter Data System to determine payment according to the risk adjustment model. A diagnosis can only be used for risk adjustment if it is from an acceptable provider type (i.e., hospital inpatient, hospital outpatient, or professional); coded in accordance with the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding guidelines; results from a face-to-face visit; and is documented in a medical record.[4,5] CMS has established the inpatient and outpatient facilities and professional encounters that are acceptable for risk adjustment, as well as the methodologies to identify diagnoses to be used for payment purposes. CMS groups diagnoses into 266 Hierarchical Condition Categories (HCCs) and uses just a subset of the HCCs to ensure that diagnoses included in the model are specific, are not discretionary in treatment or coding, and are medically significant, enduring, and predictive of costs.[6] The risk adjustment model is prospective—that is, diagnoses and demographics (age, sex, Medicaid dual eligibility, disability status) from 1 year are used to predict costs for the following year.

CMS continues to refine MA risk adjustment to improve its ability to predict costs. For example, the new CMS-HCC model 2024 (version 28) includes updated diagnosis and spending data, ICD-10 rather than ICD-9 diagnosis codes, and clinically informed revisions to ensure that conditions included in the model are more stable predictors of costs.[7] CMS has also removed or constrained payments associated with conditions where diagnosis and coding patterns vary across plans and providers.[8] This is expected to reduce the reward for coding intensity without meaningfully increasing favorable selection.[9] The new risk adjustment model is also expected to help reduce overpayments due to coding practices, with the most impact expected on MA plans that code most intensively.[10,11,12]

CMS conducts oversight of MA payments and the risk adjustment system through various mechanisms, including tracking attestations and compliance with data submission requirements, rerunning prior years' data to determine whether plans received overpayments as a result of diagnoses that were later deleted, and conducting risk adjustment data validation (RADV) audits.[13,14] For the audits, CMS first selects risk-based samples of MA organizations and enrollees within their plans for audit, then MA organizations and their providers identify and share with CMS applicable medical records for those enrollees from the audit year, and CMS assesses the documentation to determine whether it appropriately supports the diagnoses submitted for those enrollees.[15,16] CMS can then request repayments from the MA organizations, and MA organizations may appeal if they disagree with the audit findings.[17] RADV audits are designed to detect improper payments, including overpayments due to both errors (which can contribute to waste and abuse) and fraud.

Potential for FWA

It is appropriate for MA organizations to add diagnoses and receive higher payment if the resulting risk scores reflect the cost of caring for an enrollee. However, on average, the current system results in higher risk scores in MA than for comparable beneficiaries in TM.[18,19] As a result, CMS applies a "coding intensity adjustment" that reduces the risk scores for all MA plans by 5.9% (the statutory minimum).[20] Even after the coding intensity adjustment and recent improvements to the risk adjustment approach, coding intensity still results in overpayments to MA relative to TM. The Medicare Payment Advisory Commission (MedPAC) estimated that coding intensity would result in payments that are $22 billion (4%) higher for MA beneficiaries than if the beneficiaries were enrolled in TM in 2026.[21] CMS estimated that coding intensity would have resulted in MA payments between 1.5% and 2% higher than TM if the latest risk adjustment approach had been applied in 2022.[22] The CMS estimate is lower because it used data from a different year and did not take into account the growth over time in coding intensity.[23] In addition, because the coding intensity adjustment is the same for all plans, it rewards MA organizations that code more intensively by maintaining their higher revenue

relative to other plans; that additional revenue may provide greater opportunities to increase market share through marketing or more generous plan designs.[24]

Coding intensity that results from more thorough capture of diagnoses in MA may contribute to waste. In TM, diagnosis coding may be incomplete because physicians are generally paid for services rendered and thus have less incentive to document all diagnoses each year. Greater coding intensity in MA distorts payments because the risk adjustment model is built on potentially under-coded diagnoses from TM. In addition, CMS currently uses diagnoses from a single year of data both to calibrate the risk adjustment model based on TM claims and to determine payments based on MA plans' encounter data.[25] This single-year approach may exacerbate the differences in coding between MA and TM because, without incentives to code diagnoses, providers in TM may not always list all diagnoses on claims, resulting in some beneficiaries with a chronic condition having no record of that diagnosis in some years.[26] These coding intensity incentives may contribute to waste in the form of MA organizations diverting resources to identifying and documenting diagnoses each year rather than delivering patient care.

Coding intensity can also present risks of fraud and abuse. For example, submitting intentionally inaccurate diagnoses could be fraud, and recording a diagnosis for a condition that does not require treatment based on professionally recognized standards could be abuse. In addition, MA organizations have faced legal challenges based on various coding intensity practices including:

- Submitting unsupported diagnoses, where diagnoses lack appropriate medical record documentation;[27,28,29,30]
- Instructing providers to use improper diagnosis codes or to add diagnoses retrospectively to increase payment;[31,32]
- Editing medical records to add diagnoses;[33]
- Conducting "one-way" chart reviews, which involve reviewing medical records to identify unrecorded diagnoses and submitting them for additional payment without checking for inaccurate diagnosis codes that should be deleted and therefore require repayment;[34,35]and
- Conducting in-home health risk assessments (HRAs) to collect diagnoses without proper diagnostic testing or imaging, treatment, or supporting documentation from other health care providers.[36]

Some MA organizations conduct chart reviews and HRAs to capture additional diagnoses. Chart reviews are used to identify conditions that health care providers may have missed or submitted incorrectly in encounter data records.[37,38] HRAs involve gathering diagnostic

information directly from enrollees as part of an initial or annual wellness visit or during a standalone home visit expressly for the purpose of the assessment. The impact of these activities is significant. In 2023, the HHS Office of Inspector General (OIG) found that chart reviews and HRA-only diagnoses resulted in $7.5 billion in risk-adjusted payments.[39] A *Wall Street Journal* analysis found that Medicare paid $50 billion for diagnoses added by MA organizations in the 3 years to 2021.[40] A study of 2019 data found that risk scores increased among 9.5% of beneficiaries who received HRAs due to diagnoses that were not recorded on other encounters and that their risk scores increased by 12.8% on average.[41] Similarly, a study of 2015 data found that risk scores changed among 4.5% of beneficiaries due to chart reviews and that their risk scores increased by 4.1% on average.[42] Because payment is generally based on utilization of specific services rather than diagnoses, providers in TM have less incentive to use chart reviews and rely on HRAs in a more limited way, resulting in fewer opportunities to capture diagnoses.[43] MA organizations that use chart reviews and HRAs have higher coding intensity relative to TM and to MA organizations that pursue these strategies less aggressively.

HRA and chart review practices can create risks of fraud, waste, and abuse. HRAs are rarely conducted by the patient's primary care provider, and those administering the assessments may be unable to conduct the appropriate tests to confirm a diagnosis.[44,45] Risks of unsubstantiated diagnoses may be even greater when MA organizations use chart reviews of information gathered during HRAs—also known as HRA-linked chart reviews—to identify additional diagnoses because enrollees' providers are not involved in either process.[46] Indeed, there is evidence that these practices have led to many instances of diagnoses that patients do not have either because they are impossible (e.g., cataracts in patients that have already received cataract surgery), highly unlikely (e.g., HIV diagnoses in patients not receiving antiretroviral treatment), diagnosed at unusually high rates, or otherwise confirmed as nonexistent following subsequent physician confirmation.[47,48] These practices also present risks to beneficiaries, who may be pressured or offered financial incentives to agree to participate in home HRAs, and who may be denied needed care if the MA organizations do not provide appropriate follow-up care for legitimate diagnoses identified during HRAs.[49]

Risks of improper upcoding—that is, using diagnosis codes for a more serious condition than actually exists—may be greater for vertically integrated MA plans and for other situations where MA organizations can exert more control over providers' coding practices and have greater access to the data needed to design profitable risk coding programs (see chapter on vertical integration). For example, risk score payments have been found to increase 25% in the first 2 years and 35% in the first 5 years after primary care physicians are employed by practices that are integrated with MA organizations.[50] Providers also may be incentivized or encouraged to increase coding intensity through such arrangements as receiving payments for submitting more diagnostic codes, requirements to use artificial intelligence (AI) tools or prompts to

identify additional diagnoses, sharing a percentage of the MA premium, or MA organizations directing their provider organization employees to identify more diagnoses.[51,52,53,54] These practices may increase the risk of fraud and abuse and create conflicts of interest for providers.

Risks of FWA are exacerbated by challenges with the RADV system audit processes and by legal challenges to CMS's audit authority. The HHS OIG conducted audits similar to RADV and found in November 2023 that among a group of high-risk diagnoses, 90% of diagnoses contained errors, indicating a significant need for oversight.[55] However, CMS is several years behind on audits,[56] faces legal challenges to proposed changes in audit methods (e.g., extrapolating audit findings beyond the sample of audited enrollees) that could increase penalties for inappropriate coding,[57] and must navigate a lengthy appeals processes.[58] As a result, CMS has recouped only a fraction of the estimated improper payments.[59] A September 2025 ruling vacated the 2023 RADV final rule, creating questions regarding the extent of CMS' audit authority that are unlikely to be resolved without additional Congressional or rulemaking activity.[60] The audit system thus is less effective in deterring fraud and errors, and there is greater waste because CMS audits are not recouping a majority of the improper overpayments. In addition, the RADV program's effectiveness is threatened by increasing vertical integration between payers and providers because it creates less distance between the encounter and the medical record.

Favorable selection also contributes to overpayments. For example, in 2026, MedPAC predicts that Medicare will spend $57 billion more on MA beneficiaries than it would if those same beneficiaries were enrolled in TM due to favorable selection; this is in addition to the higher payments that would result from coding intensity described above.[61] Although there are disagreements about both how to measure favorable selection and to what extent it is a problem,[62,63] there is general agreement that some favorable selection still exists in MA.

The incentives for favorable selection may lead to behaviors that constitute fraud, waste, or abuse. Drivers of favorable selection include proactive MA plan strategies, including marketing, benefit designs, utilization management, and the structure of provider networks and care management systems; and consumer behavior, including preferences for certain benefits and higher disenrollment rates among high-need enrollees.[64,65,66] Despite risk adjustment, MA plans can still benefit from favorable selection if they can attract healthier, lower-cost individuals to enroll *among those with similar risk profiles.* Problematic behaviors include incentivizing insurance agents and brokers to identify and enroll beneficiaries with lower health care utilization and avoiding beneficiaries who are expected to be more expensive (see the chapter on enrollment, agents, and brokers). Additionally, enrolling beneficiaries like veterans, who may receive most of their health care from another payer, can contribute to waste (see the chapter on cost shifting to the Veterans Affairs). Similarly, plans can nudge beneficiaries to disenroll

when their health status declines or their health care utilization increases.[67] Problematic plan behaviors include creating ghost networks or narrow specialty networks and using prior authorization to make it difficult to seek care for expensive conditions and drive selective disenrollment (see the chapters on network adequacy and misrepresentation of provider networks and prior authorization and other utilization management approaches). Benign behaviors can also contribute to favorable selection—for example, when MA plans deliver less of the low-value care that might contribute to higher utilization among beneficiaries with a given risk score in TM.[68]

In the next two sections, we describe approaches for mitigating the FWA risks associated with coding intensity and favorable selection through policy and oversight. Policy approaches generally include reducing incentives and opportunities for FWA, while oversight approaches include deterring, identifying, and holding plans accountable for inappropriate coding intensity and favorable selection.

Mitigation Approaches: Policy

Eliminate chart reviews from risk adjustment. One option raised by several stakeholders is for CMS or Congress to eliminate from risk adjustment any diagnoses documented only in chart reviews (also known as unlinked chart reviews),[69,70,71,72,73] or to limit how much risk scores could increase as a result of chart reviews.[74] Consistent with this approach, CMS announced that, as of 2027, it will exclude diagnoses obtained from unlinked chart review records from risk adjustment calculations, except for beneficiaries who switch to a plan with a different MA organization.[75] Studies have estimated that chart reviews account for around one-third of coding intensity overpayments[76,77] and that eliminating chart reviews as a source of diagnoses for risk adjustment would reduce MA payments by roughly $7 billion annually.[78,79] The new CMS policy is more limited in that it only excludes diagnoses from chart reviews if they are not also identified in another health care encounter. However, implementing this option should still help reduce risks of fraudulent upcoding, waste of resources due to unnecessary chart reviews, and abuse in cases where beneficiaries do not receive treatment based on additional diagnoses.[80] In addition, the impact will be greatest on those plans that use chart reviews most aggressively.[81]

There are potential challenges and limitations associated with removing chart reviews as a source of diagnoses for risk adjustment. As with other policy options to reduce overall MA payments, some contend that MA organizations will respond by using more stringent utilization management processes or other methods to encourage providers to deliver less care.[82] This policy could also increase favorable selection because reduced pay-offs for coding intensity (or higher costs) could increase the incentive for MA plans to avoid beneficiaries who are expected

to have higher costs relative to payments.[83] An industry group argued that Dual Eligible Special Needs Plans (D-SNPs) should be excluded from policies prohibiting the use of chart reviews to capture diagnoses for risk adjustment because safety-net providers used by D-SNP enrollees often lack proficiency in optimal documentation and coding and chart reviews can help to ensure accurate diagnoses.[84] Studies have estimated that excluding diagnoses obtained through chart reviews would still leave plans that code most intensively with substantially higher risk scores than other plans, suggesting that additional policies will be required to address the discrepancies.[85] There may also be a trade-off with accuracy in terms of the risk adjustment model's ability to predict utilization.[86] Finally, the reduction in coding intensity from this option may be temporary because MA organizations have other options to capture diagnoses, such as through office-based encounters.[87]

Eliminate HRA-only diagnoses from risk adjustment. CMS or Congress could eliminate from risk adjustment any diagnoses documented only in HRAs (also known as unlinked HRAs) or in a subset of HRAs such as in-home HRAs or HRA-linked chart reviews, or limit how much risk scores could increase as a result of HRAs.[88,89,90,91,92,93,94,95,96] Studies have estimated that diagnoses from HRAs account for around one-sixth of coding intensity overpayments, and removing HRA diagnoses from risk adjustment could similarly reduce overpayments significantly.[97,98] This policy could reduce FWA associated with inappropriate use of HRAs, and the impact would be greatest on those plans that use HRAs most aggressively.[99]

CMS has considered this policy, including in a 2014 proposal to exclude from risk adjustment any diagnoses from home HRAs that were not confirmed by a subsequent clinical encounter.[100] However, it elected not to implement the policy after opposition from many commenters and instead opted for further study using new data. [101] Some commenters argued that diagnoses obtained from home HRAs should be considered legitimate depending on the nature of the visit, the provider, or the enrollee. As of 2024, CMS has continued to study the feasibility of excluding diagnoses obtained during home visits and has described outstanding challenges including difficulties in distinguishing visits for diagnostic versus treatment purposes, potential disincentives for MA organizations to provide home-based care, and the risk of missing timely home HRA diagnoses that are subsequently treated.[102]

There are some challenges with implementing this policy. For example, there is no definitive method to identify whether and for what purpose HRAs are conducted in beneficiaries' homes.[103,104] There are also concerns that removing HRA-derived diagnoses from risk adjustment could reduce MA organization incentives to encourage preventive screenings and associated care and instead incentivize unnecessary visits with health care providers to confirm diagnoses, which could increase utilization and costs.[105] Other potential challenges with this policy mirror those associated with removing chart reviews from risk adjustment. Namely, MA

organizations may respond by using more stringent utilization management processes or other methods to encourage providers to deliver less care;[106] the policy could increase favorable selection;[107] the risk adjustment model may be slightly less accurate in predicting utilization;[108] if used in isolation, the policy would be insufficient to bring the plans with the most intense coding practices in line with other plans;[109] and D-SNPs may be disproportionately affected by the policy because their safety-net providers code incompletely and D-SNPs can use HRAs for care management and to connect beneficiaries with needed care.[110]

A related option is for CMS to require that MA organizations provide (or make efforts to provide) follow-up treatment or care coordination for any new diagnoses identified in HRAs or that they only include diagnoses for risk adjustment if they are actively managed.[111,112,113,114] This is similar to proposals that would only allow diagnoses from chart reviews or HRAs if they also appear in another health care encounter record. Although this would reduce the incentive to use HRAs solely to collect diagnoses and ensure that patients are receiving necessary care, it may also require countermeasures to address the potential for induced overutilization.

Finally, the HHS OIG has recommended audit and monitoring activities related to diagnoses from HRAs. It recommended that CMS conduct audits to validate diagnoses reported on in-home HRAs and chart review-linked HRAs.[115] OIG also recommended that CMS conduct monitoring to identify MA organizations that receive a disproportionate share of payments from diagnoses identified through HRAs or chart reviews and determine whether specific diagnoses associated with a large share of payments from in-home HRAs and HRA-linked chart reviews are a particular risk for inappropriate or highly variable coding.[116] CMS concurred with these recommendations and indicated that it has plans to consider targeting diagnoses from HRAs in audits and noted that the new version of the risk adjustment model (version 28) excludes or limits diagnoses that are most susceptible to coding variations.[117]

Use 2 years of diagnosis data for risk adjustment. MedPAC, the sponsors of a Senate bill, and others have proposed that CMS use 2 years of diagnostic data for risk adjustment.[118,119,120,121,122] The Congressional Budget Office has estimated that using 2 years of diagnostic data and eliminating home HRAs from risk adjustment would save $124 billion between 2027 and 2034.[123] Proponents argue that this approach could reduce differences in coding intensity between MA and TM; improve the risk adjustment model's ability to predict MA costs, particularly for enrollees with multiple chronic conditions; and reduce MA overpayments.[124,125,126,127,128] In theory, more diagnoses would be captured for TM beneficiaries, thereby making risk scores more similar between MA and TM, reducing the incremental payments that MA plans receive for each diagnosis, and ultimately reducing overpayments.[129] MA organizations would still have a strong incentive to capture all diagnoses, meaning that this change would have little or no impact on coding-related fraud or abuse, while

the impact on favorable selection is unclear. However, this approach could reduce reliance on collecting diagnoses annually and potentially reduce slightly the waste associated with using resources to identify and document diagnoses. It may also benefit MA organizations that invest less in activities designed to maximize diagnosis capture.[130]

There are also significant challenges to using 2 years of diagnostic data for risk adjustment calculations. Implementation challenges include managing with smaller sample sizes, particularly for smaller subgroups, because it would exclude beneficiaries who have less than 24 months of data; assessing the validity of older diagnoses, such as for conditions that may be inactive; and dealing with an additional year's delay before beneficiaries are assigned a risk score.[131] Further, this option could incorrectly reduce payments for D-SNPs and other MA plans with higher proportions of enrollees who are new or have multiple chronic conditions.[132,133] In addition, based on preliminary findings, CMS has found that using 2 years of diagnostic data would not improve the accuracy of model payments.[134]

Refine the coding intensity adjustment factor. Several stakeholders have proposed that CMS increase the coding intensity adjustment factor and evaluate and set the factor annually to fully account for coding differences between TM and MA.[135,136,137] The Congressional Budget Office has estimated that, between 2027 and 2034, increasing the minimum adjustment to 8% across all plans would reduce payments by $159 billion while increasing the adjustment to 20% would reduce payments by more than $1 trillion.[138] However, it is possible that the adjustment factor provides implicit permission and an incentive for MA organizations to increase coding intensity to stay ahead of the adjustment.[139] Other potential impacts of a large increase in the coding intensity adjustment include a reduction in less profitable plans, increased MA cost sharing, reduced supplemental benefits, reduced MA and Part B premiums, and other actions by MA organizations to reduce costs.[140,141] In addition, uncertainty about the impact of the HCC version 28 model in reducing coding intensity[142,143] will make it difficult to reach consensus on changes to the adjustment until the impact is clear. The potential impact on favorable selection is also unclear.

An increase in the adjustment factor for all plans is unlikely to reduce FWA because the adjustment would continue to reward MA organizations that code more intensively.[144,145,146] To improve fairness and remove the competitive advantage gained by MA organizations that code most intensively, CMS could introduce coding adjustments tailored to each MA organization's (or plan's) level of coding intensity or assign plans to tiers for coding adjustments.[147,148,149,150] A graduated approach is more likely than a single coding adjustment to reduce FWA associated with intensive coding. The impact on competition is also a factor. For example, it has been reported that representatives from some small and regional plans prefer approaches that would target adjustments by coding intensity, rather than a blanket increase in the adjustment

factor, which they believe would further penalize them unfairly and drive some plans out of business.[151] The implementation of a tiered approach would be contentious because assigning plans to tiers with different adjustments would introduce cliff effects, where small differences near coding intensity thresholds could result in large financial impacts for MA organizations. Assuming that implementation is technically feasible, plan-level coding adjustments would both improve fairness and reduce the potential for gaming or appeals from MA organizations attempting to move to a more favorable tier.

Changes to the coding intensity adjustment would face several challenges. Some industry stakeholders favor retaining the current coding intensity adjustment, contending that it will achieve stable, predictable, and adequate payments and ensure that MA organizations and providers have the data needed for early intervention and care management.[152] There are also concerns that tailored coding adjustments would continue to leave some plans relatively overpaid or underpaid and would not eliminate incentives to maximize payment.[153] Other considerations include the extent to which changes would lead to higher premiums, fewer benefits, slower enrollment growth, or reduced profits to MA organizations; whether a sufficient TM comparison group is available to determine a coding intensity benchmark for D-SNPs in smaller geographic areas; and whether D-SNPs and similar plans could be penalized inadvertently for having sicker enrollees.[154,155]

Refine or redesign the risk adjustment approach. Many risk adjustment refinements have been proposed to predict MA costs more accurately and reduce the potential for gaming. Because risk adjustment is intended to reduce the incentive for favorable selection by paying appropriately for higher-cost enrollees, some changes to the risk adjustment approach could both reduce coding intensity and further reduce the incentive for favorable selection. Other changes may inadvertently increase the incentive for favorable selection. For example, approaches that predict costs more accurately may reduce coding intensity; however, because the current approach likely overestimates costs for groups with historically low utilization, a more accurate model could reduce payments for these enrollees and therefore disincentivize enrolling beneficiaries from these groups.[156]

As signaled in a November 2025 Request for Information, CMS is considering new risk adjustment approaches. Approaches range from minor changes to the existing risk adjustment model to more significant changes such as a "next generation" risk adjustment approach, including possible CMS Innovation Center model tests, which could help to ensure effectiveness and feasibility before widespread implementation.[157] CMS could implement most changes to risk adjustment under existing authority, but legislative changes may be needed in some cases. For example, if CMS were to introduce a revised risk adjustment approach that resulted in

significantly less intensive coding, Congress may need to repeal the requirement for coding intensity adjustments. Possible refinements to risk adjustment include the following:

- ***Updating the model regularly.*** The version 28 update to the risk adjustment model involved "recalibrating," that is, using more recent claims data to determine the payment weights. Along with other changes such as limiting the impact of diagnoses that are easily gamed, this change is expected to reduce coding intensity and overpayments significantly relative to the previous version of the model.[158,159] An additional recalibration proposed for 2027 (using data from 2023 and 2024 rather than 2018 and 2019) was anticipated to improve payment accuracy and result in further savings;[160] however, it was not implemented to allow MA organizations more time to adjust to the v28 model.[161] A regular schedule of updates, such as every 2–3 years, could help reduce the difference between data used to determine payments and current costs (including current coding practices), thereby increasing model accuracy and reducing the payoff for coding intensity. The likely impact on favorable selection is not clear.
- ***Using diagnostic and cost data from encounter data submissions to develop a risk adjustment model based exclusively on MA data*** rather than using TM data to predict costs.[162] CMS is investigating this option and is considering methodological challenges, such as how to select beneficiary samples and predict costs and the potential downstream market effects.[163] This approach could somewhat reduce the coding intensity incentive if the payoff for additional diagnoses were lower.[164] However, it could continue to reward MA organizations that code more aggressively.[165,166] In addition, because this approach could reduce payment weights for some conditions, it could increase the incentive to avoid the more expensive patients with those conditions (favorable selection) and reduce the payoff for managing chronic conditions more efficiently than would occur in TM.[167] Current law requires that CMS implement a coding intensity adjustment only until it starts using MA diagnostic, cost, and use data, so this option would likely end the adjustment.[168] There is a risk that switching to the use of encounter data while removing the coding intensity adjustment could result in a net increase in payments to MA plans. To reduce this risk, Congress could enact a law change to de-link the use of encounter data and the coding intensity adjustment, allowing CMS to use both policy levers if needed.
- ***Incorporating utilization data from prescriptions and electronic health records into risk adjustment***.[169] Although this approach should reduce the incentive to code intensively, it could encourage more prescriptions, overutilization of medications or services, and over-testing, particularly for diagnoses that could result in more profitable payments.[170] If prescription drug utilization data are used in isolation, there is also a risk of missing diagnoses not treated by prescription drugs, and this approach is estimated to be inferior to the standard HCC model in predicting utilization.[171] This approach could reduce the

incentive for favorable selection to the extent that the additional payment for a given service added to the model matches the cost of delivering that service.[172,173] Conversely, there could be new risks of favorable or adverse selection if service costs are much higher or lower than the associated marginal payments for beneficiaries with certain conditions or risk factors.

- ***Building a risk adjustment model using data that MA organizations and providers cannot influence***, such as area-level measures of upstream drivers of health, patient-reported health status or outcome measures, biometric information, or survey-reported measures of chronic condition prevalence that can be collected from beneficiaries independently from MA organizations.[174,175,176,177] Survey data could also be combined with HCC data in various ways. One study found that combining Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data and HCC data after removing eight HCCs that are prone to inflated coding was the best of nine options at predicting next-year utilization, and that other combined CAHPS-HCC options also predicted utilization better than HCCs alone.[178] With any survey-based approach, CMS would need to address issues arising from survey response biases and sampling frame limits if using existing surveys (e.g., the existing MA CAHPS survey excludes beneficiaries in institutions).[179] Surveys may need to be expanded to collect more information about health status and utilization and supplemented with other data sources, such as for rare and expensive conditions.[180,181] While potentially costly, such data collection may cost less than MA organizations currently spend on diagnosis capture and thus could potentially reduce waste, and the data could be used for population health monitoring.[182] This approach would reduce or remove coding intensity incentives potentially without increasing the incentive for favorable selection.[183]
- ***Building a risk adjustment model based on diagnoses inferred from an aggregate population***.[184] This would involve using population-level data on diagnoses and utilization and potentially upstream drivers of health along with individual-level data to assign risk scores to beneficiaries.[185] Inferred risk scores would be accurate at a group level; reduce coding intensity incentives and wasted resources to capture diagnoses; and improve fairness across plans.[186] This approach could potentially reduce the use of prior authorization or increase utilization generally if plans or providers expect the greater utilization to result in payments that offset the cost of that utilization.[187,188] There is a risk that this approach could entrench lower payments where there has been historical underutilization (e.g., rural areas), thereby penalizing MA plans serving those beneficiaries[189] or creating an incentive to avoid those beneficiaries. Some strategies could mitigate these limitations, such as using data for risk adjustment that are less prone to influence from MA organizations and adjusting risk score calculations to accurately reflect health status in areas with low spending.[190] Other challenges include data availability and

accuracy at this scale, statistical noise for smaller plans, and the risk of new gaming incentives that require further exploration before implementing this approach. CMS is developing and plans to test AI-inferred risk adjustment in a new value-based payment model,[191] with initial results available in 2028 that could also inform the approach in MA.

- ***Using AI or machine learning to predict costs more accurately***.[192] A machine learning algorithm named "Franklin" that is based on age, sex, and diagnosis codes from traditional Medicare claims data was three times more accurate than the current approach at predicting costs, and accuracy gains were greatest among beneficiaries with zero or one HCCs, a group that has some of the greatest overpayments.[193] Franklin was also estimated to reduce overpayments due to favorable selection by 21%.[194] Although this or a similar approach may improve payment accuracy, it is not clear whether it would change MA organization behavior in terms of coding intensity. A model like Franklin that is based on all diagnosis codes could reduce coding intensity or make it more difficult to execute, whereas a model that used the same diagnosis codes as the HCC model could instead increase incentives to over code.[195,196] There is also a risk that such models could weaken incentives to avoid overutilization and entrench existing areas of underutilization.[197] Ensuring transparency about how a model predicts costs would be an important implementation challenge.[198,199]
- ***Limiting the impact of diagnosis codes that are easily gamed***. The existing risk adjustment approach uses a statistical technique called "constrained regression" that limits the impact of specific factors on payments, including diagnoses that are vulnerable to gaming.[200] This approach could be expanded to improve the accuracy of payments while reducing incentives to code intensively.[201] For example, prior year spending predicts current-year spending, but including prior year spending in the risk adjustment model would incentivize increased utilization.[202] With constrained regression, CMS could ensure higher payments for beneficiaries with higher prior year spending without adding spending variables to the model that would encourage overutilization.[203] A similar option would be to limit diagnoses used in risk adjustment based on disease severity or the setting of the patient encounter.[204] In its version 28 model, CMS has removed or constrained payments associated with conditions where diagnosis and coding patterns vary across plans and providers and ensured that conditions included in the model are stable predictors of costs.[205] These changes are expected to reduce coding intensity incentives without appreciable negative impact on favorable selection.[206] However, there may be some small additional risk of favorable selection with this approach. For example, the HCC version 28 model forces payments to be equal across different severities of diabetes, which means costs for the most severe diabetes category are underpredicted.[207] Although this reduces the incentive

to use more severe diabetes diagnosis codes, it may inadvertently introduce an incentive to avoid beneficiaries with more severe diabetes.

- ***Simplifying the HCC model***. One study found that just 10 diagnoses accounted for almost all the difference in risk scores between TM and MA; excluding them from payment calculations would align risk scores between the two programs and remove most of the discrepancy among plans with different levels of coding intensity.[208] MA organizations could shift their coding intensity efforts to the remaining diagnoses still used for risk adjustment, but these conditions may be less at risk of overcoding given that their prevalence is similar between MA and TM.[209] However, with a simpler model, MA organizations could be incentivized to avoid beneficiaries with the excluded diagnoses or scale back efforts to manage these conditions because they would no longer receive additional payments for those beneficiaries.[210] The impact would be similar if machine learning or AI were used to identify a simpler model (that is, using fewer diagnoses for risk adjustment).[211,212] Some of the risks of this approach could be mitigated if combined with a reinsurance policy, as described below.
- ***Adding social determinants of health metrics to the risk adjustment model.***[213] This approach could help predict spending and reduce the importance of diagnostic codes.[214] Given that individual-level indicators are not consistently collected and potentially can be gamed (e.g., incentives may emerge for physicians to over-report health-related social needs), CMS could investigate the use of area-level proxies (e.g., area indices, county designation, median income) or individual proxies (e.g., months of Medicaid enrollment in the last year) because these factors cannot be gamed by MA organizations.[215] It is unclear how this would work with the current risk adjustment approach, and there is no evidence regarding whether it would actually improve payment accuracy or reduce gaming behaviors. In addition, although this approach has been suggested to reduce favorable selection,[216] there is no evidence that that is the case, and it could introduce new risks of favorable selection based on social characteristics.
- ***Developing a hybrid model that involves concurrent risk adjustment*** (i.e., based on data during the payment year) for beneficiaries with chronic, costly, and easily verifiable conditions ***and prospective risk adjustment*** (i.e., based on data in the year prior to the payment year) for all other beneficiaries.[217,218] This approach has the advantage of providing more immediate funding to plans for beneficiaries who develop high-cost conditions.[219] In theory, if plans were reimbursed based on current health status, predicted payments would track closer to actual costs and there would be less incentive to avoid enrollees who might become more expensive or to employ plan designs—such as limited provider networks or prior authorization processes—that could encourage enrollees to disenroll if they develop expensive conditions.[220] Additionally, plans should have less

incentive to market selectively to individuals expected to have low utilization relative to their risk profiles.[221] However, one study found that this hybrid model was worse than CMS' prospective model at predicting costs, particularly in the base year.[222] This could *increase* the risk of favorable selection because MA organizations would have better information about costs in that year, and it could increase the incentive to code intensively.[223]

- ***Making risk adjustment zero sum.*** This would be similar to the risk adjustment approach used for Marketplace plans, where risk adjustment payments to plans with above-average risk scores are offset by charges to plans with below-average risk scores so that risk adjustment payments are zero sum across plans.[224] Although this would reduce the impact of coding intensity on total costs to Medicare, it would not reduce coding intensity incentives and would maintain financial advantages for MA organizations that code most intensively.
- ***Developing separate risk adjustment models for specific complex, or high-cost, conditions***, similar to how CMS currently handles end-stage renal disease.[225] This option would enable more accurate cost predictions within the subset of beneficiaries with certain conditions and reduce the incentive for favorable selection among that subset.[226] However, this option would only be possible for highly prevalent conditions where the sample is large enough to ensure accurate predictions; many of these conditions overlap, making this option difficult to implement.
- ***Adjusting MA rates to account for recent switchers to MA.***[227,228] Beneficiaries who are new to Medicare and chose to enroll in MA are assigned a risk score based on demographics alone, while beneficiaries who switch from TM to MA are assigned a risk score based on the diagnoses they received the previous year in TM. This adjustment would address the phenomenon that new MA enrollees usually have lower actual costs than predicted by average MA rates for a given risk score.[229] CMS would group beneficiaries by their risk scores, rank their historical expenditures into percentiles, and calculate their actual spending compared to averages.[230] Using these ratios, payments to MA plans for recent switchers would be proportionally adjusted.[231] The policy would need to specify how long after beneficiaries switch to MA to implement the adjusted MA payment rates.[232] With risk adjustment based on TM spending for recent switchers, there would be less incentive for MA plans to recruit and enroll healthier, low-cost individuals as payments would align more closely with plan costs.[233]

Introduce a reinsurance policy. Part D Medicare and Marketplace plans have access to reinsurance that protects issuers from the financial risks of enrollees whose costs far exceed expectations. In Medicare Part D, for example, CMS covers either 20% or 40% of drug costs (depending on the drug) once a beneficiary reaches the catastrophic threshold.[234] A similar

one-sided reinsurance policy for MA plans could increase costs to Medicare, incentivize overspending, and fail to reduce the incentive to code intensively,[235] but it may have advantages for favorable selection.[236] Variants of this approach have been proposed, including a budget-neutral, two-sided reinsurance approach that requires MA organizations to repay some amount to Medicare when the plan payments received far exceed plan spending on a beneficiary's care while also reimbursing MA organizations for high-cost outliers. [237,238] If combined with an approach to optimize the risk adjustment model, proponents argue that reinsurance could reduce the influence of diagnoses where risk-adjusted payments exceed spending; further reduce the incentive to code intensively because unusually high costs would be covered regardless of HCC scores; and reduce the incentive for favorable selection.[239,240,241] Related implementation challenges include reinsurance being operationally complex and the fact that the lack of comprehensive cost information in MA encounter data would necessitate the additional collection of more granular cost data.[242,243] One potential disadvantage of reinsurance is that using actual spending to determine payments may increase incentives for greater utilization.[244,245] In addition, coding intensity incentives would remain throughout most of the cost distribution, while reducing plans' responsibility for enrollees with the highest costs. Further, this policy does not fully eliminate the incentives for favorable selection, particularly among beneficiaries whose costs are high but fall below the point at which reinsurance would apply.[246] MA plans already have the option to spread risk across enrollees, which is the most feasible for plans with large numbers of enrollees, or to purchase reinsurance privately. Government reinsurance may be most beneficial to those smaller local and regional plans that would experience a reduction in private reinsurance costs.[247]

A related option is to remove outliers from the risk adjustment model and to cover high-cost outliers through a high-cost pool.[248] This approach could improve the accuracy of the risk adjustment model in predicting costs and would reduce the impact of high-cost outliers on plans.[249] This approach could also be tailored by risk adjustment model segment. For example, plans could allow for different outlier thresholds for beneficiaries who are eligible for Medicare based on age versus disability. However, this option is unlikely to reduce FWA because it will not reduce the incentive to code intensively. In addition, it could create a new risk of FWA, namely unnecessarily increasing utilization or overreporting spending to move cases into the high-cost pool.

Limit contractual arrangements that incentivize providers to capture more diagnosis codes. Limits on certain contractual arrangements such as paying providers to submit codes or to use tools that identify additional diagnoses could help reduce coding intensity.[250,251] For example, Congress could enact a ban on using percentage of premium contracts, gainsharing contracts, and other arrangements that incentivize providers to assist MA organizations in increasing Medicare payments.[252] This could be achieved by treating such arrangements as kickbacks and

by prohibiting MA organizations from paying for them.[253] Congress could consider imposing additional limits on payer-provider vertical integration to increase providers' independence or even outlaw payer ownership of providers as has been proposed in a recent bill.[254] Implementation could be challenging given the high prevalence of vertical integration and the large number of provider contracts that could be affected.

Introduce competitive bidding. This approach would involve MA organizations bidding to set the benchmark price or competing for contracts to deliver MA plans.[255] CMS might select two or three organizations, similar to the approach taken by many employers offering insurance benefits to employees, or limit the number of plans a MA organization can offer in an area.[256,257] Benchmarks would be based on MA plan bids, such as using the second-lowest or average bid to determine the benchmark.[258,259] This approach could be an alternative to or used in combination with a benchmark based on TM (similar to the current approach) to avoid increasing costs where competition is insufficient to ensure that bids are priced below TM spending.[260] Competitive bidding would require benefit packages to be standardized (e.g., to specify cost-sharing levels and supplemental benefits in addition to required Part A, B, and D covered services) so that MA organizations compete on price and quality. This would be in contrast to the current approach, where CMS sets the prices and MA organizations compete on plan benefits and quality.[261] It would be a major change, likely requiring Congressional action to grant CMS the authority to implement competitive bidding through regulation.

Competitive bidding has pros and cons. It is generally proposed as an option to reduce government spending on MA because it would incentivize MA organizations to submit bids that are expected to be lower than the current benchmarks.[262] Competitive bidding could also reduce the payoff from coding intensity because higher coding intensity would affect how payments are distributed among MA organizations rather than increasing costs relative to TM.[263] Payments would still be adjusted for risk based on health status, leaving a risk of favorable selection among beneficiaries with similar risk scores. The difference would be that MA organizations' approaches to favorable selection would improve their competitive advantage rather than increasing total costs to Medicare.[264] Indeed, the plans with the greatest cost savings due to favorable selection may be able to submit lower bids, increasing downward pressure on benchmarks.[265] Competitive bidding would reduce stakeholder pressure on CMS and Congress to change benchmark rates.[266] However, competitive bidding could significantly reduce choice, which could simplify enrollment decisions but also remove valuable options for beneficiaries.[267,268] It could also change plan designs, potentially reducing the generosity of supplemental benefits and increasing out-of-pocket costs for enrollees, and also reduce the flexibility to innovate.[269,270,271] It is unclear to what extent, or for how long, savings could be maintained if competitive bidding were used to determine the benchmark, or whether it could ultimately lead to plan exits, reduced competition, and increased costs.[272,273]

Set benchmarks administratively. Instead of using the current method for setting benchmarks, in which benchmarks are based on observed TM spending, there has been discussion of setting MA benchmarks administratively. Under this approach, benchmarks initially would be set to correct for coding intensity and favorable selection and updated annually based on a predetermined growth rate calculation, similar to some Medicare fee-for-service payment systems.[274] Such an approach would require Congressional action to grant CMS the authority to implement the benchmarks. Rate updates could be based on a formula (e.g., linked to inflation and adjusted for improvements in provider productivity similar to the inpatient prospective payment system approach).[275] This would minimize administrative discretion and the associated pressure on CMS and Congress if rate updates were viewed unfavorably.[276] In addition, methodology changes could be designed to ensure budget neutrality.[277] However, setting the initial rate would be contentious, and, if based on either TM or MA spending, would entrench existing distortions.[278] Although this approach may initially correct for coding intensity, coding incentives are likely to persist to the extent that payments are still risk adjusted. Administrative benchmarks could also put downward pressure on payments, reducing the incentive and resources for—but not completely eliminating—favorable selection.

Limit MA marketing tactics. In 2022, the Senate Committee on Finance uncovered evidence that Medicare beneficiaries were being targeted with aggressive MA marketing and other tactics that could contribute to favorable selection.[279] Although such marketing is not inherently problematic, the large proportion of MA advertising depicting healthy, active people, and the fact that there was none depicting people with disabilities or other visible health challenges, suggests that marketing is designed to appeal to healthier beneficiaries.[280] Marketing could also contribute to favorable selection if it is targeted to beneficiaries who are likely to have lower MA costs (e.g., veterans who receive services from the Veterans Health Administration) or if its intent is to avoid enrolling beneficiaries who are expected to have higher MA costs relative to payments. For example, brokers and agents working on behalf of large MA organizations have allegedly avoided enrolling beneficiaries with disabilities in MA plans as those beneficiaries were expected to be less profitable.[281] The Senate Committee on Finance's report called on CMS and Congress to take multiple corrective actions, including monitoring MA disenrollment patterns, using enforcement authority to hold bad actors accountable, requiring agents and brokers to follow best practices, strengthening regulations around MA marketing materials, and closing regulatory loopholes that allow sales-related cold calls to beneficiaries.[282] Limiting aggressive marketing or other tactics that are meant to attract or avoid beneficiaries who are likely to be more or less profitable could help reduce favorable selection.

Interventions targeted at agents and brokers could also reduce favorable selection. Agents, brokers, and third-party marketing organizations can identify and selectively market to

beneficiaries who are expected to have lower health care costs[283] by using screening questions to request information on beneficiaries' prescriptions, health status, and health care utilization. Favorable selection could be reduced by increasing funding to impartial advisory sources such as State Health Insurance Assistance Programs (SHIPs) relative to agents and brokers, who are paid by MA organizations.[284] Additionally, introducing restrictions on agents and brokers, such as limiting their ability to collect health-related information in some circumstances, could reduce favorable selection. Challenges with these approaches include insufficient capacity among alternative sources of enrollment advice (e.g., SHIPs) and the need for agents and brokers to use some beneficiary health information to identify appropriate plans.

Introduce multiyear MA plans. Increasing the time between enrollment periods is a policy option that could have implications for favorable selection. To reduce favorable selection, a "lock-in" policy was phased in for MA plans between 2007 and 2011. Under that policy, enrollees could no longer switch from MA to TM—often in response to changing health needs—at the end of any month. Instead, they could switch only during annual open enrollment, during a special enrollment period triggered by an event such as moving to a different county, or once per year to enroll in a 5-star plan.[285] The lock-in policy reduced consumer behavior that contributed to favorable selection among MA beneficiaries.[286]

Expanding on the lock-in approach, multiyear enrollment in MA plans has been proposed as a way to reduce payments to agents and brokers,[287] improve patient experience and reduce disenrollment or switching, and increase plans' incentives to invest in longer-term outcomes.[288] Examples of investments in longer-term outcomes include preventive care, value-based provider contracts with longer measurement periods, upstream drivers of health, and treatments with high initial costs but longer-term benefits. CMS could test 3- to 5-year contract periods through an Innovation Center model or through regional demonstration projects to assess different aspects of multiyear enrollment.[289,290]

Multiyear enrollment could reduce or increase favorable selection. One report suggested that such a policy could create *adverse* selection because, assuming that multiyear plans are optional alongside single-year plans, multiyear plans would be most attractive to beneficiaries with expensive long-term conditions.[291] This could be desirable from a program perspective, and any negative impact on MA organizations could be mitigated through mechanisms such as risk adjustment or risk corridors.[292] With fewer open enrollment periods, there would also be fewer opportunities for undesirable behaviors from agents and brokers that can contribute to favorable selection, and fewer opportunities for MA plans to encourage beneficiaries to disenroll during annual open enrollment. However, multiyear plans would have significant challenges, including the long lock-in period, which would reduce an important protection: beneficiaries' freedom to choose to disenroll if an MA plan is not meeting their needs.[293] This

would be an even greater concern if enrollment in multiyear plans was mandatory, as proposed in a House bill.[294] The bill also includes a provision to allow disenrollment due to a hardship event, including serious illness.[295] This could increase the risk of MA organizations, agents, and/or brokers engaging in inappropriate behaviors to encourage beneficiaries to disenroll when they develop expensive conditions, thereby increasing the risk of favorable selection. This policy option would need robust oversight and appeals processes in place to ensure that beneficiaries who are "locked-in" are able to receive needed care. Furthermore, CMS might consider expanding the reasons for special enrollment periods for beneficiaries who are enrolled in multiyear plans.

Auto-enroll beneficiaries in MA plans. CMS leadership and a house bill recently raised the possibility of enrolling beneficiaries in MA plans rather than TM as the default when they first become eligible for Medicare,[296,297] a policy that is likely to have implications for favorable selection. Congress could introduce legislation to implement such a change, or CMS could test the approach through an Innovation Center model or demonstration.[298] Proponents of default enrollment into MA contend that it would improve outcomes because patients would be in an accountable care relationship,[299] that it would ensure that these beneficiaries have access to the supplemental benefits and lower out-of-pocket costs that are a feature of MA plans,[300] and that MA organizations would spend less on agents and brokers.[301] The impact on favorable selection is unclear. Such a policy could reduce favorable selection because a wider range of beneficiaries would be in MA plans; however, disproportionate opt-out (to TM) remains likely among beneficiaries who expect to have high health care costs and consider their MA plan's networks or other policies to be barriers to receiving necessary care. It could also reduce MA organizations' concerns that offering benefits that attract higher-cost enrollees could result in adverse selection.[302] Auto-enrollment in MA also carries significant challenges, such as the risk that it could increase total costs to Medicare, that beneficiaries could struggle to obtain Medigap policies when they disenroll, and that it could disrupt patient-provider relationships.[303,304]

Require broader provider networks. Broader provider network requirements, particularly for specialty services, could reduce favorable selection by increasing enrollment among beneficiaries with chronic conditions and by reducing the number of beneficiaries who disenroll due to difficulty accessing specialty services.[305] MA organizations design provider networks based on quality and costs, considering the impact on their plans' Star Ratings, rebates, and financial positions.[306,307] However, limited networks can discourage beneficiaries from enrolling if they require more costly services. For example, MA plans may limit the extent to which their networks include comprehensive cancer centers or other providers that patients with complex medical needs may require.[308] Therefore, patients with higher-cost medical needs may avoid enrolling in MA plans or, if they enroll and have difficulty getting care, will be encouraged to

switch back to TM.[309,310,311] Broader networks can appeal to and provide access to care for patients with complex and high-cost medical needs and reduce the extent to which they avoid or differentially disenroll from MA plans.[312,313]

Mitigation Approaches: Oversight

Many of the policies discussed earlier would require significant changes to oversight approaches, such as auditing any utilization data used for payment purposes and monitoring and investigating impacts on favorable selection. The oversight approaches discussed in the sections that follow assume no changes or limited changes to the approach used to pay MA organizations.

Increase the number and timeliness of RADV audits. Ultimately, CMS would like to audit all MA plans annually.[314,315] One option that could increase the number of audits is for CMS to implement a recovery audit contractor (RAC) program for MA that is consistent with the RAC program for TM.[316] Current law authorizes a RAC program for MA, and CMS has sought information on proposals for the MA RAC program.[317] However, CMS has not implemented the program because vendors do not consider the approach viable due to payment structures, narrow scope of errors, and unlimited appeal timelines.[318] CMS also indicated that it has been able to achieve the same goals through the use of other contractors who conduct medical record reviews, payment error calculations, and other RADV tasks.[319]

In 2025, CMS again proposed auditing all MA plans each year and announced an ambitious plan to use advanced systems to flag errors, aggressively expand its team of medical coders to review flagged errors, and complete all audits for payment years 2018 through 2024 by early 2026.[320] As of March 2026, CMS had initiated audits for payment years 2018 and 2019 and published a schedule for initiating audits for payment years 2020 through 2025 by April 2027.[321,322,323] CMS has also selected increasing numbers of plans for audit, up from 30 in payment year 2013 to 58 in payment year 2018 and 355 in payment year 2019.[324,325,326] This indicates that CMS has made progress toward improving timeliness and increasing the volume of audits. Regardless of whether CMS can audit all plans annually, the announcement of this intent and its progress to date may have a deterrent effect on coding behavior. For example, MA organizations may try to identify undocumented diagnoses (due to both errors and fraud) that were subject to audits of prior years and reconsider internal strategies for ensuring comprehensive documentation for future payment years.

The increased pace, number, and impact of audits will increase pressure on MA organizations to identify medical records selectively, submit them in a timely manner, and make corrections within shorter timelines.[327,328] Providers may also receive increased requests for medical records, even for plans with which they have no current contracts, and in some cases may be

liable for some of the overpayments, depending on their contracts with MA organizations.[329,330] However, there is also some industry support for auditing all plans each year because it would provide more certainty for bidding, accounting, and financial reporting and enable MA organizations to obtain medical records from providers more easily.[331]

In addition to recommending an increase in the number and timeliness of audits, the U.S. Government Accountability Office (GAO) has recommended that CMS make several changes to improve the timeliness of RADV audits and appeals.[332]

CMS has implemented some of the proposed strategies, including eliminating the lag between audit notification and requesting beneficiary records and reducing the number of medical records submitted per diagnosis.[333] CMS is still using the Centralized Data Abstraction Tool, which was associated with challenges in transferring medical records to CMS in earlier audits, but the reduction in the number of medical records permitted per diagnosis could reduce pressure on the system in the absence of other upgrades.[334,335] Additional adjustments to improve the timeliness of the audit and appeals processes could reduce the lag time between overpayments and recoupments, which could also increase incentives for accurate coding because overpayment liabilities will occur earlier.

Extrapolate results from RADV audits. Following RADV audits through 2017 (the most recent year completed as of November 2025), CMS has sought recoupments only for the enrollees sampled for audit and found to have associated overpayments, which would be some proportion of the 201 enrollees sampled per contract.[336] Consistent with audit extrapolation approaches used in TM and other programs, CMS finalized a method that would allow extrapolation of RADV findings from the sampled enrollees to all audit-relevant enrollees, starting with audits for the 2018 plan year.[337,338] For example, if the audit focused on a cohort of enrollees with a specific set of diagnoses, any audit findings would be extrapolated to other enrollees with one of those same diagnoses in the applicable payment year.[339] This would result in significantly larger recoupments and a greater disincentive for MA organizations to submit unsupported diagnoses, including some of those identified through coding intensity strategies. Although extrapolation may be applied to increase recoupments from previous years, any announcements regarding extrapolation will have an impact on future FWA by altering MA organization and provider coding behaviors for future payment years.

Stakeholders disagree about whether CMS should pursue extrapolation. Some believe the greater penalties resulting from extrapolation are necessary to ensure overpayments are returned to Medicare and to provide a sufficient disincentive against inaccurate and fraudulent overcoding.[340] However, there is significant industry opposition to this approach, including criticism that it is unfair to change the recoupment policy years after MA organizations

submitted bids for the plan year in question, and concerns that it could adversely affect MA plan offerings.[341,342] There is also a risk that recoupments from extrapolated audit findings could be delayed or not realized due to appeals and legal challenges.[343] Indeed, a judge vacated the regulation enabling extrapolation in 2025.[344] CMS has appealed the ruling and intends to continue the RADV program to the extent possible while complying with the court ruling.[345] However, it will not be able to implement extrapolation without a favorable decision on the appeal, additional rulemaking, or Congressional action.[346]

An industry group has supported extrapolation set at the lower bound of the 99% confidence interval of the estimated overpayment point estimate.[347] This method, proposed by CMS in 2012,[348] would mean that many plans with an estimated overpayment would not be required to make any repayments and those that do would pay much less on average than their estimated overpayment,[349] likely reducing the deterrent effect of the audits and extrapolations. CMS has since emphasized that it will use any appropriate and statistically valid extrapolation method and has proposed a less conservative approach of using the lower bound of the 90% confidence interval of the point estimate to determine recoupments for the 2018 and 2019 payment years.[350,351,352] Using the lower bound of the 90% confidence interval to determine recoupments or risk score changes is consistent with the approaches used by the HHS OIG for MA audits and by CMS for Marketplace plans.[353,354]

Target audits and monitoring based on HRAs and chart reviews. Several stakeholders have proposed that CMS should look to identify improper use of HRAs and chart reviews to obtain unsupported diagnoses. Methods could include validating through audits those diagnoses that are reported only through in-home HRAs, HRA-linked chart reviews, any chart reviews, or any chart reviews for beneficiaries with no records of health care encounters; targeting oversight to those MA organizations that receive the greatest portion of payments driven by in-home HRAs; or requiring that MA organizations flag in encounter data any HRAs they initiate.[355,356,357] CMS indicated that diagnoses from chart reviews were one of its selection factors for RADV audits for the 2018 payment year.[358] These targeted audits could incentivize MA organizations to use HRAs and chart reviews more carefully and could potentially reduce coding intensity resulting from unsupported diagnoses.

Finance audits through MA plan user fees. In the absence of extrapolation, the RADV program could have a negative return on investment, assuming the program's operating costs are $51 million per year and that the expected recoupments without extrapolation are just $41 million in total for payment years 2011–2017.[359] A negative return on investment could threaten the viability of the RADV program to deter and identify fraud and abuse. Section 1893(h) of the Social Security Act indicates that MA RACs should be paid a portion of the overpayment amounts they recover through collections, consistent with payments for TM RACs. Such a

payment structure would help ensure that audit costs are covered. In the absence of MA RACs, audits could be financed by MA organizations through other mechanisms, potentially with larger audit fees for plans that have higher rates of unsupported diagnoses.[360] This approach could help ensure that CMS and its contractors have the resources and capacity they need to conduct sufficient audits and allow the audit program to adapt to fluctuations in the number of MA plans.

Increase financial or enrollment penalties. Several options have been proposed to increase financial penalties for submitting unsupported diagnoses, mostly with the aim of recouping more overpayments. Such a policy could also deter fraud. Some options include recouping overpayments from all prior years, extrapolating error rates to recoup overpayments for all similar beneficiaries in the plan (see above), recouping overpayments from audits conducted by the HHS OIG as well as CMS, and levying fines for unsupported diagnoses independent of recoupment amounts.[361] Fines in particular could help with deterrence if they are more immediate than recoupments and less susceptible to delays from appeals and reconsiderations. For example, Congress could increase penalties or CMS could use its civil monetary penalties authority to penalize plans with high error rates. CMS could also exclude plans from MA if error rates remain high.[362] CMS recently suspended an MA organization's enrollment and beneficiary communication activities as sanctions for sustained noncompliance, including failure to report risk adjustment data appropriately, delete undocumented diagnosis codes, and report and return overpayments within 60 days.[363] Financial penalties also could be greater for audit findings that lead to prosecution under the False Claims Act, but meeting the standard of proof required for such cases might be difficult.[364,365]

Focus audits on the plans most likely to have high rates of improper payments. For its audits of 2007 and 2011 plan year data, CMS selected a sample that included plans with low, medium, and high coding intensity.[366] The GAO has recommended strategies to focus on plans that are likely to have high rates of improper payments, which would increase repayments and the detection of fraudulent practices relative to the previous approach.[367] Recommended strategies include the following:

- excluding plans with low coding intensity scores and selecting more plans with high coding intensity scores
- selecting plans that had high rates of unsupported diagnoses in previous audits
- in cases where a plan that had previously high rates of unsupported diagnoses is no longer operating, selecting another plan in that service area from the same parent organization
- selecting some high enrollment plans that have either high coding intensity or high rates of unsupported diagnoses in previous audits[368]

For its audits of plan year 2018 data, CMS announced it would select plans that, among other characteristics, scored in the top 10% in one of two improper payment prediction models.[369] This is consistent with GAO recommendations and could help disincentivize fraud.

Improve calculation of coding intensity for RADV purposes. In earlier audits, CMS calculated and used a measure of coding intensity to classify plans as high, medium, or low coding intensity and selected plans from each group for audit.[370] The GAO recommended that CMS make several adjustments to the calculation of coding intensity to improve its ability to predict which plans might have a high proportion of unsupported diagnoses and, therefore, efficiently identify and recoup overpayments.[371] Although audits can uncover both errors and fraud, focusing audits through a more informative measure of coding intensity could help CMS to identify a greater proportion of fraudulent coding and create a stronger disincentive against engaging in fraud.

Introduce prepayment reviews. Rather than relying exclusively on retrospective audits, CMS could review medical records for targeted diagnoses before making risk-adjusted payments to MA organizations.[372,373] This approach could reduce the need for RADV audits and associated appeals that can delay recoupments and prevent some inaccurate or fraudulent payments, but such an approach would be costly to implement.[374]

Improve oversight of favorable selection. It may be possible for CMS to strengthen existing oversight to reduce the risk of inappropriate favorable selection. Regulations require that CMS reviews benefit designs for features that might "discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services" (42 CFR § 422.100 (f)(2)).[375] CMS guidance also notes that MA organizations must not request or encourage a beneficiary to disenroll and must apply disenrollment policies consistently.[376] It is unclear how CMS conducts oversight of these requirements, or how often plan applications are denied or other penalties issued for failure to meet these requirements. The HHS OIG or another independent party could review CMS oversight procedures, identify any important favorable selection risks that CMS may not be monitoring, and recommend approaches to improve oversight and reporting.

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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

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.

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.

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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