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Fraud, Waste, and Abuse Risks in Medicare Advantage

Introduction

Medicare provides health coverage for about 69 million Americans aged 65 years and older and younger people with disabilities at an annual cost of more than $1 trillion. More than half (51%) of Medicare beneficiaries have enrolled in Medicare Advantage (MA), or Part C, where they select managed care plans sponsored by private insurers that are responsible for covering all eligible Parts A and B Medicare services. MA plans can be attractive alternatives to traditional Medicare because they can offer lower out-of-pocket costs, limits on catastrophic out-of-pocket costs, and supplemental benefits, such as for vision, dental, and hearing services.

Given the size and importance of Medicare, proactively combating fraud, waste, and abuse is key to Medicare sustainability and public confidence. Some of the risks and incentives for fraud, waste, and abuse differ between traditional Medicare and MA, primarily because of different payment methods. In traditional Medicare, fee-for-service (FFS) payment incentivizes hospitals, physicians, and other providers to deliver more services regardless of quality, as measured by greater volume or intensity of services delivered. Thus, strategies to combat fraud, waste, and abuse in traditional Medicare are aimed largely at providers to ensure the amount and type of services delivered are appropriate.

Instead of receiving piecemeal FFS payment for services provided to beneficiaries, MA organizations receive a fixed risk-adjusted amount per beneficiary, per month to provide all Medicare-covered Parts A and B services. Some MA plans also provide Part D prescription coverage. Such a payment approach, coupled with meeting certain quality metrics, is designed to encourage MA organizations to

ensure providers deliver care in an efficient, high-quality manner that benefits both beneficiaries and Medicare. The risk of individual provider or beneficiary fraud or abuse is assumed by the MA organization. At the same time, new fraud, waste, and abuse risks are introduced—for example, manipulating risk adjustment through coding intensity to gain higher payments or using prior authorization to delay or deny necessary care for MA beneficiaries.

With an increasing number of Medicare beneficiaries choosing to enroll in MA plans and thus an increasing amount of taxpayer money going to these plans, policymakers need to consider the range of potential fraud, waste, and abuse risks in MA to identify and prioritize policy and oversight interventions. Risks are driven by incentives built into the MA program; consideration of their potential impact is important even in the absence of any misconduct by MA organizations.

Purpose of this study and research aims: Health policy experts at the American Institutes for Research (AIR) conducted a targeted review of recent literature on MA risks and conducted 14 interviews with expert stakeholders from industry, research, advocacy, and government perspectives to identify how program incentives contribute to fraud, waste, and abuse risks that can ultimately have adverse, unintended effects on Medicare, beneficiaries, and providers.

Findings

In this section, we describe MA fraud, waste, and abuse risks associated with the MA payment system, marketing to beneficiaries, provider networks and plan design, and management of beneficiary protections.

MA Payment System

Coding intensity. Coding intensity is when providers or MA organizations identify and record more, or more serious, diagnoses among MA-enrolled beneficiaries than would be expected for traditional Medicare beneficiaries. Payments to MA organizations are made on a per-beneficiary, per-month—or capitated—basis and are risk adjusted to account for beneficiary health status and other factors that, on average, predict health care service costs. Diagnosis codes play a major role in risk adjustment and MA plan payments, incentivizing MA organizations to document as many diagnoses as possible to gain higher payments.

Audits have revealed that the data MA organizations submit to the Centers for Medicare & Medicaid Services (CMS) for risk score and payment calculations are not always substantiated by beneficiary medical records. The Medicare Payment Advisory Commission (MedPAC) estimates that in 2025, coding intensity will result in payments that are $40 billion higher for MA beneficiaries than if the beneficiaries were enrolled in traditional Medicare. MA organizations use various strategies to increase risk scores—and, therefore, MA plan payments—including include chart reviews, where they review beneficiary medical records to identify additional diagnoses, and health risk assessments (HRAs), where health

professionals collect medical information directly from beneficiaries, to add diagnoses that increase beneficiary risk scores. For example, the U.S. Department of Health and Human Services Office of the Inspector General (HHS OIG) found that in 2016, $9.2 billion in payments originated from diagnoses that were reported only through chart reviews and HRAs but in no other service records. Furthermore, 20 of the 162 MA organizations were responsible for a disproportionate share of those payments.

Experts interviewed by AIR reported that coding intensity has created an "arms race" to maximize MA payments. In some cases, plans offer beneficiaries incentives, such as gift cards, to participate in home HRAs, which MA organizations use to collect diagnosis codes. While it is legal and appropriate for plans to conduct some degree of review to ensure necessary beneficiary diagnoses are identified, these activities may cross into fraud and abuse if false or inaccurate diagnoses are added—for example, when a beneficiary does not receive care related to diagnoses or when diagnoses are not confirmed by a physician. Even in the absence of any misconduct, some consider the higher payments achieved through coding intensity to be a wasteful use of Medicare funds.

Risk Adjustment Data Validation (RADV). Some interviewees expressed concerns about the effectiveness of RADV audits, an oversight mechanism used by CMS to validate MA organizations' diagnosis coding and check for inaccurate payments. For example, CMS has had limited ability to detect overpayments because of small audit samples and a large backlog. Another concern is whether the lengthy duration of RADV audit appeals processes may make it difficult for CMS to recoup overpayments when eventually confirmed. In 2025, CMS announced plans to expand, strengthen, and accelerate RADV audits; however, a federal court decision has created additional challenges to implementing audit plans.

Star Ratings. Each year, CMS publishes Star Ratings that help beneficiaries and others compare the quality of MA plans. The aim of Star Ratings is to provide beneficiaries and their caregivers with meaningful information about quality, alongside information about benefits and costs, to assist them in comparing plans and choosing the Medicare coverage option that best fits their needs. MA plans can receive a rating of up to five stars. Plans with four or more stars are eligible for a quality bonus in the form of a 5% increase to the county benchmark (the county-level per-capita payment amount before risk adjustment) and larger rebates if they bid below the benchmark.

Interviewees raised several concerns about Star Ratings. Bonuses and rebates linked to MA plan Star Ratings are not budget neutral and could contribute to waste by driving up total Medicare costs. There are also concerns that Star Rating bonuses have failed to improve quality. Double bonuses in certain urban counties[1] are particularly costly and may be unnecessary to maintain access to MA plans. There also may be a risk that MA organizations could manipulate scores for Star Ratings measures they report directly to CMS, although measure audits should reduce this risk. In addition, MA organizations may influence decisions about the design of the Star Rating system, creating a risk that changes could increase costs without improving quality. For example, CMS reversed an earlier decision and reduced the weighting of patient experience/complaints and access measures for the 2026 ratings (covering the

2024 measurement period) after "taking into consideration additional stakeholder feedback we have received and the effect of the policy on the 2023 Star Ratings."

While research suggests Star Ratings are not the most important factor in plan selection, some interviewees expressed concerns that Star Ratings lack meaningful quality information to guide enrollment decisions and could potentially mislead beneficiaries. For example, interviewees said there can be important differences between the quality of the parent MA contract (the level at which Star Ratings are determined) and an individual MA plan; beneficiaries may assume that a plan with a four-star rating is performing better than average, which may not be the case given the lack of a normal distribution; and despite a high overall rating, the plan could be performing poorly on certain measures that may be more important to the beneficiary.

Cost Shifting. To retain more revenue, MA organizations may shift costs to other parties, including beneficiaries and other payers. This could occur by designing plans or networks so that beneficiaries pay out of pocket for some covered services (e.g., if they are forced to seek care out of network or at a higher-cost tier because in-network providers are not available) or shifting costs to another payer, such as the Veterans Health Administration (VHA), if the MA beneficiary has another source of coverage. Veterans' enrollment in MA presents a particular risk because the lack of coordination of benefits between Medicare and VHA means MA organizations can receive a full capitated payment for veterans who receive all or most of their services through the VHA. In this case, the federal government is making duplicate payments for health coverage for these beneficiaries, including an estimated $1.3 billion per year in payments for VHA enrollees who received no care from their MA plan.

Favorable Selection. Plans may try to enroll beneficiaries who are healthier than their peers and therefore less costly, known as *favorable selection*. Improvements in risk adjustment methods have removed some disincentives to enroll higher-risk beneficiaries; however, MA organizations can still predict within each risk stratum which beneficiaries are likely to be less costly. MA enrollees continue to be less costly than similar beneficiaries in traditional Medicare, despite the use of risk adjustment and other MA regulations intended to limit favorable selection, such as requiring plans to cover full county areas in most cases and prohibition against discrimination against beneficiaries based on health status. Activities designed to leverage favorable selection include plan marketing practices and designs that encourage enrollment among healthier beneficiaries, as well as plan designs that cause dissatisfaction among higher-cost enrollees and prompt their disenrollment. MedPAC estimates that favorable selection will result in Medicare paying $44 billion more in 2025 for enrollees in MA than it would have paid for those beneficiaries under traditional Medicare, in addition to the $40 billion excess attributed to coding intensity.

An interviewee noted that, in addition to being able to choose any combination of counties (or regions, in the case of regional MA plans) in which to offer a plan, an MA organization may offer a plan in a partial county. While this requires additional justification (to show it is necessary, nondiscriminatory, and in beneficiaries' best interests), partial-county plans may present a risk of favorable selection if MA

organizations can select a less costly portion of the county and still receive the benchmark rate for the full county. The risk is exacerbated because there is no publicly available information on partial-county service areas or justifications, so the scope of the issue and the extent of CMS oversight are unclear.

Vertical Integration. Risk-based payments create incentives for MA organizations to purchase providers—including physician practices, home health agencies, hospitals, and businesses that provide supplemental benefits—that give MA organizations greater control over coding and care delivery. For example, MA organizations may offer providers financial incentives to engage in certain behaviors, such as conducting annual wellness visits or patient assessments to identify and document all chronic conditions. Moreover, MA organizations' access to data on beneficiaries' diagnoses and medical encounters provides opportunities to increase coding intensity. While kickbacks to providers for referrals within the organization could be illegal, providers may have other incentives to refer within the larger organization that may limit beneficiary choice of providers. Vertical integration can also facilitate gaming of medical loss ratio requirements.[2] By showing profits at the provider rather than the plan level, MA organizations can receive a larger profit than otherwise would be permitted, which can increase costs to Medicare and, depending on the circumstances, may represent fraud, waste, or abuse. There is also a lack of transparency regarding MA organization ownership interests and provider acquisitions, making oversight more challenging.

Marketing to Beneficiaries

Despite CMS regulations and guidelines, aggressive marketing tactics and false and misleading information have been the subject of many complaints and lawsuits about MA plans and marketing organizations, and these activities can include fraud risks. The lack of marketing for traditional Medicare, misleading MA marketing content, and concerns about fraud by agents and brokers selling MA plans can lead to beneficiaries misunderstanding their options or enrolling in unsuitable MA plans. For example, interviewees noted that oversight of agents and brokers can be difficult because they are removed from the MA organizations, and their contracts with MA organizations and payment structure may incentivize steering beneficiaries to select plans or omitting information on relevant options.

Supplemental Benefits as a "Hook." Supplemental benefits like dental, vision, and hearing services, which are not covered by traditional Medicare, are popular features of MA plans. However, these benefits may introduce fraud, waste, and abuse risks through favorable selection or misleading advertising if the supplemental benefits are more limited than disclosed. For example, beneficiaries may not qualify for advertised supplemental benefits if they do not have a qualifying chronic condition, may be unable to access them because of a lack of in-network providers (e.g., there are no network adequacy requirements for vision, dental, or hearing providers), or may be misled regarding cost sharing or generosity of the benefits. An example of how supplemental benefits may be used for favorable selection is the coverage of worldwide emergency or urgent care, which would be disproportionately attractive to healthier and higher-income beneficiaries who are able to travel outside the country. This can create wasteful spending because the capitation rates for these beneficiaries are high relative to their health care costs. Finally, limited encounter data surrounding the

availability and use of supplemental benefits create challenges for assessing whether they are delivered as advertised.

Provider Networks and Plan Design

Design and Representation of Provider Networks. MA organizations may structure provider networks to help control costs by limiting which providers can participate. However, fraud, waste, and abuse risks associated with network design exist. For example, provider networks can be leveraged for favorable selection by adopting narrow networks for specialty services that discourage higher-needs beneficiaries from enrolling or encourage them to disenroll when a higher level of care becomes necessary.

There are also concerns about the effectiveness and enforcement of provider network adequacy standards and their transparency. For example, while beneficiaries might find coverage of telehealth services attractive, plans do not need to disclose that they can provide less access to in-person providers in some specialties if they offer those services via telehealth. Similarly, there are no requirements for providers in MA plan networks to accept new patients, and a beneficiary might choose a plan based on the expectation of accessing a provider only to discover that the provider is unavailable. In some cases, beneficiaries have found that providers listed in plan directories do not exist or are not in network, a phenomenon commonly referred to as *ghost networks*. Such actions could amount to fraud if the plan provides intentionally misleading information about whether a provider is in network, the provider's specialty, or a provider's address. For 2026 open enrollment, CMS introduced functionality enabling beneficiaries to search by provider on Medicare Plan Finder. This should make directories more transparent and easier to use for enrollment decisions, but it is not clear whether it will lead to any improvements in ghost networks.

Oversight of Provider Contracting and Networks. MA plans are required to have contracted provider networks that are sufficient to provide access to Medicare-covered services. Interviewees indicated that existing network adequacy standards are insufficient to ensure that beneficiaries get the care they need. Such standards also lack sufficient monitoring and enforcement, according to interviewees. For example, for tiered provider networks, where there are different levels of beneficiary cost sharing depending on which provider they use, network adequacy is assessed at the MA contract level, and beneficiaries in one of the contract's tiered-network plans may only have access to a narrower network at the preferred provider copayment or coinsurance rate. There also are no requirements to provide beneficiary-facing materials that explain the network adequacy standards they should expect from an MA plan provider network. Contracts between MA organizations and providers could also present a risk of fraud, waste, and abuse because the contracts are not publicly available and the extent of CMS oversight is not clear, particularly in the context of limited CMS authority in this area. An interviewee noted that the noninterference clause (§ 1854(a)(6)(B)(iii) of the Social Security Act), which prevents the HHS Secretary from requiring a MA organization to contract with a particular provider or require a particular price structure for MA plan payments to providers, limits CMS oversight. However, the interviewee did not support abolishing the clause, recognizing it has other benefits.

Data Transparency and Benefit Standardization. Several interviewees raised concerns about the transparency of the MA plan bidding and application process. There may be fraud, waste, and abuse risks if MA organizations can game the bidding process (e.g., by inflating estimated medical expenses), exacerbated by insufficient verification of the data used in plan bids. There are also risks associated with the lack of standardization of benefits, making it more difficult for beneficiaries to make informed decisions. Medigap and Marketplace plans are standardized—that is, designed to fit into a specific category based on member costs—whereas MA organizations can design their plans' cost-sharing and supplemental benefit levels as they choose. Standardization of benefits would reduce the burden for beneficiaries when selecting a plan, make value comparisons easier, and make it harder for bad actors to mislead beneficiaries into unsuitable enrollment choices.

Dual Eligible Special Needs Plans (D-SNPs). Enrollees eligible for both Medicare and Medicaid have higher risk scores on average and are more likely to have undiagnosed health conditions. This can translate into higher payments for MA plans; however, it is unclear whether higher payments are justified by the higher costs driven by those beneficiaries' health needs. Given that enrollment in D-SNPs has grown in recent years, these beneficiaries may be particularly profitable for MA plans. This could be due to favorable selection of beneficiaries who have low health care utilization relative to others with similar risk scores, or due to these beneficiaries being less concerned about prices because Medicaid covers many of their out-of-pocket costs. Greater oversight may be necessary given potential risks for increased coding intensity and delay or denial of needed care through utilization controls such as prior authorization. Dually eligible beneficiaries also may be misled by D-SNP "look-alike" plans that are not required to provide the same level of care as D-SNPs. CMS has taken steps to reduce proliferation of D-SNP look-alike plans in 2025 and 2026, but the impact is not yet clear, and similar risks remain for other special needs plans with high enrollment among dually eligible beneficiaries.

Employer Group Waiver Plans (EGWPs).[3] Around 5.4 million beneficiaries were enrolled in EGWPs in 2023. An interviewee raised concerns that beneficiaries can be automatically shifted to MA, for example, from employer-sponsored insurance when aging into Medicare or from an employer-sponsored Medigap plan, without their consent or knowledge. CMS has indicated that it will deny Freedom of Information Act requests regarding the identity of employers offering EGWPs, citing the protection of proprietary information. This makes it difficult for beneficiaries and external researchers to identify fraud, waste, and abuse risks associated with these plans and to analyze CMS oversight of EGWPs.

Medigap. An interviewee discussed concerns that Medicare beneficiaries can be trapped in MA because beneficiaries can be subject to higher premiums if they enroll in Medigap after switching from MA, rather than when they first become eligible for Medicare. These higher costs are due to medical underwriting that bases the Medigap premium on a beneficiary's health status at the time they purchase the Medigap plan. A beneficiary who drops a Medigap policy to join an MA plan for the first time has a single 12-month trial period to return to traditional Medicare and get that Medigap policy back (if the same insurance company still sells the policy). If that Medigap policy is not available, the beneficiary can buy a different Medigap policy they qualify for that is sold by an insurance company in

their state (except for Medigap Plans M and N). A beneficiary who enrolls in an MA plan upon first gaining eligibility for Medicare Parts A and B can choose from any Medigap policy sold by an insurance company in their state if they switch to traditional Medicare within the first year of Medicare eligibility. Other limited exceptions to medical underwriting for Medigap policies when MA beneficiaries return to traditional Medicare include situations where beneficiaries move from an MA plan service area or the MA plan is terminated. Lack of access to Medigap coverage is a special concern for beneficiaries with complex health needs or those receiving high-cost treatments. These beneficiaries are more likely to disenroll from MA and face higher Medigap premiums due to underwriting. While agents, brokers, and MA organizations should make this risk clear to potential MA enrollees, it is unclear whether failure to provide this information would be considered sufficiently misleading to constitute fraud or abuse. An interviewee noted that another risk exists when the same issuers offer both MA and Medigap plans in a market, giving them additional information about enrollees' health status and utilization that they may be able to use for rating, pricing, or to influence enrollment choices.

Management of Beneficiary Protections

Utilization Management. Several utilization management practices, such as prior authorization and denials of care, can pose fraud, waste, and abuse risks if used inappropriately. An HHS OIG study found that, through actions such as requesting unnecessary documentation and using clinical criteria not documented in Medicare coverage rules, MA organizations denied or delayed prior authorization requests and payments that met Medicare coverage rules and therefore should have been approved. Even when denials are later reversed, they may prevent or delay receipt of medically necessary care and could be considered abuse. Risks may be greater when automation or artificial intelligence is used for utilization management because of the scale at which claims can be denied and the increased likelihood of inappropriate application of Medicare coverage rules and insufficient clinical oversight. Although MA organizations must publish some information, such as the list of services requiring prior authorization, interviewees noted that these documents are often presented in complicated language and formats that may be inaccessible to beneficiaries, making it difficult for beneficiaries to make informed decisions when choosing plans, and presenting an opportunity for bad actors to mislead or obscure critical information. Referral (or gatekeeper) requirements can further limit beneficiaries' access to providers, such as by delaying care, and are not always clear to beneficiaries.

The fraud, waste, and abuse risks of utilization management are exacerbated by oversight challenges. For example, MA encounter data do not have a payment denial indicator, and the existing adjustment codes cannot be used to identify inappropriate coverage denials. This means oversight entities must make separate requests to MA organizations to identify denied claims in their data, adding time and burden to investigations.

Appeals. Most interviewees agreed that the MA beneficiary appeals process is confusing and time consuming, particularly for dually eligible enrollees who may need to work through separate appeal processes with their MA plan and Medicaid agency or managed care plan. Interviewees noted that a

burdensome appeals process can pose fraud, waste, and abuse risks by reducing beneficiary appeals, masking the scope of inappropriate denials, and limiting information CMS receives about problem areas.

Conclusions

This analysis describes a range of issues and situations where risks of fraud, waste, and abuse may be driven by incentives in MA payment and sometimes exacerbated by data limitations, complexity, and gaps in oversight. Some issues meet the threshold for repayments, sanctions, or prosecution and may be addressed through oversight and enforcement activities when possible, given limited resources and legal challenges. Others need to be addressed through policy changes because they are permissible strategies that MA organizations can use to increase or retain revenue, even though they create waste for Medicare and may pose harm to beneficiaries and providers. There is a need for additional research on policy and oversight interventions that considers the evidence for potential Medicare savings as well as compliance costs and the likely impact on beneficiaries, providers, and MA plans.

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[1] Plans with four or more stars in urban counties with low traditional Medicare spending and historically high MA enrollment receive a double bonus—that is, a 10% increase to the county benchmark.

[2] Most MA and Medicare Part D plans are required to have a medical loss ratio (MLR) of at least 85%; that is, plans must spend at least 85% of premiums on benefits to enrollees including clinical services, prescription drugs, and quality improvement programs. Higher-than-expected profits can mean a plan will not reach the minimum MLR and may have to make repayments to CMS. If this is sustained over successive years, the plan may be prohibited from taking new enrollees or the contract may be terminated.

[3] Employer Group Waiver Plans (EGWPs) are MA plans offered by an employer or union to Medicare-eligible employees, retirees, or union members. They must provide all Parts A and B benefits but receive waivers from some MA requirements, permitting premiums to differ across groups of enrollees, departures from standard marketing, and different periods for plan years and open enrollment.