Medicare Advantage? If You Say So. Fraud, Waste, And Abuse In Medicare Part C

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Abstract. Debates about health care often emphasize distributive justice. How should society allocate finite resources? Who will get access to them, who will not? Is the allocation fair? Who decides and by what standard? Answers to these questions rarely consider health care fraud, waste, and abuse. This is a material omission. Fraud alone costs the health care system billions of dollars annually, dissipating limited funds and degrading quality of care. This paper considers how fraud, waste, and abuse occur in Medicare Part C – better known as Medicare Advantage – an increasingly popular coverage option. Medicare Advantage experiences unique challenges that undermine the program and squander the public's investment in it. Only by accounting for these programmatic vulnerabilities can we then go on to assess whether Medicare Advantage is an effective, cost-efficient, and equitable mechanism for delivering health insurance coverage.

Keywords. Medicare Advantage, Part C, fraud, waste, abuse, capitated rate, risk adjustment, coding intensity, disenrollment.

INTRODUCTION

Distributive justice considers how a society allocates benefits and burdens among its members. When fixed on health care, debates about distributive justice contemplate whether and how to make finite resources satisfy infinite wants and needs.[1] One may embrace traditional accounts of justice, whether consequentialist, which chase outcomes, or libertarian, which forward individual liberty, private property, and market transactions. Or one may or prefer emerging approaches that accent how health is instrumental to the good life. Whatever theory of justice one accepts, the core dilemma is the same – how to deal with scarcity. Beauchamp and Childress observe that "conditions of scarcity sometimes force a society to make tragic choices, and in the process, even valid principles of justice may be justifiably infringed, compromised, or sacrificed."[2] They are correct of course, limit setting is inevitable and can be brutal.[3] In some instances, however, the tragic choices that confront a society are self-inflicted. Fraud, waste, and abuse consume health care resources and exacerbate scarcity, yet they are rarely mentioned in discussions about distributive justice. These factors warrant a more prominent place in debates about health care and the programs that we design to allocate it. This paper discusses how fraud, waste, and abuse occur in one such program – Medicare Part C, better known as Medicare Advantage.

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[1] Daniels, Norman. 1985. *Just Health Care.* Cambridge: Cambridge University Press.

[2] Beauchamp, Tom L., and James F. Childress. 2019. *The Principles of Biomedical Ethics.* 8th. New York: Oxford University Press, 268.

[3] Morreim, E Haavi. 1991. "Gaming the System: Dodging the Rules, Ruling the Dodgers." *Archives of Internal Medicine* 151 (3): 443-47. 10.1001/archinte.1991.00400030013003.

Enrollment in Medicare Advantage has doubled since 2013.[4] It now tops 29 million people.[5] If enrollment continues growing at this pace, Medicare Advantage will soon cover over half of all Medicare beneficiaries. Put differently, Part C is about to supplant Parts A and B – traditional Medicare – as the primary way that beneficiaries receive Medicare coverage.[6] As enrollment increases, so will spending. In 2021, payments to Medicare Advantage plans totaled $350 billion;[7] by the end of 2022, that number is expected to hit and perhaps eclipse $420 billion.[8,9] How should we assess these trends? Are they sustainable? And what do they portend for patients, providers, and the health care system?

Most attempts to answer these questions emphasize how Medicare Advantage affects quality,[10,11] cost,[12] and access to care.[13] Fewer spotlight the program's vulnerabilities. Medicare Advantage is susceptible to fraud, waste, and abuse. This is, to be sure, not saying very much. Fraud, waste, and abuse are endemic to the health care system generally, and to government health care programs in particular.[14] Even so, features peculiar to Medicare Advantage jeopardize the program's integrity and deplete the public's investment in it. Only by accounting for the unique challenges that beset Medicare Advantage can we then assess whether the program is an effective, cost-efficient, and equitable way to distribute health insurance coverage.

This paper has five sections. Section One summarizes the Medicare Advantage program and identifies how it differs from traditional Medicare. Section Two addresses health care fraud. A spate of whistleblower lawsuits, government enforcement actions, and administrative investigations suggests that misconduct is pervasive.[15] This paper spotlights the fraud claims against Kaiser Permanente because they exemplify the allegations in cases filed against leading Medicare Advantage plans and illustrate the structural weaknesses that plans allegedly exploit for financial gain. Section Three highlights waste in Medicare Advantage. Habitual overpayments coupled with lackadaisical oversight cost taxpayers billions each year. Section Four targets abuse, focusing on prior authorization, one of several tools that Medicare Advantage plans employ to manage care. Section Five concludes by considering the distributive justice implications of the Medicare Advantage program.

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[4]Medicare Payment Advisory Commission. 2022. *July 2022 Data Book: Health Care Spending and the Medicare Program.* Washington, D.C.: MedPac, 117. https://www.medpac.gov/document/july-2022-data-book-health-care-spending-and-the-medicare-program/.

[5]Centers for Medicare & Medicaid Services. 2022. "CMS Fast Facts." Vers. August 2022. *Data.CMS.gov.* Accessed November 11, 2022. https://data.cms.gov/fact-sheet/cms-fast-facts.

[6]Palosky, Craig. 2022. "Medicare Advantage Is Close to Becoming the Predominant Way That Medicare Beneficiaries Get Their Health Coverage and Care." *KFF.org.* August 25. https://www.kff.org/medicare/press-release/medicare-advantage-is-close-to-becoming-the-predominant-way-that-medicare-beneficiaries-get-their-health-coverage-and-care/.

[7]The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2022. "2022 Annual Report of The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds." Washington, D.C., 12, 161. https://www.cms.gov/OACT/TR.

[8]Congressional Budget Office. n.d. "Details About Baseline Projections for Selected Programs." Vers. Medicare, May 2022. *CBO.gov.* https://www.cbo.gov/system/files?file=2022-05/51302-2022-05-medicare.pdf.

[9]Freed, Meredith, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. 2022. "Medicare Advantage in 2022: Enrollment Update and Key Trends." *KFF.org.* August 25. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/.

[10]Ochieng, Nancy, and Jeannie Fuglesten Biniek. 2022. "Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature." *KFF.org.* September 16. https://www.kff.org/report-section/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature-report/.

[11]Agarwal, Rajender, John Connolly, Shweta Gupta, and Amol S Navathe. 2021. "Comparing Medicare Advantage and Traditional Medicare: A Systematic Review." *Health Affairs* 40 (6): 937-44. doi:10.1377/hlthaff.2020.02149.

[12]Biniek, Jeannie Fuglesten, Juliette Cubanski, and Tricia Neuman. 2021. "Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges." *KFF.org.* August 17. https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges/.

[13]Aggarwal, Rahul, Suhas Gondi, and Rishi K Wadhera. 2022. "Comparison of Medicare Advantage vs Traditional Medicare for Health Care Access, Affordability, and Use of Preventive Services Among Adults with Low Income." *JAMA Network Open* 5 (6): e2215227. doi:10.1001/jamanetworkopen.2022.15227.

[14]United States Department of Health and Human Services, Office of Inspector General. n.d. *Health Care Fraud & Abuse Control Program Report.* https://oig.hhs.gov/reports-and-publications/hcfac/index.asp.

[15]Abelson, Reed, and Margot Sanger-Katz. 2022. "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions." *New York Times,* October 8. https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html.

I.   MEDICARE PART C: THE MEDICARE ADVANTAGE PROGRAM

Medicare is a federal health insurance program for people who are 65 and over, have a disability, or suffer from end-stage renal disease.[16] Traditional Medicare comprises (1) Part A, which is hospital insurance that covers inpatient and comparable services, such as hospice and skilled nursing care;[17] and (2) Part B, which is optional medical insurance that covers physician and other outpatient services.[18] Most beneficiaries receive Part A automatically without additional cost beyond the Medicare taxes that they have already paid. Part B is optional, those who want the coverage must pay a monthly premium for it. Traditional Medicare is fee-for-service, meaning that the program reimburses health care providers per service that they render. Medicare also offers prescription drug coverage under Part D.[19] Like Part B, the drug benefit is optional. Beneficiaries who want the coverage must join an approved drug plan and pay a monthly premium. Some beneficiaries also purchase supplemental insurance – Medigap – to cover costs that traditional Medicare does not (*e.g.,* deductibles and co-payments).[20]

If Parts A and B cover hospital and medical services, and Part D adds drugs, what exactly does Part C do? It provides an alternative. Under Part C, beneficiaries may opt out of traditional Medicare and enroll in private health plans operated by Medicare Advantage Organizations (MAOs). Medicare Advantage plans must provide the same coverage as traditional Medicare (except for hospice and some benefits related to kidney transplants),[21] and most plans include prescription drug coverage as well.[22] In other words, Medicare Advantage is akin to one-stop shopping for health insurance.[23] From a prospective enrollee's vantage, the program differs from traditional Medicare in two salient ways. *First*, Medicare Advantage plans offer supplemental benefits[24] that traditional Medicare does not,[25] including coverage for routine medical services, like vision, hearing, and dental care,[26] and non-medical perks that are "primarily health related,"[27] like transportation and home modifications to prevent falls.[28] *Second*, Medicare Advantage plans manage care, employing strategies like network restrictions and prior authorization to monitor utilization and control costs,[29] unlike traditional fee-for-service Medicare.[30] The program's extra benefits and convenience attract beneficiaries, while its promise of cost savings entices policymakers. That promise has not been realized. "Historically, one goal of the Medicare Advantage program was to leverage the efficiencies of managed care to reduce Medicare spending. However, the program has never generated savings relative to traditional Medicare. In fact, the opposite is true."[31] One explanation for this is structural; namely, how CMS pays MAOs for the coverage that their plans provide.

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[16]42 U.S.C. §§ 1395c, 1395j. Persons with amyotrophic lateral sclerosis – ALS – are also entitled to Medicare and are exempt from the 24-month waiting period applicable to those who seek coverage due to disability. 42 U.S.C. § 426(h).

[17]42 U.S.C. § 1395d.

[18]42 U.S.C. § 1395k.

[19]42 U.S.C. § 1395w-101(a)(3)(A).

[20]Centers for Medicare & Medicaid Services. n.d. *Medigap (Medicare Supplement Health Insurance).* https://www.cms.gov/Medicare/Health-Plans/Medigap.

[21]42 U.S.C. § 1395w-22.

[22]Freed, Meredith, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. 2022. "Medicare Advantage 2023 Spotlight: First Look." *KFF.org.* November 10. https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/.

[23]Neuman, Patricia, and Gretchen A Jacobson. 2018. "Medicare Advantage Checkup." *New England Journal of Medicine* 379 (22): 2163-72. doi:10.1056/NEJMhpr1804089.

[24]42 C.F.R. § 422.102.

[25]Centers for Medicare & Medicaid Services. 2019. "2019 Announcement." *CMS.gov.* Release date: April 2, 2018, 207-08. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

[26]Over 90% of Medicare Advantage plans will offer some level of coverage for vision, hearing, and dental care 2023. Freed *et al., supra* n 22, fig. 9.

[27]Centers for Medicare & Medicaid Services. n.d. "Medicare Managed Care Manual (Internet Only Manual, Pub. #100-16)." *CMS.gov,* Ch. 4 § 30.1. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf.

[28]Kornfield, Thomas, Matt Kazan, Miryam Frieder, Robin Duddy-Tenbrunsel, Shruthi Donthi, and Alessandra Fix. 2021. "Medicare Advantage Plans Offering Expanded Supplemental Benefits: A Look at Availability and Enrollment." *Commonwealth Fund.org.* February 10. https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/medicare-advantage-plans-supplemental-benefits.

[29]42 U.S.C. § 1395w-22; 42 C.F.R. § 422.111.

[30]McGuire, Thomas G, Joseph P Newhouse, and Anna D Sinaiko. 2011. "An Economic History of Medicare Part C." *The Milbank Quarterly* 89 (2): 289-332. doi:10.1111/j.1468-0009.2011.00629.x.

[31]Biniek *et al., supra* n 12.

Under Part C, the Centers for Medicare & Medicaid Services (CMS) contracts with MAOs to operate Medicare Advantage plans.[32] Pursuant to these contracts, CMS pays MAOs a capitated rate for each beneficiary that their plans cover.[33] The capitated payment is a fixed amount per beneficiary, per month that does not depend on the volume or type of services that the beneficiary receives.[34] In other words, MAOs get paid the same whether utilization and concomitant expenses are sky-high or zero. This payment system offloads risk from Medicare to MAOs and, in doing so, is supposed to align MAOs' financial interests with beneficiary health outcomes. By efficiently and effectively managing care – for example, emphasizing prevention that obviates the need for pricier treatment later – MAOs and their plans keep their beneficiaries healthy and their costs down, at least in theory.[35] In practice, this payment system creates perverse incentives, particularly for patient selection. If CMS were to pay the same amount per beneficiary no matter how much or how little a plan expended to provide coverage, then MAOs would skew their risk pools toward healthy people who on average cost less to cover and shun sicker persons whose conditions are likely to require expensive management. Strategies for engineering a favorable risk pool might range from outright discrimination to subtle plan designs that appeal to active persons – by, for example, offering gym memberships – and are less attractive to higher-need individuals.[36]

To prevent this kind of cherry-picking, CMS employs a risk-adjusted payment system.[37] Its purpose is "to ensure that plans are adequately and fairly compensated for treating all categories of enrollees—those with high medical costs as well as those with less health care utilization."[38] To achieve fair and adequate compensation, CMS increases or decreases a plan's capitated payment based on the risks and projected expenses associated with covering a beneficiary. The agency pays more for sicker individuals because they are likely to require more spending, less for healthier persons who are expected to cost less. By adjusting payments up and down to correspond to the risks and projected costs associated with different beneficiaries, CMS tries to eliminate selection bias among Medicare Advantage plans.[39] Under the agency's risk-adjusted payment system, a plan's capitated payment is the product of two factors: (1) base rate, and (2) risk score (Figure 1).

Figure 1. Basic Capitated Payment Formula.

Base rate. CMS uses a bidding process to determine a plan's base rate.[40] Each year, MAOs submit bids for their Medicare Advantage plans. A bid is supposed to project the monthly revenue that a plan needs in order to provide Part A and B benefits to an average beneficiary, plus overhead and profit.[41] CMS compares the bids to benchmarks, which are determined by a statutory formula

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[32]42 U.S.C. § 1395w-27; 42 C.F.R. § 422.503; *see also* 42 C.F.R. § 422.2 (defining Medicare Advantage organization and plan).

[33]42 U.S.C. § 1395w-23; 42 C.F.R. § 422.304.

[34]Grimm, Christi A. 2022. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care (OEI-09-18-00260).* Office of Inspector General, United States Department of Health and Human Services, Washington, D.C.: Office of Evaluations and Inspections, 2 n 5. https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp.

[35]Aggarwal *et al.*, *supra* n 13.

[36]Cooper, Alicia L, and Amal N Trivedi. 2012. "Fitness Memberships and Favorable Selection in Medicare Advantage Plans." *New England Journal of Medicine* (366) 2: 150-57. doi:10.1056/NEJMsa1104273.

[37]42 U.S.C. § 1395w-23(a)(1)(C)(i); 42 C.F.R. § 422.308(c).

[38]Medicare Payment Advisory Commission. 2022. *March 2022 Report to the Congress: Medicare Payment Policy*. Washington, D.C.: MedPac, 432. https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/.

[39]Geruso, Michael, and Timothy Layton. 2020. "Upcoding: Evidence from Medicare on Squishy Risk Adjustment." *Journal of Political Economy* 12 (3): 984-1026. doi:10.1086/704756.

[40]42 U.S.C. § 1395w-24(a)(1); 42 C.F.R. § 422.254(a)(1).

[41]42 U.S.C. § 1395w-24(a)(6)(A); 42 C.F.R. § 422.254(b)(3).

that factors in county-level data.[42] A benchmark is the maximum amount that CMS will pay a Medicare Advantage plan to cover an average enrollee in a county.[43] CMS announces county benchmarks annually. For instance, according to the agency's 2022 Medicare Advantage Rate Book, the benchmark for Bexar County, Texas was $997.85.[44] Benchmarks are adjustable based on quality ratings. Plans with high ratings receive up to a 5% benchmark increase.[45] In 2022, the highest-rated plans in Bexar County would thus have enjoyed a benchmark of $1,097.64.[46]

If a plan's bid exceeds the applicable benchmark, CMS caps the plan's base rate at the benchmark.[47] To recover the difference between its base rate/benchmark and its bid, a Medicare Advantage plan charges its beneficiaries a premium.[48] If instead a plan bids under the benchmark, then the plan's base rate equals its bid.[49] When a plan's bid is below the benchmark, it does not need to charge a premium to make up the shortfall. Instead, the plan receives a rebate from CMS. The rebate is a portion of the difference between the plan's base rate/bid and the benchmark. A plan must return the rebate to its beneficiaries by lowering premiums, reducing cost-sharing, or adding benefits.[50] Figure 2 depicts a simplified base rate determination.

FIGURE 2. SIMPLIFIED BASE RATE DETERMINATION
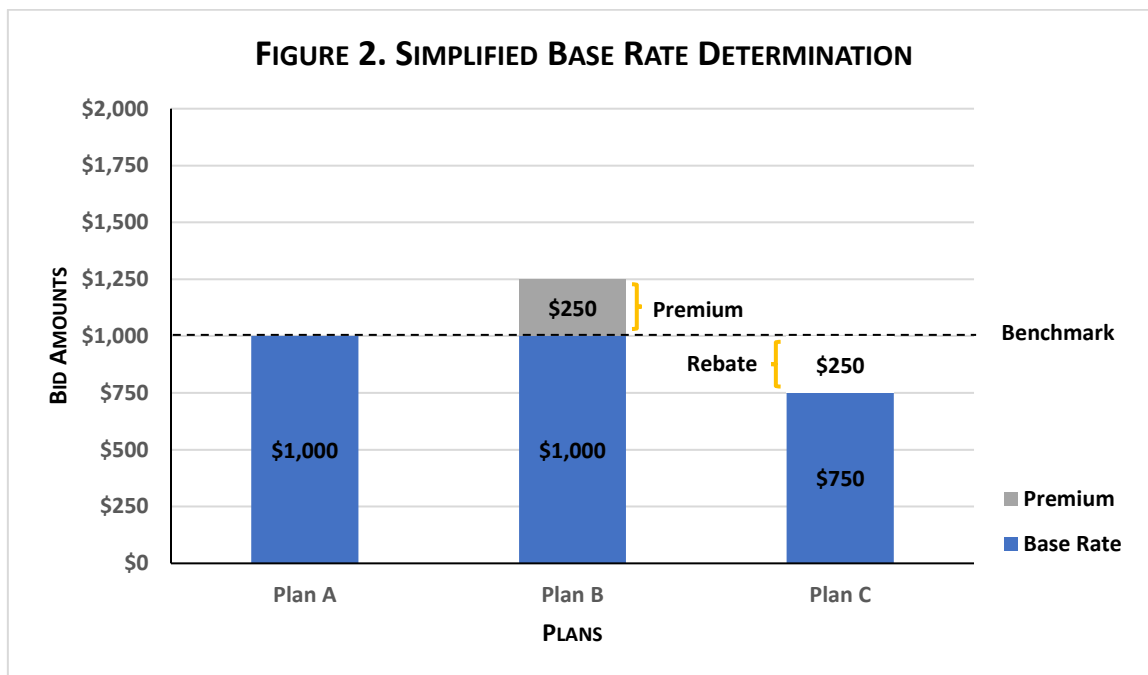
Risk score. CMS assigns a risk score to each beneficiary that a Medicare Advantage plan covers. A risk score is an attempt to predict how much it will cost a plan on average to cover a beneficiary based on several demographic and diagnostic variables, like age,

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[42]42 U.S.C. § 1395w-23(j).

[43]42 C.F.R. § 422.252.

[44]Centers for Medicare & Medicaid Services. 2022. "2022 Medicare Advantage Rate Book and Prescription Drug Rate Information." *CMS.gov.* https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsratebooks-and-supporting-data/2022.

[45]Morgan, Paulette C. 2019. *Medicare Advantage (MA)–Proposed Benchmark Update and Other Adjustments for CY2020: In Brief.* CRS Report, Washington, D.C.: Congressional Research Service, 2 n 5. https://crsreports.congress.gov/product/pdf/R/R45494/3.

[46]Centers for Medicare & Medicaid Services, *supra* n 44.

[47]42 U.S.C. § 1395w-23(a)(1)(B)(ii); 42 C.F.R. § 422.304(a)(2).

[48]Centers for Medicare & Medicaid Services. n.d. "Medicare Managed Care Manual (Internet Only Manual, Pub. #100-16)." *CMS.gov.* Accessed November 22, 2022, Ch. 8 §§ 60.1, 60.4. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c08.pdf.

[49]42 U.S.C. § 1395w-23(a)(1)(B)(i); 42 C.F.R. § 422.304(a)(1).

[50]Medicare Advisory Payment Commission. 2022. *Medicare Advantage Program Payment System.* Washington, D.C.: MedPac, 3. https://www.medpac.gov/document/medicare-advantage-program-payment-system/.

sex, disability, Medicaid eligibility, and health status.[51] Each demographic and diagnostic variable corresponds to "a coefficient that represents the expected medical costs associated with that" variable.[52] To calculate a beneficiary's risk score, CMS examines the beneficiary's individual characteristics (*e.g.,* age) and diagnoses (*e.g.,* diabetes) and aggregates the coefficients associated with them. Diagnoses are central to the risk-adjustment process. CMS organizes diagnoses into Hierarchical Condition Categories (HCCs), which are "disease groupings . . . that predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to MA payments."[53] The agency links a beneficiary's diagnoses to their corresponding HCCs to determine the appropriate coefficients to assign. HCCs that encompass severe and chronic conditions have higher coefficients because they are likely to involve greater treatment costs. CMS then adds the beneficiary's diagnostic coefficients to the coefficients for the beneficiary's demographic traits. The sum of these variables is the beneficiary's risk score, which the agency uses to adjust the plan's base rate and set its monthly capitated payment. Specifically, CMS multiplies the plan's base rate by the beneficiary's risk score.[54] The product is the plan's capitated payment, an individualized amount tied to the anticipated cost of caring for the beneficiary. To illustrate the calculation, if a beneficiary had a .5 risk score, the plan's capitated payment would equal 50% of its base rate (base rate x .5). If the same beneficiary's risk score jumped to 1.5, the payment would be 150% of its base rate (base rate x 1.5). CMS repeats this risk-adjustment process annually for each beneficiary that a plan covers to ensure that the plan is paid accurately and is neither over- nor undercompensated.

The risk-adjustment process is forward-looking. It is an attempt to project anticipated costs of care. CMS uses demographic and diagnostic information from one year (base year) to adjust a plan's payment for the upcoming year.[55] Suppose that a beneficiary receives a new congestive heart failure diagnosis in the base year (Y_1) that will increase the cost of caring for that person. The coefficient for the congestive heart failure diagnosis is added to the beneficiary's risk score. Because diagnoses do not stand alone, but coexist with other conditions, the congestive heart failure diagnosis might lead to additional upward adjustments. If, for example, the beneficiary also had diabetes, the interaction between their diabetic and heart conditions would augment their risk score as well.[56] CMS identifies the relevant diagnostic changes and interactions and aggregates the relevant coefficients associated with them to adjust the beneficiary's risk score, which the agency then applies prospectively to recalculate the plan's capitated payment for Y_2. What happens in Y_1 thus influences payment in Y_2. If the beneficiary were to receive a new diagnosis in Y_2 that elevated their risk score even more, that diagnosis would be accounted for in the risk-adjusted payment for Y_3, and so on.

CMS also uses a backward-looking reconciliation process to ensure proper payment.[57] Under the agency's risk-adjustment system, there may be a lag between events that impact a beneficiary's risk score (*e.g.*, a plan adds a new diagnosis or deletes an old one) and a plan's submission of pertinent diagnostic information to CMS. As a result of this lag, the plan may receive interim capitated payments that are too high or too low. CMS uses the reconciliation process to recalculate the plan's risk scores and either makes additional payments or recoups overpayments based on the recalculation.

II.   FRAUD IN MEDICARE PART C: UPCODING

The Medicare Advantage payment system swaps one problem for another. By adjusting payments to account for risk and projected expenses, the system attempts to compensate plans fairly and eliminate selection bias – the impulse to screen in healthy persons and screen out less-healthy individuals with pre-existing, severe, or chronic conditions. In doing so, this risk-adjustment process creates a new problem – it incentivizes plans to make their beneficiaries seem sicker on paper than they are in person. MAOs and their Medicare

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[51]Medicare Managed Care Manual (Internet Only Manual, Pub. #100-16)." *CMS.gov*. Accessed November 22, 2022, Ch. 7 §§ 20, 50. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c08.pdf.

[52]Medicare Payment Advisory Commission. 2022. "June 2022 Report to the Congress: Medicare and the Health Care Delivery System." *MedPac.gov*, 145. June 15. https://www.medpac.gov/document/june-2022-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

[53]42 C.F.R. § 422.2.

[54]Frontz, Amy J. 2021. "Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS (A-07-19-01187)." Office of Inspector General, United States Department of Health and Human Services, Washington, D.C., Office of Audit Services, 4. https://oig.hhs.gov/oas/reports/region7/71901187.asp.

[55]Centers for Medicare & Medicaid Services. n.d. "Report to Congress: Risk Adjustment in Medicare Advantage-December 2021." *CMS.gov,* 14 § 2.3, 27 § 2.6.2. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/ReportToCongress.

[56]Ibid., 19 § 2.4.2

[57]42 C.F.R. § 422.310(g)(2).

Advantage plans are financially motivated. The risk-adjustment process confers the means to act on their motive. By manipulating risk scores to make their beneficiaries appear worse off and pricier to care for than they really are, plans can increase their capitated rates without incurring additional risk. They can inflate risk scores by stacking diagnoses,[58] mischaracterizing them to seem more serious, or fabricating them entirely. Inflated risk scores increase capitated payments, resulting in more monthly revenue. This kind of manipulation is a form of health care fraud known as upcoding – the knowing submission of inaccurate or exaggerated diagnostic codes to boost reimbursement.

Upcoding is bread-and-butter health care fraud, but it works differently in Medicare Advantage than it does in traditional Medicare. In the latter, upcoding occurs per service. A family practitioner, for instance, might mischaracterize a patient encounter by selecting a procedural code (e.g., CPT 99205) that corresponds to a more comprehensive (and more expensive) office visit than the physician really performed (e.g., CPT 99203).[59] By billing the higher code, the physician reaps a higher payment from Medicare. Because Medicare Advantage plans do not bill per service, but receive a fixed, monthly rate irrespective of the nature and volume of the services that their beneficiaries receive, upcoding in the Medicare Advantage program looks different. It occurs when plans overstate their beneficiaries' health needs. By adding diagnoses or portraying them as more severe than they really are, plans ratchet up risk scores and enhance their capitated rates. A rash of whistleblower lawsuits, government enforcement actions, and administrative investigations suggests that this type of upcoding plagues the Medicare Advantage program.[60] Total losses are difficult to calculate but they are undoubtedly substantial. CMS reports that it has overpaid by nearly $37 billion for Part C coverage since fiscal year 2016.[61] In FY22 alone, the agency estimates that it overpaid by $12.7 billion.[62] Due to the amount of money at stake, the United States Department of Justice (DOJ) designated Medicare Advantage fraud an enforcement priority.[63] DOJ has investigated and filed suit against many of the leading MAOs, alleging that they swindled the Medicare Advantage program by manipulating the risk-adjustment process.

The government's case versus Kaiser Permanente is instructive.[64] As an initial matter, the claims against Kaiser are just that – claims. The government has not yet proven them at trial and may never do so. The court recently narrowed the government's case by tossing one of its theories of liability.[65] Even so, the claims against Kaiser depict the alleged upcoding that occurs in Medicare Advantage and the features that render the program vulnerable to it. This paper highlights the government's case against Kaiser not because it is especially egregious, but because it is representative.

Kaiser's Medicare Advantage plans cover 1.8 million people, about 6% of the total Medicare Advantage population.[66] On October 25, 2021, the government filed a complaint under the federal False Claims Act accusing Kaiser and its plans of perpetrating a billion-dollar fraud on the Medicare Advantage program.[67] The complaint asserts that Kaiser gamed the program's risk-adjustment

[58]Kronick, Richard, and W. Pete Welch. 2014. "Measuring Coding Intensity in the Medicare Advantage Program." *Medicare & Medicaid Research Review* 4 (2): E1-19, E2-3. doi:10.5600/mmrr2014-004-02-a06.

[59]Current Procedural Terminology or CPT codes provide a uniform system for describing medical services. CPT codes 99202 to 99205, for instance, are evaluation and management codes that physicians use to describe and bill new patient office visits. Higher codes correspond to more comprehensive visits and greater reimbursement. CMS pays a physician more for a visit billed under 99205 than for a visit billed at 99204 or a lower code.

[60]Abelson & Sanger-Katz, *supra* n 15.

[61]Between FY16 and FY22, the net Part C payment error – overpayments less underpayments – equalled $36.47 billion. Centers for Medicare & Medicaid Services. 2022. *Medicare Part C Improper Payment Measurement (IPM).* https://www.cms.gov/research-statistics-data-systems/improper-payment-measurement-programs/medicare-part-c.

[62]Net of underpayments, the the agency overpaid by $11.4 billion in FY22. Centers for Medicare & Medicaid Services. 2022. "Error Rate Findings and Results." *CMS.gov.* https://www.cms.gov/files/document/fy-2022-medicare-part-c-error-rate-findings-and-results.pdf-0.

[63]United States Department of Justice. 2020. *Assistant Attorney General Jody H. Hunt delivers remarks to the Federal Bar Association 2020 Qui Tam Conference.* February 27. *Justice.gov.* https://www.justice.gov/civil/speech/assistant-attorney-general-jody-h-hunt-delivers-remarks-federal-bar-association-2020.

[64]*United States of America ex rel. Osinek v. Kaiser Permanente, et al.,* no. 3:13-cv-3891-EMC (N.D. Cal.)

[65]Ibid., Dkt. #223. The court's decision is also available on Westlaw. *See United States of America v. Permanente Medical Group, Inc.,* 2022 WL 16925963 (N.D. Cal. Nov. 14, 2022).

[66]Freed *et al., supra* n 9, fig. 8.

[67]Under the False Claims Act, 31 U.S.C. § 3730(b), a whistleblower (called a relator) may file a civil *qui tam* action for the United States alleging that a defendant has committed fraud or submitted false claims to a government program. Upon the filing of a *qui tam* action, the government receives time to investigate the whistleblower's claims and decide whether to intervene in and assume control of the lawsuit. If the suit is successful, the whistleblower shares in the government's recovery. The case against Kaiser began in 2013 as a *qui tam* action filed on behalf of the United States by Ronda Osinek, a medical coder

system by making its beneficiaries look sicker than they really were, earning Kaiser more money per beneficiary. To carry out this scheme, Kaiser allegedly altered patient records and submitted false diagnoses that either did not exist or that the examining physician had not made, often long after the underlying patient encounters had occurred. Between 2009 and 2018, Kaiser plans purportedly added 500,000 after-the-fact diagnoses, increasing patient risk scores and generating approximately $1 billion in extra revenue.[68]

To carry out this scheme, Kaiser allegedly used high- and low-tech methods to scour patient files for ways to maximize revenue.[69] Combining algorithms and data-mining techniques with manual chart reviews, Kaiser allegedly searched medical records for information to justify more diagnoses, which its physicians then retroactively documented via addenda to patient files. Kaiser allegedly searched "for anything that might support a risk-adjusting diagnosis and then had the physician retrospectively create an addendum to the medical record to make it appear as if the diagnosis was part of the original patient visit, regardless of whether it actually was."[70] To make it easier for physicians to create addenda, Kaiser allegedly developed SmartPhrases, an application that imported scripted language into electronic medical records. The SmartPhrase ".DXOMITTED" supposedly populated the following language – "After review of my note for this visit encounter, I recall this encounter and am addending this note to state that this patient has diagnosis of . . . ."[71] In addition to hunting for new diagnoses, Kaiser allegedly searched for old diagnoses that its physicians had documented in prior years but did not carry forward. Kaiser supposedly referred to omitted diagnoses as "missed opportunities," and developed a program called "refresh" to ensure that revenue-generating diagnoses did not disappear over time.[72]

Once Kaiser identified diagnoses – new or old – it purportedly issued queries to prompt physicians to create an addenda to add them.[73] In addition to queries, Kaiser allegedly used incentives and disincentives to induce and pressure physicians to document additional diagnoses.[74] The government's complaint asserts that Kaiser established target risk metrics for beneficiaries and saw its average risk score climb from .9 in 2004 to 1.16 in 2014.[75] A .26 risk score increase over a decade may not seem substantial, but Kaiser purportedly realized a 30% revenue increase per beneficiary from its risk-adjustment efforts. If this is true, then Kaiser may have transformed its beneficiaries into more lucrative revenue units without taking on additional risk or incurring more expense.

A hypothetical example of how a risk-adjustment scheme might work is elucidating (Figure 3). Suppose that an MAO pursues a retrospective chart-review to ensure that its plans have documented all possible diagnoses. The MAO focuses on conditions that entail upward risk adjustments and commensurate payment increases, such as aortic atherosclerosis (AA). To confirm that its plans have captured AA diagnoses, the MAO hires radiology consultants to examine patient chest x-rays going back several years. The consultants search for the presence of calcium in the aorta and report it as potential AA for further consideration. They tag their reports and related images with uniform language identifying potentially missed AA diagnoses. Once the review is done, data miners come in behind the consultants to search for the AA tags. They use the tags to create queries for treating physicians, prompting them to revisit their charts for missed diagnoses. Once prompted, the physicians use tagged reports to create addenda that modify their patients' medical records. To facilitate this process, the MAO creates keystrokes that allow the physicians to import prefabricated language to add the AA diagnoses and explain their initial omission. Data miners oversee the process and report physician compliance to the MAO. The MAO rewards physicians who code for AA and shunts to revenue cycle training all those who resist. Once the addenda are complete, the MAO submits them to CMS, which raises patient risk scores, increases the MAO's capitated rates going forward, and generates backward-looking reconciliation payments. Net of expenses, the chart-review program earns the MAO $40 million in added reimbursement.

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and former Kaiser employee. Several additional *qui tam* actions followed, and *Osinek* became the lead case in the consolidated proceedings. The United States investigated the whistleblowers' claims and eventually intervened in the case by filing a superseding complaint against Kaiser and its plans. *Osinek, supra* n 64 (Dkt. #110).

[68]*Osinek, supra* n 64 (Dkt. #110, ¶¶1-4, 97-98, 332-336).
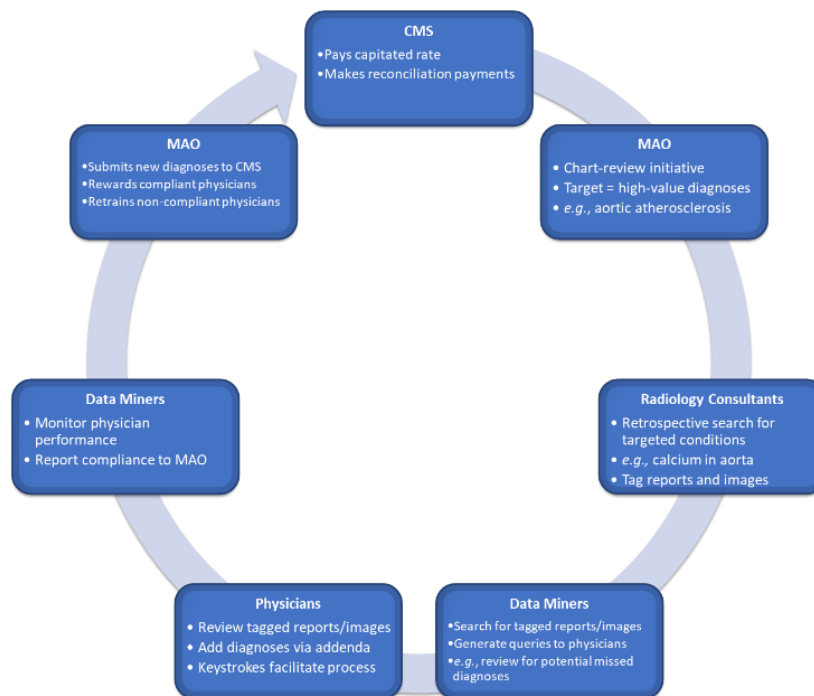
[69]Ibid., ¶¶4, 7, 122, 127, 143.

[70]Ibid., ¶98.

[71]Ibid., ¶219.

[72]Ibid., ¶¶7, 128.

[73]Ibid., ¶¶8, 128-31.

[74]Ibid., ¶¶9, 226, 234.

[75]Ibid., ¶120.

Figure 3. Hypothetical Risk-Adjustment Scheme.

This embellished scenario may seem far-fetched, but it is modeled on actual claims that the government leveled at Kaiser.[76] Kaiser allegedly pursued a revenue-capture scheme to target and add as many AA diagnoses as possible, believing that the diagnosis could generate a $40 million payday.[77] The government's allegations describe an assembly line of fraud involving a coordinated, *post hoc* search for and addition of atherosclerosis diagnoses that either did not exist or that were immaterial to the beneficiaries' health.

Kaiser is not alone and the claims against it are not unique. The government has accused UnitedHealth, Anthem, and Cigna, among others, of comparable misconduct.[78,79,80] These enforcement actions are essential, but they are not viable as long-term solutions. The government cannot enforce its way out of this conundrum. Thoughtful and sustained legislative and regulatory attention are necessary but lacking. Congress and CMS have tried to neutralize upcoding, but their fixes have proven inadequate. Health care fraud continues to hobble Medicare Advantage, but it is not the only problem that the program faces. Section Three addresses another concern – waste.

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[76]Ibid., ¶¶244-68.

[77]Ibid, ¶¶252-53.

[78]In its suit against UnitedHealth, the government alleged that the defendants financially induced physicians "to increase the number and severity of diagnoses they reported." *United States ex rel. Poehling v. UnitedHealth Group, Inc.,* 2018 WL 1363487, at *5 (C.D. Cal. Feb. 12, 2018).

[79]The government accused Anthem of pursuing a retrospective chart review program to hunt for new diagnoses "while turning a blind eye to negative results where chart reviews could not substantiate the diagnosis codes that Anthem has previously submitted to CMS." *United States v. Anthem, Inc.,* no. 20-cv-2593-ALC (S.D.N.Y.) (Dkt. #26, ¶6).

[80]In its filing against Cigna, the government asserted that the defendants "fraudulently submitted false and invalid patient diagnosis information to the Government to improperly inflate the payments they received from the Medicare Part C program, also called the Medicare Advantage Program." *United States v. Cigna Corp., et al.,* no. 3:21-cv-748 (M.D. Tenn.) (Dkt. 178, ¶1).

III.   WASTE IN MEDICARE PART C: OVERPAYMENTS

Waste refers to acts and omissions "that, directly or indirectly, result in unnecessary costs to the Medicare program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources."[81] Medicare Advantage is rife with waste, as CMS habitually overpays MAOs and their plans for coverage. The program's risk-adjusted payment system allows overpayments to occur, but they continue unabated because CMS has not taken decisive action to stop them.

The risk-adjustment process renders the Medicare Advantage program vulnerable to *coding intensity* – a euphemism for a plan's tendency to add diagnoses to augment reimbursement. In a fee-for-service paradigm, like traditional Medicare, health care providers have little incentive to include extraneous diagnoses in their claims for payment beyond the diagnoses necessary to justify the procedures that they performed. The opposite is true in a capitated paradigm, like Medicare Advantage. Plans are paid a risk-adjusted amount that varies with each beneficiary's diagnoses. "This payment system creates incentives for MA plans to find and report as many diagnoses as can be supported by the medical record."[82] Based on the relative incentives, one might expect to see the same patient characterized differently depending on whether they are covered by traditional Medicare or Medicare Advantage. The reported number of diagnoses and resulting risk score will typically be higher in the latter, even though the patient's health and risk profile are identical. This is coding intensity – "the difference between the [risk] scores that a group of beneficiaries would have if enrolled in MA and their scores in FFS."[83] Although Medicare Advantage beneficiaries are, on average, in comparable health, and may even be better off than their counterparts in traditional Medicare, coding intensity elevates their risk scores, making them appear sicker and more expensive to cover. The increased expense is largely "due to differential coding between MA and FFS, not to real change in the relative acuity of MA members."[84] In other words, Medicare Advantage costs more because of plans not patients. To be sure, some coding intensity may be legitimate. MAOs have a financial incentive to control costs and may scrupulously document patient conditions so that they can more efficiently and effectively manage care.[85] Still, the spate of lawsuits and investigations implies that something beyond heightened diligence is at work.[86]

Whether one views coding intensity as a legitimate albeit unintended byproduct of the risk-adjustment process or as evidence of fraudulent upcoding (or both), the practice has consequences for Medicare Advantage. The most pressing is that the program routinely overpays for coverage. A recent analysis calculates that in 2019 it cost CMS $321 more to cover a beneficiary under Medicare Advantage than it would have cost to cover the same beneficiary under traditional Medicare.[87] This per-beneficiary differential translated into $7 billion in unnecessary spending for the year.[88] An earlier study noted that the growth in Medicare Advantage risk scores consistently outpaced traditional Medicare, and predicted that, if the trend held, outlays would bloat by $200 billion over the ensuing decade due to coding intensity.[89]

CMS is fully aware of coding intensity. To address it, the agency applies a second statutory adjustment when calculating plan payments.[90] Unlike risk adjustment, which increases a plan's rate to account for the higher cost of covering sicker persons, the coding intensity adjustment reduces payments to neutralize a plan's tendency to stockpile diagnoses. The adjustment is supposed to counter financially driven coding practices and ensure that plans are paid based on the health conditions and risks that their beneficiaries actually present. The minimum downward adjustment is 5.9%, although CMS has the prerogative to increase the percentage to control payments

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[81]Centers for Medicare & Medicaid Services. n.d. "Medicare Managed Care Manual (Internet Only Manual, Pub. #100-16)." *CMS.gov*. Accessed November 29, 2022, Ch. 21 § 20. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.

[82]Kronick & Welch, *supra* n 58, E3.

[83]Ibid., E4.

[84]Committee for a Responsible Federal Budget. 2021. *Reducing Medicare Advantage Overpayments*. Washington, D.C., 4. https://www.crfb.org/papers/reducing-medicare-advantage-overpayments.

[85]Kronick & Welch, *supra* n 58, E16.

[86]Medicare Payment Advisory Commission, *supra* n 38, 413-14.

[87]Biniek *et al.*, *supra* n 12.

[88]Ibid.

[89]Kronick, Richard. 2017. "Projected Coding Intensity In Medicare Advantage Could Increase Medicare Spending By $200 Billion Over Ten Years." *Health Affairs* 36 (2): 320-37. doi: 10.1377/hlthaff.2016.0768.

[90]42 U.S.C. § 1395w-23(a)(1)(C)(ii)(III).

and prevent overcompensation.[91] Despite calls to do so,[92,93] CMS announced that the adjustment will remain at the statutory minimum for 2023 – 5.9%.[94] That percentage is insufficient to prevent overpayments and has been for years. According to one calculation, the downward coding intensity adjustment should have been 15.4% as far back as 2017 – more than twice the percentage that CMS actually applied that year.[95] In 2020, the Medicare Payment Advisory Commission determined that Medicare Advantage risk scores were 9.5% higher than they were for comparable beneficiaries in traditional Medicare. Thus, even when CMS applied the 5.9% downward coding intensity adjustment, a 3.6% difference remained. That differential meant that CMS paid Medicare Advantage plans about $12 billion more than it would have paid to cover the same beneficiaries under traditional Medicare.[96] Paying billions more for coverage that could have been purchased for less, and doing so year after year, is the quintessence of wasteful spending. Such waste is due as much to coding intensity as it is to CMS's failure to stop it.

Concerns about improper payments in Medicare Part C are nothing new. The Government Accountability Office reported that CMS overpaid billions in 2012 and 2013 due to coding intensity and admonished the agency to improve its oversight and recovery efforts.[97,98] Yet overpayments persist. The reason is an amalgam of regulatory half-measures, exemplified by CMS's hesitance to increase the coding intensity adjustment, lax oversight, and inaction.

CMS must protect the fiscal integrity of the Medicare program. That duty has many facets, including preventing, detecting, and recovering overpayments.[99] The United States Department of Health and Human Services Office of Inspector General (HHS-OIG) monitors how well CMS discharges these obligations. In mid-2022, HHS-OIG issued an audit report focused on CMS's efforts to recover traditional Medicare overpayments.[100] The audit scrutinized a 27-month period that involved overpayments surpassing $498 million. In response to the audit, CMS claimed that it had recovered $272 million, but the agency could only document about $120 million. The $152 million balance – the difference between what CMS said it collected and what the agency's records supported – is a pittance compared to overall Medicare spending, but the absolute amount is substantial and reflects poorly on the agency's stewardship of public funds. What is more, CMS acknowledged that it had not collected $226 million of the outstanding overpayments. Thus, for the audit period, the agency either did not collect or could not account for over 75% of the funds that it improperly expended.[101] While these audit results pertain to traditional Medicare, they are especially concerning for Medicare Advantage given the program's propensity to overpay. If CMS neither prevents nor recoups improper payments, the public investment in Medicare Advantage is wasted. The precise amount of waste is elusive, but recent Part C audits provide a sense of the magnitude. The following table depicts the results of HHS-OIG compliance audits of diagnosis codes that MAOs submitted to CMS as part of the risk-adjusted payment process:

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[91]Ibid.

[92]Committee for a Responsible Federal Budget, *supra* n 84, 5-7.

[93]Kronick, Richard. 2020. "Why Medicare Advantage Plans Are Being Overpaid By $200 Billion And What To Do About It." *Health Affairs Blog.* January 29. doi:10.1377/forefront.20200127.293799.

[94]Centers for Medicare & Medicaid Services. 2022. "2023 Announcement." *CMS.gov.* Release date: April 4, 2022. Accessed November 27, 2022, 4. https://www.cms.gov/medicarehealth-plansmedicareadvtgspecratestatsannouncements-and-documents/2023.

[95]Committee for a Responsible Federal Budget, *supra* n. 84, 6.

[96]Medicare Payment Advisory Commission, *supra* n 38, 440.

[97]United States Government Accountability Office. 2012. "Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices (GAO-12-51)." Report to Congressional Requesters, Washington, D.C. https://www.gao.gov/products/gao-12-51.

[98]United States Government Accountability Office. 2013. "Medicare Advantage: Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments (GAO-13-206)." Report to Congressional Requesters, Washington, D.C. https://www.gao.gov/products/gao-13-206.

[99]Executive Office of the President, *Finding and Recapturing Improper Payments*, Barack Obama. 75 Fed. Reg. 12119, Washington, D.C.: Office of the Federal Register, 2010.

[100]Grimm, Christi A. 2022. *CMS Reported Collecting Just Over Half of the $498 Million in Medicare Overpayments Identified by OIG Audits (A-04018-03085).* Office of Inspector General, United States Department of Health and Human Services, Washington, D.C., Office of Audit Services. https://oig.hhs.gov/oas/reports/region4/41803085.asp.

[101]Ibid, 8-14.

MAO	MA CONTRACT	AUDIT # (AND TYPE)[102]	PAYMENT YEAR	TOTAL PAID TO MAO	SAMPLE[103]	RESULTS[104]	ESTIMATED OVERPAYMENT[105]
Humana	H1036	A-07-16-01165 Diagnosis code audit	2015	$5.6 billion	1,525 HCCs for 200 beneficiaries	1,322 validated 203 unvalidated	$197.7 million
Scan Health Plan	H5425	A-07-17-01169 Diagnosis code audit	2015	$1.9 billion	1,577 HCCs for 200 beneficiaries	1,413 validated 164 unvalidated	$54.3 million
Cigna Health-Spring of Florida	H5410	A-03-18-00002 Diagnosis code audit	2015	$845 million	1,470 HCCs for 200 beneficiaries	1,401 validated 69 unvalidated	$39,612
Inter Valley Health Plan	H0545	A-05-18-00020 Diagnosis code audit	2015	$263 million	1,553 HCCs for 200 beneficiaries	1,411 validated 142 unvalidated	$5.4 million
Anthem Community Insurance	H3655	A-07-19-01187 Targeted diagnosis code audit	2015 & 2016	$2.3 billion	7 high-risk diagnosis groups for 203 EY	80 EY supported 123 EY not supported	$3.47 million
UPMC Health Plan	H3907	A-07-19-01188 Targeted diagnosis code audit	2015 & 2016	$2.3 billion	10 high-risk diagnosis groups for 280 EY	86 EY supported 194 EY not supported	$6.4 million
Coventry Health Care of Missouri	H2663	A-07-17-01173 Targeted diagnosis code audit	2014, 2015, & 2016	$1.5 billion	6 high-risk diagnosis groups for 275 EY	49 EY supported 226 EY not supported	$548,852
Tufts Health Plan	H2256	A-01-19-00500 Targeted diagnosis code audit	2015 & 2016	$2.3 billion	7 high-risk diagnosis groups for 212 EY	58 EY supported 154 EY not supported	$3.7 million

[102]The table provides a report number and descriptor for each audit. There are two descriptors – (1) diagnosis code audit, and (2) targeted diagnosis code audit. Diagnosis code audits examined the HCCs that MAOs submitted to CMS. For each audit, the agency identified the beneficiaries under the relevant contract who had at least one HCC factored into their risk scores. From this universe, CMS selected 200 beneficiaries and scrutinized whether their medical records and diagnoses supported their HCCs. The goal was to test the accuracy of the diagnostic information that MAOs submitted to CMS. Targeted diagnosis code audits examined specific diagnoses. For each audit, CMS chose high-risk diagnoses (*e.g.,* acute stroke) and the beneficiaries who had them during the relevant period. From this universe, CMS evaluated a sample to determine whether the medical records supported the high-risk diagnoses that MAOs submitted to the agency. The goal was to assess the accuracy of diagnoses that were at heightened risk of being miscoded and causing overpayments.

[103]The table uses two abbreviations, HCC and EY, to describe the audit samples. As explained in Section I, an HCC is a hierarchical condition category that CMS uses to adjust risk scores. HCCs were the focus of CMS's diagnosis code audits. An EY is an enrollee year, the focus of the agency's targeted diagnosis code audits. To audit overpayments in specific payment years (*e.g.,* 2015 and 2016), CMS had to examine diagnoses from the pertinent base years (2014 and 2015). Because beneficiaries could have targeted diagnoses in more than one year, the agency classified these beneficiaries according to the condition and payment year, which it referred to as an enrollee year. The audit sample comprised enrollee years or EYs.

[104]HHS-OIG audited records related to risk-adjustment. For the diagnosis code audits, it examined medical records to discern whether they supported the diagnoses that each MAO submitted to CMS. Based on the records, HHS-OIG determined that the codes were either validated or unvalidated. For the targeted diagnosis code audits, the agency reviewed medical records related to the high-risk diagnosis groups for the relevant EYs. Based on its review, HHS-OIG ascertained the number of EYs for which the records did or did not support the codes.

[105]HHS-OIG estimated the net overpayments that MAOs received. The agency employed a conservative estimation method that is supposed to produce a result that is less than the actual overpayment 95% of the time.

MAO	MA CONTRACT	AUDIT # (AND TYPE)[102]	PAYMENT YEAR	TOTAL PAID TO MAO	SAMPLE[103]	RESULTS[104]	ESTIMATED OVERPAYMENT[105]
Healthfirst Health Plan	H3359	A-02-18-01029 Targeted diagnosis code audit	2015 & 2016	$3.3 billion	7 high-risk diagnosis groups for 240 EY	85 EY supported 155 EY not supported	$5.2 million
Peoples Health Network	H1961	A-06-18-05002 Targeted diagnosis code audit	2015 & 2016	$1.3 billion	7 high-risk diagnosis groups for 242 EY	98 EY supported 144 EY not supported	$3.3 million
WellCare of Florida	H1032	A-04-19-07084 Targeted diagnosis code audit	2015 & 2016	$2.3 billion	7 high-risk diagnosis groups for 250 EY	97 EY supported 153 EY not supported	$3.5 million
Highmark Senior Health	H3916	A-03-19-00001 Targeted diagnosis code audit	2015 & 2016	$3.6 billion	6 high-risk diagnosis groups for 226 EY	66 EY supported 160 EY not supported	$6.2 million
Humana-Choice	R5826	A-05-19-00039 Targeted diagnosis code audit	2016 & 2017	$9.2 billion	9 high-risk diagnosis groups for 270 EY	63 EY supported 207 EY not supported	$34.4 million
BCBS of Tennessee	H7917	A-07-19-01195 Targeted diagnosis code audit	2016 & 2017	$1.8 billion	9 high-risk diagnosis groups for 270 EY	60 EY supported 210 EY not supported	$7.8 million
Cariten Health Plan	H4461	A-02-20-01009 Targeted diagnosis code audit	2016 & 2017	$2.4 billion	9 high-risk diagnosis groups for 270 EY	64 EY supported 206 EY not supported	$9.2 million
Regence BCBS of Oregon	H3817	A-09-20-03009 Targeted diagnosis code audit	2015 & 2016	$1 billion	7 high-risk diagnosis groups for 179 EY	68 EY supported 111 EY not supported	$1.8 million
Cigna-Health-Spring of Tennessee	H4454	A-07-19-01193 Targeted diagnosis code audit	2016 & 2017	$1.9 billion	10 high-risk diagnosis groups for 279 EY	84 EY supported 195 EY not supported	$5.9 million
BCBS of Rhode Island	H4152	A-01-20-00500 Targeted diagnosis code audit	2016 & 2017	$1.1 billion	9 high-risk diagnosis groups for 270 EY	58 EY supported 212 EY not supported	$4.8 million
California Physicians' Service	H0504	A-09-19-03001 Targeted diagnosis code audit	2015 & 2016	$1.8 billion	7 high-risk diagnosis groups for 196 EY	79 EY supported 117 EY not supported	$2 million
							Total = $356 million

MAO	MA CONTRACT	AUDIT # (AND TYPE)[102]	PAYMENT YEAR	TOTAL PAID TO MAO	SAMPLE[103]	RESULTS[104]	ESTIMATED OVERPAYMENT[105]

Source for diagnosis code audits: United States Department of Health and Human Services Office of Inspector General. (n.d.). *Risk Adjustment Data – Sufficiency of Documentation Supporting Diagnoses.* OIG.HHS.gov. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000150.asp.

Source for targeted diagnosis code audits: United States Department of Health and Human Services Office of Inspector General. (n.d.). *Medicare Advantage Risk-Adjustment Data – Targeted Review of Documentation Supporting Specific Diagnosis Codes.* OIG.HHS.gov. https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000422.asp.

The audits summarized in the table encompass MAOs, beneficiary populations, and overpayments of varying sizes. What is important to keep in perspective is that the table reflects a modest number of MAO contracts. At the end of 2017, CMS had 468 Medicare Advantage contracts; that total ballooned to 776 as of January 2023.[106] Extrapolating from the 19 audit results in the table, even conservatively, to the number of MAO contracts currently in place implies that CMS has overpaid billions for coverage under Medicare Part C.

CMS's uninspired response to coding intensity, coupled with the agency's inconsistent recovery efforts, are concerning for program integrity. Equally troubling is the agency's continued payment of funds once it has detected misconduct. Federal law requires MAOs to (1) certify that the risk-adjustment data that they submit to CMS are accurate, complete, and truthful;[107] and (2) report and return overpayments to CMS within 60 days of identification.[108] In *United States ex rel. Poehling v. UnitedHealth Group, Inc.*, another whistleblower action, the government accused United of violating these obligations. According to the government's complaint, United and its co-defendants conducted a chart review program to find new diagnoses that the MAO could submit to CMS to increase its risk-adjusted payments.[109] Instead of *looking both ways* – a metaphor for identifying diagnosis codes to add and deleting unsupported diagnoses – defendants allegedly piled up new diagnoses and ignored potentially invalid ones.[110] They allegedly set revenue targets for the chart review program and tasked coders with finding justifications to sustain as many diagnoses as possible.[111] In 2011 alone, defendants reportedly reviewed 1.5 million charts, which increased its risk adjustments and upped revenue.[112] As a result of this alleged scheme, the government accused United and its co-defendants of (1) falsely certifying that it had submitted accurate, complete, and truthful risk-adjustment data and as a result (2) knowingly obtaining and retaining capitated payments to which it was not entitled.[113]

United responded to these charges by moving to dismiss the government's complaint. In analyzing the motion, the court emphasized United's contention that "[d]espite doubts about the validity of Defendants' Attestations, including based on CMS' own audits of Defendants' diagnoses, CMS . . . continued to pay Defendants based on their submitted Attestations and risk adjustment data."[114] In other words, CMS suspected that United had doctored its risk-adjustment data, secured inflated payments, and knowingly failed to return them, and yet the agency kept on paying United's claims for reimbursement. While such knowledge did not preclude the government's fraud claims,[115] it does suggest a programmatic flaw. Either CMS needs better tools to arrest overpayments, or it lacks

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[106]Centers for Medicare & Medicaid Services. 2023. "Contract Summary 2023 01" *CMS.gov.* https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/monthly/contract-summary-2023-01.

[107]42 C.F.R. § 422.504(l).

[108]42 U.S.C. § 1320a-7k(d); 42 C.F.R. § 422.326(b)-(d); *UnitedHealthcare Insurance Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. 2021).

[109]*See supra* n 78, *3-5.

[110]Ibid.

[111]Ibid., *4.

[112]Ibid.

[113]Health care fraud includes affirmative acts, such as upcoding, as well as knowing omissions, like failure to return ill-gotten government funds. *See, e.g.,* 31 U.S.C. § 3729(a)(1)(g). One of the government's claims against United was that the MAO knew that it received overpayments but failed to return them.

[114]*See supra* n 78, *8.

[115]Ibid., *12.

the wherewithal to use the tools that it has at its disposal. Either way, if CMS continues paying MAOs despite doubts and overlooks the resulting overpayments, waste will mount.

Questioning how CMS regulates the Medicare Advantage program is appropriate, but it would be unfair to lay all blame on the agency. CMS is not alone in enabling waste. DOJ also bears responsibility for its slow response to the upcoding problem in Medicare Advantage. For example, the whistleblower in the *Osinek* case filed her *qui tam* action in 2013, accusing Kaiser of gaming the risk-adjusted payment system and submitting upcoded diagnoses to increase its revenue.[116] In *qui tam* actions, such as *Osinek*, the whistleblower must by law give DOJ a "written disclosure of substantially all material evidence and information the person possesses,"[117] and typically sits for interrogation – referred to as a relator's interview – by DOJ and other law enforcement officials. Such interviews occur under seal, so it is usually impossible to determine exactly when they occurred or what the whistleblower revealed. Even so, what is clear is that DOJ knew of Kaiser's alleged fraud and received insider information about it in 2013, when the whistleblower filed suit – *eight years* before it finally intervened and levied civil claims against Kaiser. It was not until October 25, 2021, that DOJ filed its own complaint in the case. While DOJ generally takes time to investigate a whistleblower's claims before intervening – and independently investigates whether to bring criminal charges parallel to or in lieu of civil action – an eight-year delay is extreme even for a case of this size and moment. All the while, public funds continued flowing to Kaiser, an MAO that DOJ would eventually accuse of bilking Medicare Part C out of a billion dollars.

To this point, this paper has focused on MAOs and their government regulators. Another constituency is pertinent – the people who elect Medicare Advantage for health insurance. Medicare Part C attempts to leverage the creativity and financial interests of private health plans to deliver efficient and cost-effective coverage. In doing so, however, Medicare Advantage introduces private interests into a public program, opening the door to commercial conduct and tactics that impact the program's beneficiaries. Section four confronts this problem under the rubric of abuse.

IV.   ABUSE IN MEDICARE PART C: PRIOR AUTHORIZATION

Abuse is a capacious term. Its meaning is contextual and may have elements of both fraud and waste.[118] In this paper, abuse means business practices that elevate the financial interests of MAOs and their plans over the interests of beneficiaries. Several aspects of the Medicare Advantage program have abuse potential. The capitated payment system is the most salient – "A central concern about the capitated payment model used in Medicare Advantage (also known as Medicare Part C) is the potential incentive for insurers to inappropriately deny access to services and payment in an attempt to increase their profits."[119] The program compounds this concern by giving MAOs the tools necessary to act on their economic incentive. The most powerful of these tools is prior authorization. MAOs commit abuse when they use prior authorization to serve their bottom lines instead of their beneficiaries.

Medicare Part C empowers MAOs to manage care.[120] Managed care refers to coordinated health insurance practices that constrain patient choice while attempting to improve quality and reduce costs. Utilization management is among the tools that health plans use to manage care. It refers to "a set of techniques . . . to manage health care costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision."[121] Prior authorization is perhaps the most common of these techniques. It is a prospective form of utilization management that (1) requires patients and their providers to obtain approval before treatment is rendered, and (2) enables plans to contain costs by authorizing or denying coverage for treatment before it occurs.[122] The key word here is *before*. The timing of prior authorization gives plans leverage over treatment decisions. That is the point.

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[116]*Supra* n 64.

[117]31 U.S.C. § 3730(b)(2).

[118]Centers for Medicare & Medicaid Services *supra* n 81.

[119]Levinson, Daniel R. 2018. *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (OEI-09-16-00410).* United States Department of Health and Human Services Office of Inspector General, Washington, D.C.: Office of Evaluations and Inspections, 1. https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp.

[120]42 U.S.C. § 1395w-22(c); 42 C.F.R. § 422.111(b).

[121]Institute of Medicine. 1989. *Controlling Costs and Changing Patient Care? The Role of Utilization Management.* Washington, D.C.: The National Academies Press, 17. doi:https://doi.org/10.17226/1359.

[122]Pestaina, Kaye, and Karen Pollitz. 2022. "Examining Prior Authorization in Health Insurance." *KFF.org.* May 20. https://www.kff.org/policy-watch/examining-prior-authorization-in-health-insurance/.

Plans use the power of their purse to steer patients and physicians toward conservative and cheaper options or away from low-value and pricier interventions.[123] True, prior authorization helps plans steward finite resources and stanch overutilization. When plans use evidence-based standards to manage care, prior authorization also contributes to sound clinical practice. It can even protect patients from harm by, for example, flagging when a contraindicated medication has been prescribed.[124]

But it is also true that prior authorization may delay or block access to treatment. External review makes some delay inevitable. All prior authorization takes time, but some forms take more than others. In 2018, CMS expanded prior authorization in Medicare Part C to include step therapy.[125] Step therapy is a form of prior authorization that requires physicians and patients to follow a pre-determined course of care as a condition of coverage. A plan will cover therapies if the physician and patient try them in the order that the plan has enumerated. This generally means that the physician must prescribe, and the patient must use, the least expensive option first as a condition of coverage; if that option is ineffective, then the physician-patient duo may progress to costlier therapy. For this reason, step therapy is often called *fail first*. The therapy must fail before the plan will cover the next and more expensive option. Putting aside whether step therapy reduces costs or improves outcomes, the practice delays care as patients must cycle through unsuccessful treatments before stepping up to more promising therapies.[126] Step therapy is a demanding type of prior authorization, but even its more prosaic forms can be exhausting. Seeking approval, documenting requests, appealing denials, and then waiting for answers are inefficient and time-consuming tasks.[127] Such burdens cause patients to abandon care[128] and induce physicians to change how they practice medicine.[129]

Virtually all Medicare Advantage plans require prior authorization for at least some items,[130] such as high-cost drugs.[131] How plans use prior authorization to approve and deny coverage has recently come under scrutiny. "The Centers for Medicare & Medicaid Services' (CMS's) annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment."[132] High reversal rates, idiosyncratic clinical criteria, and opaque decision-making afflict prior authorization in Medicare Part C, leading regulators to become concerned that MAOs may be abusing their managed care power to enhance their profits either by denying access to treatment or shunting patients to cheaper alternatives.[133] Triggered by these concerns, HHS-OIG conducted

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[123]Anderson, Kelly E, Michael Darden, and Amit Jain. 2022. "Improving Prior Authorization in Medicare Advantage." *JAMA* 328 (15): 1497-98. doi: 10.1001/jama.2022.17732.

[124]*Cf.* Morreim, E. Haavi. 1999. "Playing Doctor: Corporate Medical Practice and Medical Malpractice." *University of Michigan Journal of Law Reform* 32: 939-1040.

[125]Verma, Seema. 2018. "Prior Authorization and Step Therapy for Part B Drugs in Medicare Advantage." *HHS.gov*. August 7. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf.

[126]Nayak, Rahul K, and Steven D Pearson. 2014. "The Ethics of 'Fail First': Guidelines and Practical Scenarios for Step Therapy Coverage Policies." *Health Affairs* 33 (10): 1779-85. doi:10.1377/hlthaff.2014.0516.

[127]Chapman, A. "Prior Authorization: An Adversary to Timely Patient Care." *Journal of Healthcare Ethics & Administration* Vol. 8, no. 1 (Spring 2022): 13-16, https://doi.org/10.22461/jhea.1.71634.

[128]In response to a 2021 survey, 82% of physicians indicated that prior authorization at least sometimes leads patients to abandon treatment, whereas 17% said that it rarely or never did. American Medical Association. 2022. "2021 AMA prior authorization (PA) physician survey." *AMA-ASSN.org*. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf. When patients abandon treatment, health plans benefit, at least in the short run. By inducing patients to forgo care, prior authorization reduces the amount that plans pay out. The practice is, in a word, profitable.

[129]The *sentinel effect* refers to behavior changes that occur because of oversight. In medicine, this phenomenon may be responsible for the "reduction in utilization that occurs when practitioners know that utilization review is going on . . ." Zusman, J. "Utilization review: theory, practice, and issues." *Hospital & Community Psychiatry* Vol. 41, 5 (1990): 531-6. doi:10.1176/ps.41.5.531. That a sentinel effect occurs is one thing, how it works another. Prior authorization may induce physicians to be more conscientious, or it may cause them to forgo options that are subject to prior authorization requirements to avoid the hassle of dealing with insurance companies. If the latter is true, then the mere existence of prior authorization may deny patients access to medically necessary treatments due to perceived bureaucratic burden. *See, e.g.,* Kahan, Natan R, David P Chinitz, Dan-Andrei Waitman, and Ernesto Kahan. 2006. "When gatekeepers meet the sentinel: the impact of a prior authorization requirement for cefuroxime on the prescribing behaviour of community-based physicians." *British Journal of Clinical Pharmacology* 61 (3): 341-44. doi:10.1111/j.1365-2125.2006.02577.x.

[130]Freed, Meredith, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman. 2022. "Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings." KFF.org. August 25. https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/.

[131]Anderson, Kelly E, G Caleb Alexander, Carolyne Ma, Sydney M Dy, and Aditi P Sen. 2022. "Medicare Advantage Coverage Restrictions for the Costliest Physician-Administered Drugs." *American Journal of Managed Care* 28 (7): e255-e262. doi:10.37765/ajmc.2022.89184.

[132]Grimm, *supra* n 34, 2.

[133]Levinson, *supra* n 119, 17.

its own audits, which documented inappropriate service and payment denials, health and safety concerns, and potential misuse of Medicare Advantage program funds.

In its first audit, HHS-OIG examined prior authorization and payment denials for the years 2014 through 2016 and found that MAOs had to reverse most of their decisions on appeal.[134] During the relevant years, beneficiaries and health care providers appealed over 863,000 adverse prior authorization and payment decisions. Of these, MAOs reversed themselves in full in 607,000 cases and in part in 42,000 more. This translates into an aggregate 75% appeal success rate. For some MAOs, the reversal rate exceeded 90%; a handful approached 100%.[135] While most successful appeals related to payment denials, 18% pertained to prior authorization.[136] That equates to 117,000 cases in which an MAO rejected a medically necessary drug or service and then later reversed itself. This modest seeming number must be contextualized. Beneficiaries and physicians appealed just 1% of the denials that MAOs issued (1.1 million appeals out of 101.1 million denials during the audit period), suggesting that many more improper decisions went unchallenged and that beneficiaries were either deprived of needed care or had to pay for it out-of-pocket.[137] In some instances, denials and the delays they occasioned "posed a 'serious threat' to the health and safety of Medicare beneficiaries."[138] HHS-OIG recommended that CMS address suspect denials and high reversal rates to ensure that MAOs deliver the coverage that their beneficiaries need and that the law demands. Although CMS concurred with the audit recommendations in theory, it failed to implement them in practice.[139]

A second HHS-OIG audit ensued. In it, the watchdog agency inspected a random sample of prior authorization and payment denials that the 15 largest MAOs issued during a one-week period in mid-2019.[140] Together, these 15 MAOs covered 80% of the total Medicare Advantage population at the time.[141] The one-week sample contained 12,273 prior authorization denials. Of these, 13% met the requirements for Medicare coverage and should have been approved. That equates to 1,631 cases during the audit period in which MAOs improperly disallowed covered items and services; for the full year, that translates into 85,000 erroneous denials.[142] Once again, the gross numbers do not tell the whole story. HHS-OIG found that MAOs denied and obstructed coverage by (1) applying idiosyncratic clinical standards that exceeded Medicare's rules, and (2) demanding excessive documentation and then denying authorization when providers failed to supply it.[143] While the sampled denials related to sundry services, HHS-OIG called out disapprovals for pricey care, observing that "[t]o reduce their costs, MAOs may have an incentive to deny more expensive services, such as inpatient rehabilitation facility stays, and/or require that beneficiaries receive less expensive alternatives."[144] The audit results imply that MAOs acted on this financial incentive by rejecting requests to discharge beneficiaries from hospitals to appropriate post-acute settings, such as in-patient rehabilitation and skilled nursing facilities.[145] In one case, an MAO refused a request to discharge to a skilled nursing facility an 81-year-old, legally blind patient with a history of hypertension who had been hospitalized due to deteriorating dementia and acute agitation, determining that he could instead be cared for at home.[146] In another case, an MAO denied discharge to in-patient rehabilitation for a 75-year-old who suffered broken ribs, a collapsed lung, and kidney injuries in a motorcycle accident. The patient's medical history was significant for heart disease, diabetes, and chronic obstructive pulmonary disease. The MAO instead approved just five days of skilled nursing facility care.[147] In both examples, an MAO withheld permission for a higher and more expensive level of medically necessary care – in-patient rehabilitation is typically pricier than care in a skilled nursing facility, and both options are pricier than home care – raising the specter that economic considerations drove their decision-making. While HHS-OIG did not use the word abuse, the examples that the agency cited fit that description.

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[134]Ibid., 7.

[135]76 MAO contracts had overturn rates that exceeded 90%. Seven of these contracts overturned more than 98%. Ibid., 8.

[136]Ibid., 7.

[137]Ibid., 10.

[138]Ibid., 13.

[139]Ibid., App'x F; Grimm, *supra* n 34, 5.

[140]Grimm, *supra* n 34, 5-6.

[141]Ibid.

[142]Ibid., 9.

[143]Ibid., 9-11.

[144]Ibid., 14.

[145]Ibid., 16.

[146]Ibid., App'x B, 35 (Case ID D236).

[147]Ibid., 38 (Case ID D393).

V.   CONCLUSION: DISTRIBUTIVE JUSTICE

"Scarcity means that not everyone can have everything that he or she needs,"[148] much less wants. It is a core concern of distributive justice however one defines it. How should a society allocate finite resources? What are the appropriate limits and who should set them? Does a society owe to its members decent minimums? These questions and more like them are staples in classrooms, scholarly journals, and debates about justice in health care. And yet responses to them rarely consider fraud, waste, and abuse – forces that bleed billions from the health care system,[149] compounding the scarcity problem that is at the very crux of distributive justice.[150] Likewise, inquiries into health care fraud, waste, and abuse neglect distributive justice.[151] Commentators frequently quantify losses.[152] They emphasize and critique prevention, detection, and enforcement initiatives.[153] Some offer policy solutions.[154] A few even mention how fraud degrades quality of care,[155] driving overutilization and medically unnecessary procedures that can and do harm patients.[156] Virtually all overlook distributive justice implications. How can a society achieve a just allocation of health care resources if does not reckon with preventable factors that intensify scarcity?

This paper surveys how fraud, waste, and abuse occur in Medicare Part C. It is not exhaustive. Myriad challenges beyond the scope of this paper beleaguer Medicare Advantage. Even so, structural features novel to Part C – capitation, risk-adjustment, coding intensity, prior authorization – render the program uniquely susceptible to exploitation. In concert, these programmatic features create paradoxical incentives and enable MAOs to act on them. On the one hand, MAOs increase their revenue by exaggerating their beneficiaries' medical conditions; on the other, they maximize their profits by withholding approval for treatments that their beneficiaries need. In effect, Medicare Part C incentivizes and equips MAOs to portray their beneficiaries as very sick and expensive to care for but to act as if their beneficiaries are not so sick as to require the costly interventions that their diagnoses imply. Tepid regulatory oversight allows these wrongs to recur year over year. Medicare Advantage hemorrhages billions annually as CMS overpays for upcoded diagnoses only to have MAOs delay and deny medically necessary care.

That fraud, waste, and abuse occur in Part C is certain; their impact on beneficiaries is not. Studies that examine cost and outcomes do not systematically assess how fraud, waste, and abuse affect different populations. Even the government's recent civil enforcement actions feature the program's financial losses while paying modest attention to the people that the program covers.[157] The loss of public funds is undeniably important and concerns all taxpayers, but there is reason to believe that health care fraud, waste, and abuse disproportionately burden those least able to bear it. The sharp commercial practices that dissipate program funds and interfere with patient care are more likely to harm (1) persons who are unable to pay for treatments that their Medicare Advantage plans refuse to cover or to afford better care than their plans are willing to approve, and (2) individuals with severe, chronic, or disabling conditions who cannot endure the delays and hassles attributable to prior authorization. With respect to the latter, HHS-OIG has recognized that vulnerable beneficiary populations may be at heightened risk, trenchantly observing that:

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[148]Morreim, *supra* n 3, 445.

[149]Shrank, William H, Teresa L Rogstand, and Natasha Parekh. 2019. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA* 322 (15): 1501-09. doi:10.1001/jama.2019.13978.

[150]Fleischacker, Samuel. 2004. *A Short History of Distributive Justice.* Cambridge, Massachusetts: Harvard University Press.

[151]For example, simple, open-ended searches in PubMed and Medline for the terms "fraud," "distributive," and "justice" returned the same three articles, only one of which was even arguably pertinent. *See* Chan, Marjorie. 2002. "Violations of service fairness and legal ramifications: the case of the managed care industry." *Journal of Business Ethics* 36 (4): 315-36. doi:10.1023/a:1014467601008.

[152]Shrank *et al.*, *supra* n. 149.

[153]Rashidian, Aarash, Hossein Joudaki, and Taryn Vian. 2012. "No Evidence of the Effect of the Interventions to Combat Health Care Fraud and Abuse: A Systematic Review of Literature." *PLoS One* (7) 8: e41988. doi:10.1371/journal.pone.0041988.

[154]Mackey, Tim Ken, Ken Miyachi, Danny Fung, Samson Qian, and James Short. 2020. "Combating Health Care Fraud and Abuse: Conceptualization and Prototyping Study of a Blockchain Antifraud Framework." *Journal of Medical Internet Research* 22 (9): e18623. doi:10.2196/18623.

[155]Krause, Joan H. 2004. "Healthcare Fraud and Quality of Care: A Patient-Centered Approach." *Journal of Health Law* 37 (2): 161-95.

[156]Krause, Joan H. 2006. "A Patient-Centered Approach to Helath Care Fraud Recovery." *Journal of Criminal Law and Criminology* 96 (2): 579-619.

[157]The emphasis on financial losses is not confined to civil cases, it occurs in criminal health care fraud cases as well. Kyriakakis, Anthony. 2015. "This Missing Victims of Health Care Fraud." *Utah Law Review* 2015 (3): 605-57.

MAO denials of prior authorization requests for services that meet Medicare coverage rules can create significant negative effects for Medicare Advantage beneficiaries. These denials can delay or prevent beneficiary access to medically necessary care; lead beneficiaries to pay out of pocket for services that are covered by Medicare; or create an administrative burden for beneficiaries or their providers who choose to appeal the denial. These denials may be particularly harmful for beneficiaries who cannot afford to pay for services directly and for critically ill beneficiaries who may suffer negative health consequences from delayed or denied care.[158]

One population that may be especially vulnerable consists of dual-eligible beneficiaries.

Dual-eligible beneficiaries are covered by both Medicare and Medicaid based on their age or disability and low income.[159] They comprise a diverse group, but from an MAO's perspective one unifying characteristic predominates – they are more expensive to cover. In 2019, over 12 million people were dually eligible; they represented about 19% of the Medicare population but generated roughly 34% of Medicare spending.[160] As a cohort, dual-eligible beneficiaries are more likely to be disabled, have chronic conditions and comorbidities, and suffer from functional and cognitive impairments.[161,162,163] They also tend to be lower income, less educated, and have fewer social supports.[164] These traits "may reduce their ability to navigate the health care system,"[165] and presumably render them more susceptible to fraudulent, wasteful, and abusive conduct. There is cause to be concerned about this population. Dual-eligible beneficiaries are more likely to receive care in lower-quality facilities and to quit Medicare Advantage at higher rates than their non-dual eligible peers.[166] Indeed, "high-need enrollees, particularly those who are dual eligible, disenroll from MA at substantially higher rates than other enrollees."[167]

Disenrollment trends may shed light on how fraud, waste, and abuse affect beneficiaries. The highest rates of disenrollment occurred "among beneficiaries who are dually eligible for Medicare and Medicaid, beneficiaries of color, beneficiaries in rural areas, and following the onset of a functional impairment."[168] Beneficiaries suffering from Alzheimer's Disease and related dementias, for instance, reported worse care experiences and disenrolled from the program at higher rates than their peers without these conditions.[169] It is worth asking why. Why would seriously and chronically ill persons leave their Medicare Advantage plans? The structure of Part C, and the economic incentives that it engenders, may be among the reasons.

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[158]Grimm *supra* n 34, 9.

[159]Medicaid and CHIP Payment and Access Commission. n.d. *Dually Eligible Beneficiaries.* Accessed January 16, 2023. https://www.macpac.gov/topics/dually-eligible-beneficiaries/.

[160]Medicare Payment Advisory Comission and Medicaid and CHIP Payment and Access Commission. 2022. *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid.* Washington, D.C.: MedPAC and MACPAC, 29. https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf.

[161]Ibid., 33-37.

[162]Centers for Medicare & Medicaid Services. 2020. *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019.* Washington, D.C.: Medicare-Medicaid Coordination Office. https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.

[163]Cubanski, Juliette, Christina Swoope, Cristina Boccuti, Gretchen Jacobson, Giselle Casillas, Shannon Griffin, and Tricia Neuman. 2015. "A Primer on Medicare: Key Facts About the Medicare Program and the People it Covers." *KFF.org.* March 20. https://www.kff.org/report-section/a-primer-on-medicare-what-are-the-characteristics-of-people-with-medicare/.

[164]Medicare Payment Advisory Commission. 2022. *July 2022 Data Book: Health Care Spending and the Medicare Program.* Washington, D.C.: MedPac, 36, Chart 4-4. https://www.medpac.gov/document/july-2022-data-book-health-care-spending-and-the-medicare-program/.

[165]Congressional Budget Office. 2013. *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies.* Washington, D.C.: Congressional Budget Office, 4. https://www.cbo.gov/publication/44308.

[166]Meyers, David J, Momotazur Rahman, and Amal N Trivedi. 2022. "Narrow Primary Care Networks in Medicare Advantage." *Journal of General Internal Medicine* 37 (2): 488-91, 488. doi:10.1007/s11606-020-06534-2.

[167]Meyers, David J, Emmanuelle Belanger, Nina Joyce, John McHugh, Momotazur Rahman, and Vincent Mor. 2019. "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries." *JAMA Internal Medicine* 179 (4): 524-32, 531. doi:10.1001/jamainternmed.2018.7639.

[168]Ochieng & Biniek *supra* n 10.

[169]Meyers, David J, Maricruz Rivera-Hernandez, Daeho Kim, Laura M Keohane, Vincent Mor, and Amal N Trivedi. 2021. "Comparing the Care Experiences of Medicare Advantage Beneficiaries with and without Alzheimer's Disease and Related Dementias." *Journal of the American Geriatrics Society* 70 (8): 2344-53. doi:10.1111/jgs.17817.

MAOs are motivated to characterize their patients as high need, but not always to treat them as such. Indeed, financial interests may bias MAOs against their higher-need beneficiaries. The program's payment system attempts to mitigate this bias, but it does not eliminate discrimination against beneficiaries who actually require expensive care. When MAOs enroll healthy persons and reject sicker individuals, they are cherry picking patients who are more likely to be profitable. Risk adjustment ensures that MAOs are paid based on the prospective needs and complexity of their beneficiaries and so reduces cherry picking. Risk adjustment does not, however, prevent MAOs from forcing out beneficiaries who actually require pricey care and, hence, prove to be less profitable. Disparate disenrollment rates among higher-need cohorts may be evidence that MAOs are driving out beneficiaries who cost more to cover, whether intentionally or constructively. "[W]hen beneficiaries in poor health are more likely to disenroll than those in better health—which we refer to as health-biased disenrollment—it may indicate that those beneficiaries could be facing problems with access to care or the quality of services provided."[170] Access and quality problems may be attributable to many factors, including fraudulent and abusive MAO conduct that makes it harder for some beneficiaries to get the services that they need. There is little to prevent MAOs from administering their plans in ways that save money and disadvantage higher-need beneficiaries, inducing them to change Medicare Advantage plans or to leave the program for traditional Medicare. HHS-OIG's prior authorization audits revealed the tendency among MAOs to deny approval for high-priced care,[171] which may disproportionately burden sicker persons who cannot weather treatment delays and cause them to quit the program. In a more recent study, investigators found that older adults with diabetes who were covered by Medicare Advantage enjoyed greater access to primary care when compared to their peers in traditional Medicare, but that they also experienced "modestly but significantly poorer intermediate health outcomes and were less likely to be treated with newer, evidence-based antihyperglycemic therapies compared [to] Medicare FFS beneficiaries."[172] This study, like the HHS-OIG audits before it, begs a question – do MAOs withhold medically necessary treatments to protect their bottom lines to the detriment of their patients?

This paper cannot answer this question or many like it. Its goal is more modest – to show that programmatic features peculiar to Medicare Part C that allow fraud, waste, and abuse to flourish have implications for distributive justice. In Medicare Advantage, society has embraced a program that dissipates public funds and burdens those who most need health care. Going forward, programmatic, policy, and ethical analyses should consider whether and how Medicare Advantage fosters or thwarts distributive justice. It is not enough to ask questions about how the program affects cost, outcomes, and access. Considering Part C's vulnerabilities to fraud, waste, and abuse, we must also ask whether it is at bottom a just mechanism for delivering health insurance coverage.

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[170] United States Government Accountability Office. 2017. "Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight (GAO-17-393)." Report to Congressional Requesters, Washington, D.C., 3.

[171] *Supra* n 34, 118.

[172] Essien, Utibe R, Yuanyuan Tang, Jose F Figueroa, Terrence Michael A Litam, Fengming Tang, Philip G Jones, Ravi Patel, *et al.* 2022. "Diabetes Care Among Older Adults Enrolled in Medicare Advantage Versus Traditional Medicare Fee-For-Service Plans: The Diabetes Collaborative Registry." *Diabetes Care* 45 (7): 1549–1557. doi:10.2337/dc21-1178.

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