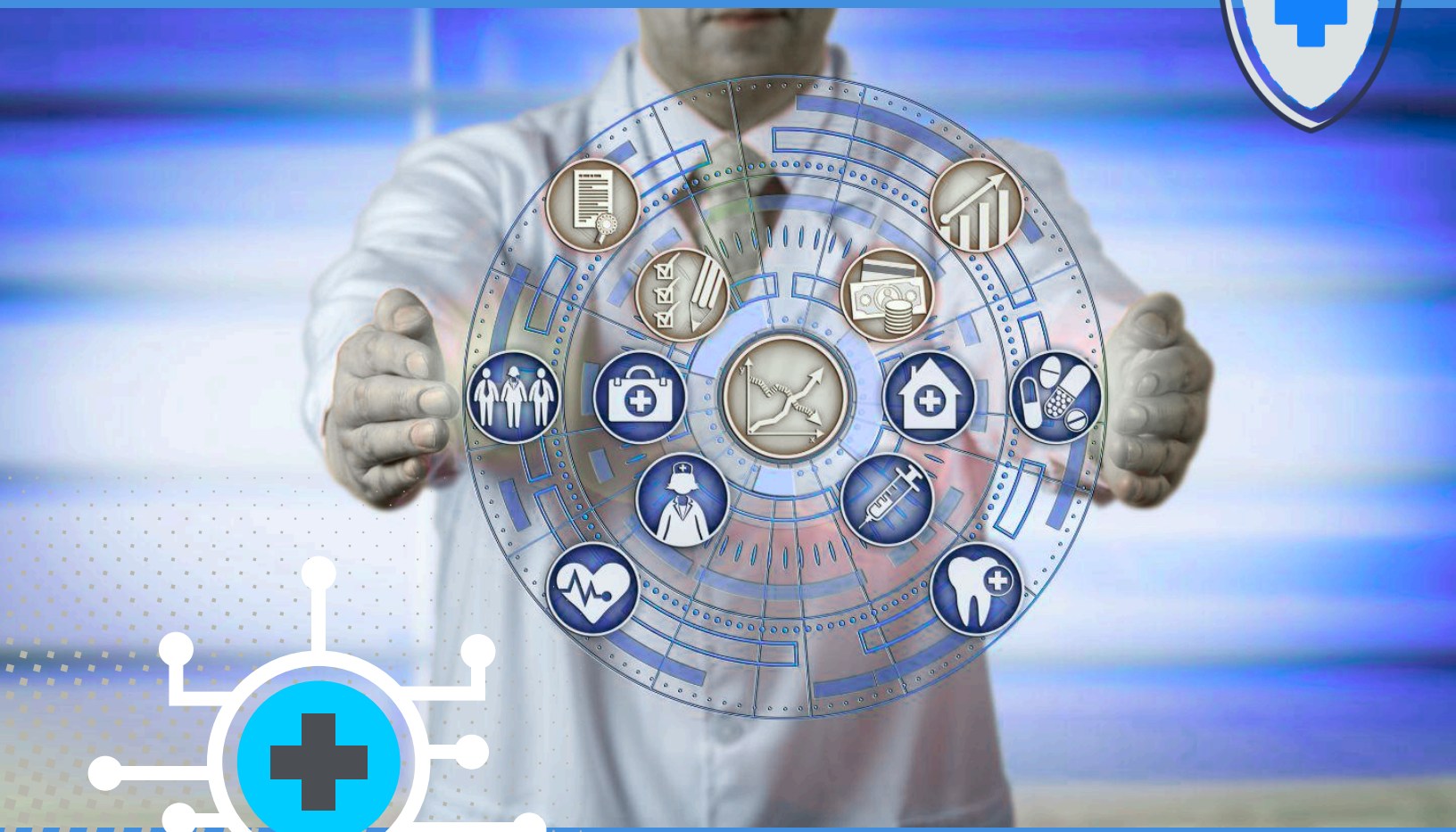
J29 SOLUTIONS

Addressing Fraud, Waste, and Abuse in Managed Care Plans and Medicare Advantage

December 2025



EXECUTIVE SUMMARY

> ***Fraud, waste, and abuse prevention is vital in managed care and Medicare Advantage because it protects taxpayer dollars, maintains program integrity, and ensures resources support quality care instead of improper payments.***

Managed Care—including Medicare Advantage and Medicaid Managed Care plans—is a cornerstone of the U.S. healthcare system, serving tens of millions of beneficiaries through coordinated provider networks. These plans aim to deliver high-quality, cost-effective care by using risk adjustment methodologies that account for enrollees' health status and expected costs. Medicare Advantage has grown rapidly, now covering over half of all Medicare beneficiaries and representing hundreds of billions in annual federal spending.

Despite their promise, managed care plans face persistent challenges with fraud, waste, and abuse (FWA). Fraud is intentional deception for financial gain, such as submitting false claims or inflating diagnoses. Waste involves the overuse or misuse of resources, often due to inefficient processes or unnecessary services. Abuse refers to practices that violate accepted standards, resulting in excess costs or compromised care. Recent investigations by the Office of Inspector General (OIG) and other agencies have found that questionable practices—especially misuse of health risk assessments—continue to drive billions in improper payments to Medicare Advantage plans each year. [1]

Medicare Advantage plans are paid by the federal government through capitated payments, where insurers receive a fixed monthly amount per enrollee. These payments are risk-adjusted, so plans get higher payments for sicker beneficiaries and lower payments for healthier ones, promoting fairness and incentivizing care for high-risk populations. Plans submit annual bids to CMS; if a bid is below the CMS benchmark, the plan receives a rebate to offer extra benefits. High-performing plans can earn bonus payments through CMS's Star Ratings system. To maintain integrity, plans must submit encounter data to CMS for validating risk scores and payments, and CMS conducts audits such as Risk Adjustment Data Validation (RADV) to identify improper payments.

The prevalence of FWA in managed care threatens the financial integrity of public health programs, undermines trust in the healthcare system, and can negatively impact patient outcomes. Addressing these issues requires coordinated efforts among federal agencies, health plans, providers, and technology partners. This white paper explores the scope and impact of FWA in managed care, highlights the urgency of the problem, and outlines actionable strategies for stakeholders to strengthen program integrity and ensure healthcare dollars are used as intended.

SIGNIFICANCE OF THE PROBLEM AT HAND

Fraud, waste, and abuse in managed care undermine the sustainability of public health programs and erode trust in the healthcare system. Federal estimates suggest that Medicare Advantage plans may overbill the government by $17 billion annually, with some projections reaching $43 billion [2]. Improper payments often stem from inflated risk scores, unsupported diagnoses, and misuse of health risk assessments.

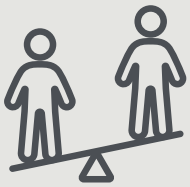
The impact is multifaceted: taxpayers bear the financial burden, beneficiaries may experience compromised care quality, and legitimate providers face increased scrutiny. CMS has responded by expanding Risk Adjustment Data Validation (RADV) audits from approximately 60 contracts per year to over 550, increasing audit sample sizes and accelerating timelines. While these measures are critical, they also introduce operational challenges for plans and oversight agencies.

Using 2016 MA encounter data, prior OIG work identified two sources of enrollee diagnoses—Health Risk Assessments (HRAs) and chart reviews—as vulnerable to misuse by MA companies. [3]

Beyond direct financial losses, fraud, waste, and abuse in managed care contribute to rising healthcare costs and insurance premiums, affecting the affordability of coverage for all Americans. The diversion of resources away from patient care undermines efforts to improve health outcomes, particularly for vulnerable populations such as seniors and those with chronic conditions. As CMS and other agencies ramp up oversight, managed care organizations and providers face mounting administrative burdens, which can strain relationships and reduce operational efficiency. Persistent FWA also erodes public trust in both government programs and private insurers, threatening the long-term viability of managed care as a solution to rising healthcare costs. With managed care enrollment at an all-time high, the urgency to address these challenges has never been greater.

HOW COULD YOU APPROACH IT?

Addressing FWA in managed care requires a multi-pronged strategy that combines technology, provider engagement, plan-level operations, and regulatory oversight. We have included various types of recommendations, and potential key approaches below:



1. Technology Solutions Incorporating a "Human-In-The-Loop"

J29 believes firmly on an incorporated human-in-the-loop process, leveraging our Subject Matter Experts (SMEs) that bring 10+ years of RADV expertise. Advanced analytics, artificial intelligence (AI), and automation can identify anomalies in claims and risk scores, streamline medical record reviews, and enhance audit efficiency. CMS, States, and plans should invest in secure, interoperable systems that support real-time monitoring and predictive modeling as audit cycles are beginning. How do you keep the experts in the loop while also leveraging technology to enhance scale and scope of efforts? Plans that are conducting fraud, such as through over-inflating the diagnosis of their beneficiaries so they can receive higher capitated payments, can have deeper trend analysis done through various advanced technologies.

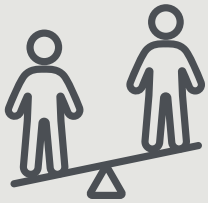
2. Provider Practices Balancing Support and External Auditing

Strengthening provider education on documentation standards and coding compliance is essential. Regular training and credentialing can reduce errors and prevent intentional misrepresentation. Providers should adopt internal auditing protocols to ensure accuracy before claims submission. Independent verification of provider practices should be regularly leveraged to provide oversight, even if not contractually required. We need to ask ourselves, "Do all Providers have intentions of fraud, waste, and abuse, or do some make genuine mistakes that need to be identified through extensive auditing?".

3. Plan-Level Operations Integrating Proven Program Integrity Practices

Managed care organizations must embed program integrity into their core operations. This includes pre-payment edits, post-payment reviews, and continuous quality assurance. Ultimately, auditing parties will conduct post-payment analysis and review to make determinations on improper payments, but how do we address root-cause Managed Care issues on the fore-front? Plans, their auditing parties, on governmental agencies, should leverage dashboards and reporting tools to monitor trends and address vulnerabilities proactively. How can high-risk diagnosis codes be address through specific plan-level operations?

APPROACH (CONTINUED)



4. Centers for Medicare and Medicaid Services (CMS) Influence

CMS, highlighted by the Center for Program Integrity, has continued to make significant strides in their processes related to RADV auditing. Additional enhancement in transparency could come by implementing independent oversight of contractors, refining RADV methodologies, and piloting emerging technologies for audit processes. As CMS looks to increase RADV efforts in the number of Medicare Advantage contracts that will be audited, the number of records requested, turnaround times, and amount of Medical Coders projected to be needed, J29, Inc. (J29) stands by to leverage our present-day corporate history of supporting the RADV program. It is important to recognize organizations that bring proven expertise to this mission.

IN CONCLUSION

Fraud, waste, and abuse in Medicare Advantage and Managed Care plans represent a significant threat to healthcare integrity and fiscal sustainability. Combating these issues requires coordinated action across technology, provider practices, plan operations, and federal oversight. By prioritizing transparency, leveraging innovation, and fostering collaboration, stakeholders can protect taxpayer dollars and ensure that every healthcare dollar serves its intended purpose—delivering quality care to beneficiaries.

Organizations like J29 demonstrate that with the right expertise and tools, program integrity goals are achievable. However, success ultimately depends on collective commitment from CMS, plans, providers, and technology partners to build a resilient, accountable managed care ecosystem. J29 has supported CMS in RADV audits and program integrity initiatives, offering proven claims auditing, record review, scalable workforce solutions, advanced analytics, and independent quality assurance frameworks.

Established in 2017 as an Economically Disadvantaged Woman-Owned Small Business (EDWOSB), and 8(a) certified company, J29 continues to serve as an award-winning employee-centered health and human service management company to clients at the commercial and government levels.

SOURCES
[1] 2024 OIG Medicare Advantage HRA Report
[2] MedPAC Reports
[3] 2025 OIG Medicare Advantage Reports