BRG

INTELLIGENCE THAT WORKS

Medicare Could Have Saved $7.0 Billion in Spending on Select Services Subject to Fraud, Waste, and Abuse if MA Techniques Had Been Employed

DECEMBER 2025

PREPARED BY:

Ruth Tabak
Director

Eric Hammelman
Director

Sarah Fox
Senior Associate

Medicare Advantage (MA) plans employ fraud detection strategies and medical management tools to protect beneficiaries from unnecessary utilization and spending on healthcare services with high rates of fraud. BRG professionals compared Traditional Medicare (TM) and MA utilization of select healthcare services that past government investigations found were subject to fraud, waste, or abuse (FWA). Selected services are illustrative of MA FWA management and the resulting impact on utilization and spending. FWA in certain service areas has since been resolved, and new areas of fraudulent activity have arisen in recent years.

MA plans are incentivized to monitor and control FWA due to accountability for total Medicare Part A and B spending among beneficiaries. Examples of strategies that MA plans employ include:

- prior authorization or step therapy for low-value and/or high-risk care
- leveraging findings from MA fraud units and commercial and Medicaid lines of business to identify and root out FWA quickly
- organization-level coverage policies on appropriate intensity of services
- negotiated contracts with providers that include capitated rates for total cost of care to encourage efficiency

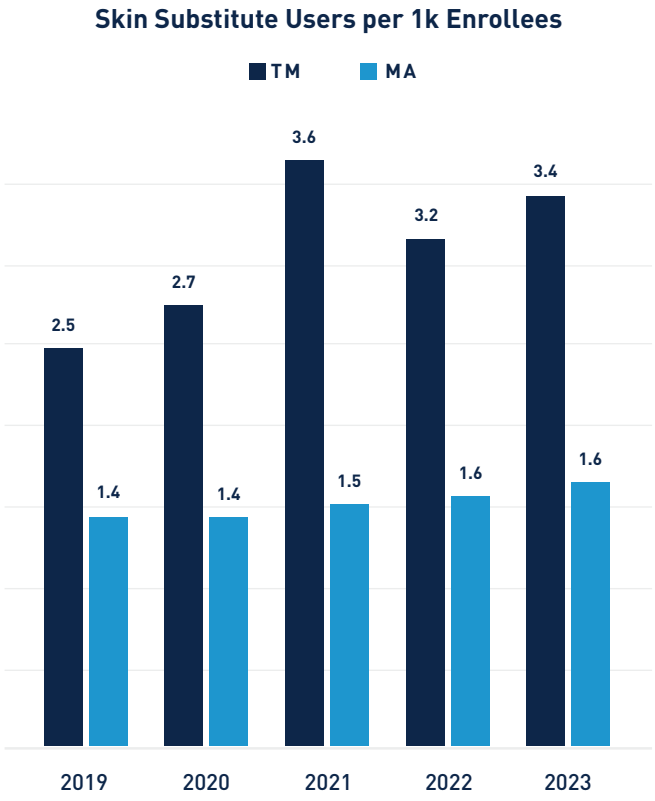
BRG found that TM would have saved nearly $7.0 billion for selected services and years if TM utilization rates had matched MA rates. For example, from 2019 to 2023, TM spending on skin substitutes was 1.5 to 6.5 times greater than MA, or in excess of $5.6 billion. The Office of Inspector General (OIG) recently noted that TM spending on skin substitutes jumped to 15 times higher than MA spending in 2024.

To conduct this analysis, BRG leveraged 100 percent 2019–2023 Medicare fee for service (FFS) claims and MA encounter data records, based on a data use agreement with the Centers for Medicare and Medicaid Services (CMS), to calculate total utilization and rates per 1,000 beneficiaries in TM and MA for each service. BRG quantified savings due to FWA measures in the MA program by estimating TM spending at MA utilization rates and TM spend per user, adjusted by a ratio of MA to TM units.

Services	Calculated Savings Years	Savings ($M)
Skin Substitutes	2019–2023	$5,640
Catheters	2019–2022	$508
Genetic Testing	2019–2021	$446
Off-the-Shelf Braces	2019–2020	$392

Medicare Could Have Saved ~$5.6 Billion by Managing Use and Mix of Skin Substitute Products for TM Patients

From 2019 to 2023, TM enrollees received wound-care products known as skin substitutes at 1.8 to 2.4 times the rate of MA enrollees. TM spend per user was 6 times larger in 2023 than in 2019 due to pricier skin substitutes, more intensive use, and fraudulent activity. Current MA plan policies may reduce unnecessary utilization, while CMS has explored but delayed changes to TM coverage policy that would reduce financial incentives for fraud. In Q3 2024, the OIG found that TM spending ballooned to 15 times higher than MA spending, driven by significantly higher use among TM enrollees, more expensive products, and fraudulent actors billing for unnecessary or undelivered services.



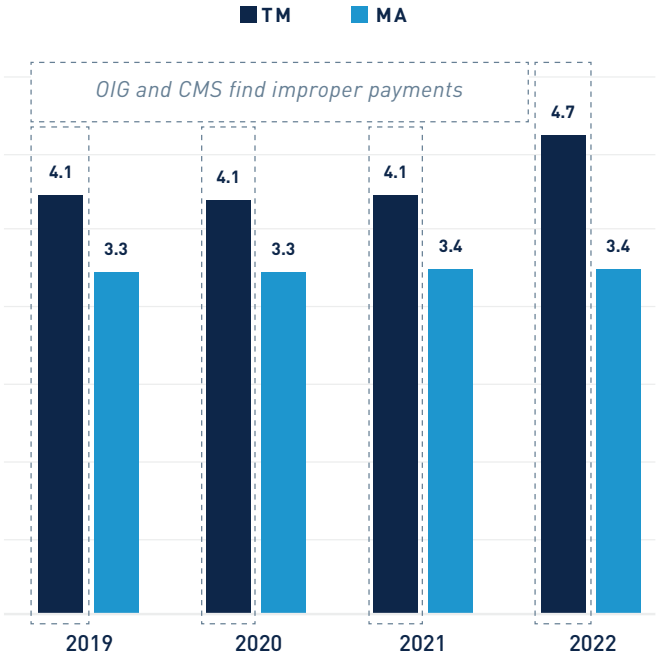
Medicare Part B covers wound-care products known as skin substitutes when reasonable and necessary for the treatment of an enrollee's condition. Until 2026, CMS treated skin substitutes like approved prescription biologics and reimbursed for them at 106% of the average sales price (ASP) while products without an ASP were paid at wholesale acquisition cost which is typically higher. CMS published a policy with specific criteria for coverage of skin substitutes but delayed the effective date until January 2026. Additionally, CMS finalized a new skin substitute payment policy for 2026 that the agency estimates will reduce spending by 90%.

Medicare Could Have Saved ~$508 Million if Catheter Use Was Similar to MA with Utilization Controls and Fraud Detection

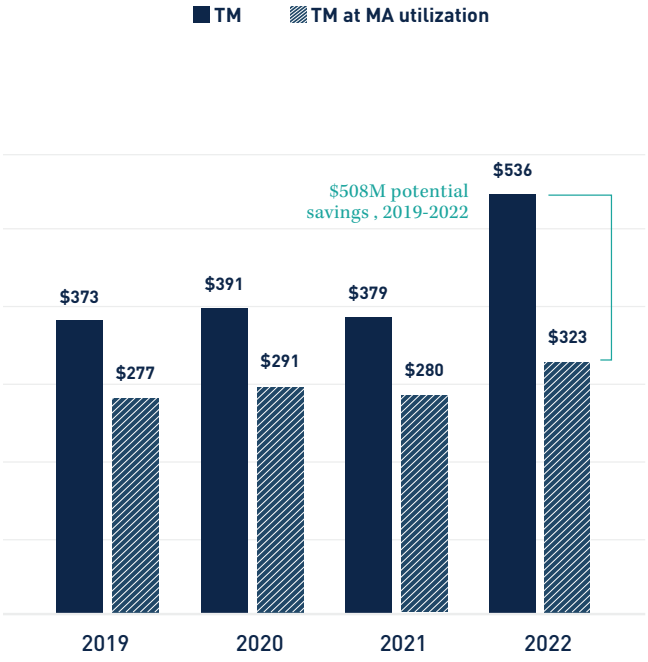
The OIG and CMS have noted fraudulent use of urinary catheters, particularly of curved tip catheters, in TM. CMS has also included urological supplies, and curved tip catheters specifically, among the top twenty durable medical equipment (DME) services or items with the highest improper payments. The OIG found that TM spending per user for curved tip catheters is 3 times higher than straight tip due to Medicare payment rates; and while curved tip catheters are covered if medically necessary, CMS advises that use should be rare. From 2021 to 2022, TM use of curved tip catheters increased 88 percent compared to 3 percent growth among MA enrollees. CMS recently proposed to include ostomy and urological supplies, including catheters, in the next round of DME competitive bidding.

MA plans use utilization management tools including quantity limits to deter fraud and unnecessary utilization. In 2023, DME suppliers billed nearly $5 billion in catheter utilization to TM, but CMS suspended payments to fraudulent suppliers. MA utilization in 2023 remained flat, potentially due to plan measures that deter fraud.

Intermittent Urinary Catheter Users per 1k Enrollees



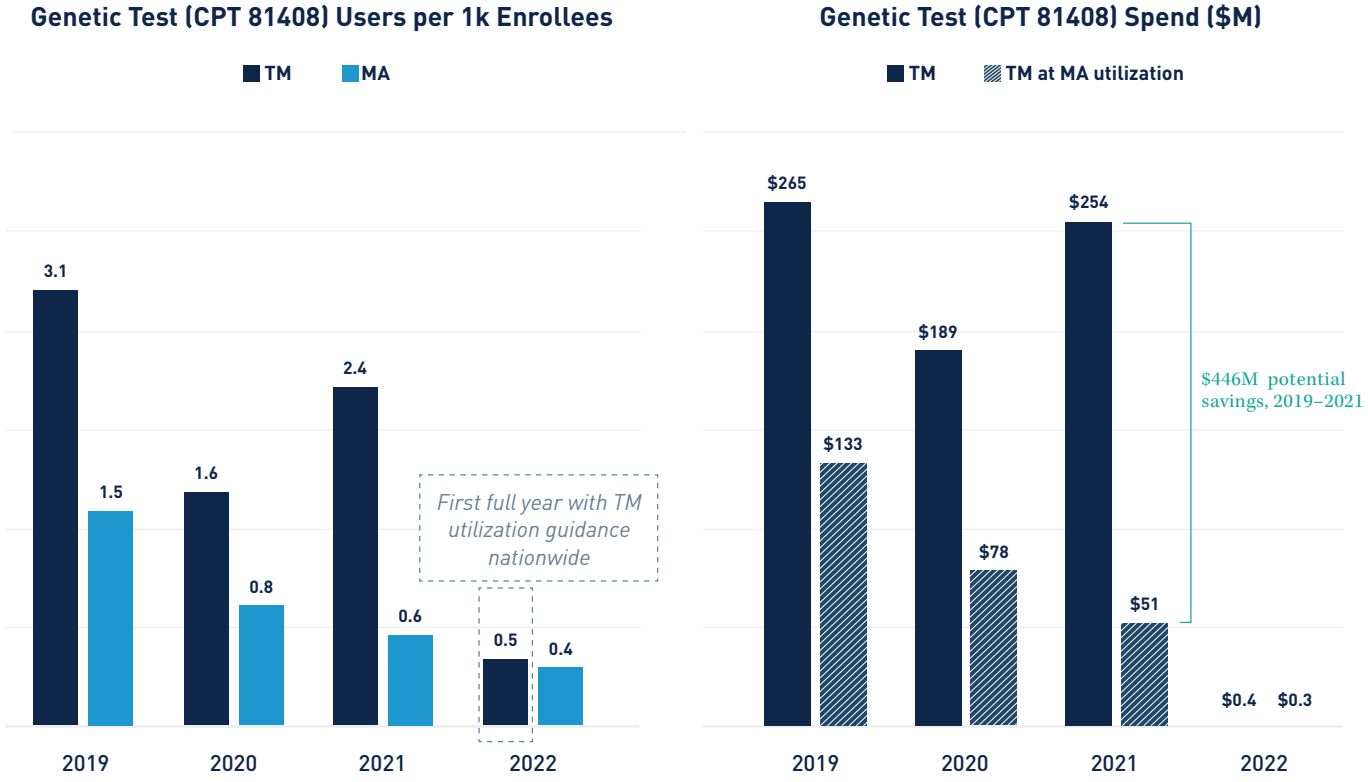
Intermittent Urinary Catheter Spend ($M)



Intermittent urinary catheters are covered under the Medicare Part B benefit for prosthetic devices for people who have a permanent impairment of urination, and include straight and curved tip catheters, and catheter kits. Curved tip urinary catheters and sterile catheter kits are paid at 3x the rate of straight tip catheters. Medicare enrollees are covered for curved tip catheters based on medical necessity. Sterile catheter kits are approved for SNF residents or Medicare beneficiaries with certain conditions, e.g., immunosuppressed, recurrent UTIs, etc.

Medicare Could Have Saved ~$446 Million with Standardized Utilization Guidelines for Certain Genetic Tests

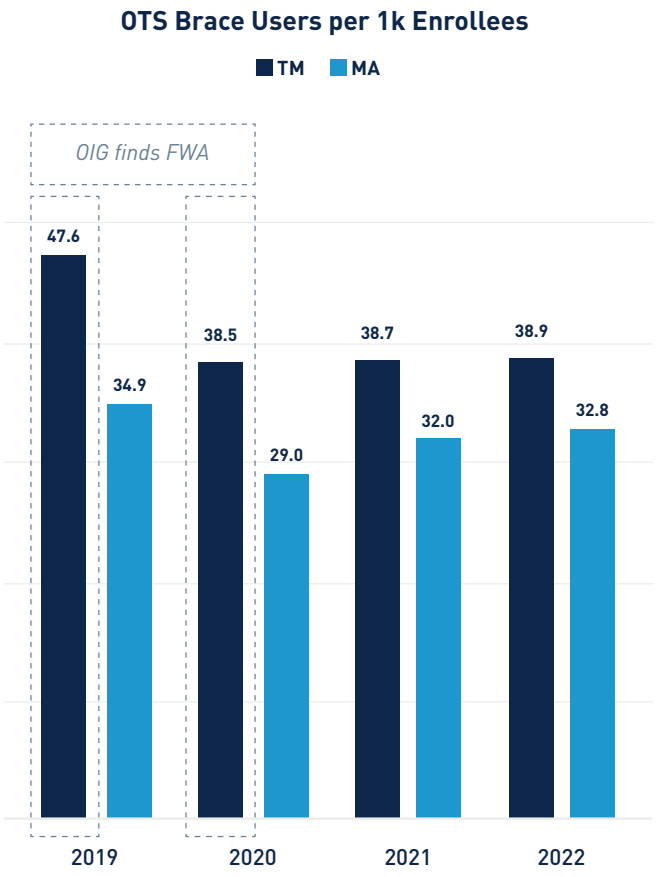
In 2023, the OIG found that lack of standardized Medicare guidelines for genetic testing allowed for FWA in TM; specifically, for a test (CPT 81408) that is billed when testing for multiple rare diseases that typically manifest in childhood. MA plans often require documentation proving medical necessity and may issue uniform national coverage guidance. Based on the OIG's prior review, the genetic test billed with CPT 81408 had the highest Medicare payment rate of molecular pathology procedures ($2,000), resulting in the second highest total Part B payments for genetic tests from 2016 to 2019. The OIG found that CPT 81408 lacked oversight by CMS's Medicare administrative contracts [MACs], particularly in two geographic jurisdictions that had not published coverage policies. Nationally, MA utilization steadily declined from 2019 to 2022, while TM utilization remained high until dropping to MA levels in 2022. This coincided with the remaining MACs issuing coverage guidance limiting the use of genetic tests billed under CPT 81408 in their geographies.

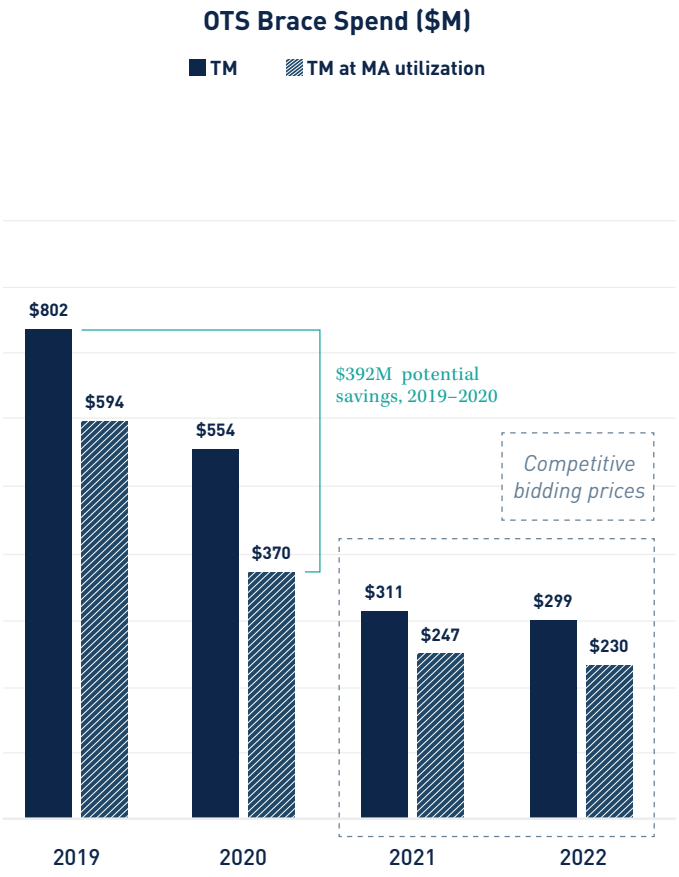


CPT 81408 is a Tier 2 molecular pathology procedure and is billed for the testing of 24 different genes that are associated with rare diseases that typically manifest in childhood, for example, muscular dystrophy. CPT 81408 may be billed multiple times if the lab is testing for multiple genes covered by the code. This test includes some genes associated with diseases that may be appropriate to test for in the Medicare population, but they are rare.

Medicare Could Have Saved $392 Million on OTS Braces with Fraud Detection, Ensuring Medical Necessity

The OIG's investigations of off-the-shelf (OTS) orthotic braces found FWA in 2019–2020 and that Medicare's allowed amounts for items not included in the DME Competitive Bidding Program were above those of non-Medicare payers. CMS found that orthotic braces were consistently in the top twenty DME items with the highest improper payment rates. Compared to TM utilization of OTS braces, MA users and spend per 1,000 enrollees were ~25 to 30 percent lower, potentially indicating that MA plans are avoiding fraudulent or wasteful claims. TM use stabilized and spending declined after CMS included OTS braces in competitive bidding in 2021, but if TM rates of use were equivalent to MA in 2019–2020, TM would have saved nearly $400 million.





Orthotic braces are rigid and semirigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part (e.g., neck, back, arm, or leg). Medicare will cover braces that are reasonable and necessary and pay to replace a brace based on its reasonable useful lifetime, typically every 5 years. OTS braces are prefabricated and allow for minimal self-adjustment by the patient or caretaker. Medicare also covers custom-fitted and custom-fabricated braces that require more adjustment or are individually made for patients.

Conclusions

Overall, MA utilization management and fraud detection tools can protect beneficiaries and the Medicare program from FWA. MA techniques can curb services subject to FWA through quick detection and removal of bad actors. While this analysis is illustrative of just four services with demonstrated FWA, additional savings could be realized by investigating other low-value, wasteful services in TM for which MA has developed utilization controls.

The OIG has attributed some wasteful spending in TM to the lack of clear guidance across various MAC jurisdictions. MA plans may issue coverage policies that cover broad geographies, even nationally, which reduce variation in coding and billing by geography. In cases of fraudulent billing, bad actors may target TM beneficiaries rather than MA if TM policies do not respond as rapidly as MA to evidence of FWA. MA plans can monitor services closely for abnormal growth in utilization to identify and remove bad actors from their networks.

Further, MA plans can leverage FWA findings from other business units, such as their commercial or Medicaid lines of business. In addition to the existing TM tools like DME competitive bidding and MAC coverage guidance noted above, CMS cited the value of MA techniques in a new CMS Innovation Center model (WISeR), which may better align TM utilization of certain services with MA in future years.

Appendix I. Methodology

Selecting Services

BRG identified healthcare services based on OIG investigations and findings of FWA. Services were narrowed further to those with evidence of FWA during the period from 2019 to 2023, the years of TM claims and MA encounter data record availability.

Utilization and Spending Analysis

BRG calculated total utilization and rates per 1,000 beneficiaries in TM and MA for each service. To calculate TM spending at MA utilization rates, BRG recalculated TM utilization to be in line with MA users per 1,000 enrollees and applied the TM spend per user to the TM utilization assumption. The revised TM spend was then adjusted by a ratio of MA to TM units. BRG adjusts by the MA to TM ratio of units to reflect different intensity of services delivered to the MA and TM populations, as well as different mix of products delivered to patients. BRG limited the analysis to beneficiaries enrolled in TM or MA for twelve months during the analysis year, thus excluding partial-year enrollees and those who switched between TM and MA during the year. BRG also excluded beneficiaries with a hospice claim during the analysis year.

Data Source

BRG analysis of 100 percent 2019–2023 Medicare FFS claims and MA encounter data, based on a data use agreement with CMS.

Limitations

This analysis does not account for lower MA spending through plan negotiated rates with providers or suppliers and may have found greater savings if MA encounter data records were priced with MA rates. Encounter data submitted by MA plans has been found to be incomplete, which would result in the appearance of lower MA utilization rates, particularly for DME. To remove the potential impact of incompleteness in the DME encounter data, BRG excluded contracts with less than 25th percentile users per 1,000 enrollees and units per user for a common DME item—wheelchair services—excluding accessory-related codes. Last, this analysis does not adjust the MA or FFS populations to account for differences in beneficiary health that could lead to variation in utilization or review medical necessity of items and services delivered to beneficiaries.

Appendix 2. Utilization Measures

BRG calculated ratios of TM utilization to MA utilization using 100 percent 2019–2023 Medicare FFS claims and MA encounter data, based on a data use agreement with CMS.

Skin Substitute	TM : MA Ratio (2023)
Users per 1,000 enrollees	2.1
Units per user	1.1
Spend per 1,000 enrollees	7.1

Urinary Catheter	TM : MA Ratio (2022)
Users per 1,000 enrollees	1.4
Units per user	1.2
Spend per 1,000 enrollees	1.7
Curved tip catheter use per 1,000 enrollees	1.6

Genetic Test (CPT 81408)	TM : MA Ratio (2021)
Users per 1,000 enrollees	3.6
Units per user	1.3
Spend per 1,000 enrollees	5.0

OTS Brace	TM : MA Ratio (2020)
Users per 1,000 enrollees	1.3
Units per user	1.1
Spend per 1,000 enrollees	1.5

Appendix 3. Description of Selected Services

Service/Item	Description	Rationale for Evaluation
Skin and tissue substitutes	Medicare Part B covers wound-care products known as skin substitutes when reasonable and necessary for the treatment of an enrollee's condition. Until 2026, CMS treated skin substitutes like approved prescription biologics and reimbursed for them at 106 percent of the average sales price (ASP).	OIG reported on significant gaps in manufacturer compliance with ASP reporting requirements for skin substitutes, leading to higher payment rates. Despite CMS efforts to address the accuracy and completeness of ASP reporting, expenditures have significantly increased since OIG released its report.
Urinary catheters	Intermittent urinary catheters are covered under the Medicare Part B benefit for prosthetic devices for people who have a permanent impairment of urination; i.e., permanent urinary incontinence (involuntary loss of urine) or permanent urinary retention (inability to voluntarily empty the bladder or pass urine).	OIG and CMS have noted fraudulent use of urinary catheters, particularly of curved tip catheters, in TM.
Genetic testing	Tier 2 genetic tests profile multiple genes corresponding to rare diseases that typically manifest in childhood.	CMS states that these tests should be performed rarely in the Medicare population, yet OIG found high program spend. Two of twelve MACs had not issued coverage guidance on use.
Off-the-shelf (OTS) orthotic braces	Orthotic braces are rigid and semirigid devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured body part (e.g., neck, back, arm, leg).	CMS found that orthotic braces were consistently among the top twenty items of DME with the highest improper payment rates. In 2019–2020 when the OIG investigated OTS brace FWA, MA users and spend per 1,000 enrollees were ~25 to 30 percent below TM, potentially indicating better management of OTS billing and avoidance of fraudulent or wasteful claims.