



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

**Testimony Before the
United States Senate Committee on Homeland Security and Governmental Affairs
Permanent Subcommittee on Investigations**

Examining Health Care Denials and Delays in Medicare Advantage

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Good morning, Chairman Blumenthal, Ranking Member Johnson, and distinguished Members of the Subcommittee. I am Megan Tinker, Chief of Staff, at the Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to appear before you today to discuss our work examining the potential barriers that seniors may face when accessing health care under Medicare Advantage.

In 2023, Medicare Advantage plans currently cover 30 million people—slightly more than half (50.4 percent) of all Medicare enrollees.¹ For the first time, Medicare Advantage has surpassed traditional Medicare in enrollment. One of OIG’s top priorities is ensuring that the Medicare Advantage program works effectively and provides quality health care for enrollees and value for taxpayers. This priority includes ensuring that Medicare Advantage enrollees have access to appropriate and medically necessary health care.

Today, I will focus my testimony on OIG’s work examining Medicare Advantage plan practices that may impede access to health care for seniors. In summary, we have identified the following concerns.

Medicare Advantage Organizations (MAOs) sometimes delayed or denied enrollees’ access to medical services, even though the requested care was medically necessary and met Medicare coverage rules. In other words, these Medicare Advantage enrollees were denied access to needed services that likely would have been approved if these individuals had been enrolled in original Medicare. These denials likely prevented or delayed needed care for enrollees. In addition, MAOs sometimes denied payments to health care providers for services that they had already delivered to patients, even though the requests met Medicare coverage rules, MAOs’ own billing rules, and should have been paid by the plan.

In my testimony, I will provide further details and context on these findings and highlight the actions that OIG has recommended the Centers for Medicare & Medicaid Services (CMS) take to better ensure that Medicare Advantage enrollees have timely access to all necessary health care services. Additionally, I will highlight the resource challenges that OIG faces to provide comprehensive oversight of Medicare Advantage and other HHS programs.

¹ Kaiser Family Foundation, “Half of All Eligible Medicare Beneficiaries Are Now Enrolled in Private Medicare Advantage Plans,” May 2023. Available at <https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/>.

MEDICARE ADVANTAGE DENIALS OF SERVICES AND PAYMENTS

In April 2022, OIG published a report examining MAO denials of requests for prior authorization, which is preapproval for a service or item before the enrollee receives it, and denials of payment requests from a provider for a service already delivered to the enrollee.²

Why Focus Oversight on Medicare Advantage Denials

Incentives. A central concern about capitated payment models, including Medicare Advantage, is the potential incentive for insurers to deny access to services for enrollees and deny payments to providers to increase profits. MAOs are paid a fixed amount of money each month for each enrollee, regardless of the number or cost of services they pay for on behalf of that enrollee.

Volume of Denials. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year. In 2021, MAOs denied 2.2 million prior authorization requests (5.5 percent of all prior authorization requests) and 56.2 million payment requests overall (9.5 percent of all payment requests) in the Medicare Advantage program.

Prior Evidence of Problems. OIG's previous analysis of Medicare Advantage appeals outcomes raised concerns about MAO denials.³ When enrollees and providers appealed service and payment denials, MAOs overturned 75 percent of their own denials during 2014–2016. Independent reviewers at higher levels of the appeals process overturned additional denials in favor of enrollees and providers. At the time the report was issued, the high rate of overturned denials raised concerns that some enrollees and providers were initially denied services and payments that should have been provided. This is especially concerning because enrollees and providers appealed only 1 percent of denials. In addition, OIG found that CMS's annual audits of MAOs from 2012 through 2016 commonly identified problems related to denials.

How OIG Assessed Medicare Advantage Denials

For our 2022 report, we selected a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs by enrollment during June 1–7, 2019.⁴ Health care coding experts reviewed case files for all cases, and physician reviewers examined medical records for a subset of cases that warranted medical necessity review. From these results, we estimated the rates at which these MAOs denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules.⁵ We also examined the reasons for these denials in our sample.

² OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, (OEI-09-19-00260), April 2022.

³ OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*, (OEI-09-16-00410), September 2018.

⁴ These 15 MAOs accounted for nearly 80 percent of Medicare Advantage enrollees.

⁵ Our sampling method enables us to project these rates to the universe of all denials by the 15 largest MAOs during this time period. However, it does not enable us to estimate MAO-specific rates or to project the reasons for denials from our sampled cases to the universe of denials.

OIG Findings Raise Concerns About MAO Denials of Services

13% of prior authorization denials were for services that met Medicare coverage rules

Among prior authorization requests that MAOs denied, 13 percent were for requests that met Medicare coverage rules. In other words, these services likely would have been approved in original Medicare. This rate projects to 1,631 prior authorization denials for requests that met Medicare coverage rules for these MAOs during the first week of June 2019.⁶ Such denials can have a range of negative impacts, such as enrollees not receiving

needed care, delays in receiving needed care, enrollees receiving an alternative service that may be less effective for their needs, enrollees paying out-of-pocket for care, and/or administrative burden for enrollees or their providers who choose to appeal the denial.

IMPACT: Denials likely prevented or delayed needed care

MAO use of internal clinical criteria contributed to many of these denials in our sample.

For many of the denials of prior authorization requests in our sample for services that met Medicare coverage rules, MAOs denied the requests by applying MAO clinical criteria that are not required by Medicare. MAOs must follow Medicare coverage rules, which specify what items and services are covered and under what circumstances. However, at the time of our evaluation, they were also permitted to use additional clinical criteria that were not developed by Medicare, as long as such criteria were “no more restrictive than original Medicare’s national and local coverage policies.”⁷

CMS guidance on the appropriate use of such criteria was insufficient. In several cases, we were unable to determine whether the prior authorization denials that met Medicare coverage rules would be considered appropriate by CMS because CMS’s guidance regarding MAO use of internal clinical criteria was not sufficiently detailed.

CMS has announced new requirements intended to protect MA enrollees from inappropriate use of prior authorization, to take effect in 2024. In our 2022 report, OIG recommended that CMS issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews. In April 2023, CMS issued a final rule that cited OIG’s report in addressing this recommendation. The final rule provisions, which take effect in 2024, confirm that MAOs must comply with traditional Medicare’s benefit and coverage conditions. They clarify that MAOs may only use internal criteria when traditional Medicare’s coverage criteria are not fully established. MAOs must ensure that their internal criteria are publicly accessible and provide clinical benefits that are highly likely to outweigh any clinical harms, including from

⁶ For an annual context, if these MAOs denied the same number of prior authorization requests in each week of 2019, they would have denied 84,812 requests for services that met Medicare coverage rules that year.

⁷ CMS, Medicare Managed Care Manual, ch. 4, sec. 10.16, p. 28. Available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf>.

delayed or decreased access to items or services. CMS is also requiring MAOs to establish Utilization Management Committees to review policies annually and ensure consistency with traditional Medicare's national and local coverage decisions and guidelines.⁸

In addition, CMS's final rule sets forth other prior authorization requirements intended to remove barriers to appropriate care for MA enrollees, including adding continuity of care requirements and reducing disruptions for enrollees. For example, the rule requires that approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation. The rule also requires that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan.⁹

We found denials of services that met Medicare coverage rules caused by other MAO practices. For example, MAOs requested copies of documentation already contained in the case file. In other cases, some prior authorization denials in our sample resulted from MAO requests for unnecessary documentation. The following example illustrates this issue:

Denial of Admission to a Skilled Nursing Facility Illustrates a Need for CMS To Direct Additional Attention to Requests for Unnecessary Documentation

An MAO denied a request for a skilled nursing facility (SNF) admission, stating that it needed to review the enrollee's most recent therapy records. However, our physician panel determined that the medical records available to the MAO were sufficient to demonstrate that the enrollee's deteriorating functional status and morbidities warranted admission to a SNF with access to physical and occupational therapy. This denial was reversed upon appeal.

Requests for unnecessary documentation may prevent or delay Medicare enrollees from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for enrollees, providers, and MAOs. CMS should update its audit protocols for MAOs to better identify these denials. For example, it could add a question for auditors examining denial cases to determine whether MAOs requested unnecessary information.

⁸ 42 CFR § 422.137(d); *see also* 88 FR 22120, 22122 (April 12, 2023).

⁹ 42 CFR § 422.112(b)(8); *see also* 88 FR 22120, 22206 (April 12, 2023).

OIG Findings Raise Concerns About MAO Denials of Payments

18% of payment denials were for claims that met Medicare coverage rules and MAO billing rules

An estimated 18 percent of payment denials met Medicare coverage rules and MAO billing rules and therefore the provider payments should not have been denied by the MAOs. This projects to 28,949 payment denials that met Medicare coverage rules and MAO billing rules for these MAOs during the first week of June 2019.¹⁰ Denying payment requests that meet Medicare and MAO rules delays or prevents providers

from receiving payment for services that they have already delivered to enrollees.

IMPACT: Denials prevented or delayed payments to providers for services already delivered

Human errors during manual reviews contributed to these payment denials. MAOs relied on their staff to manually review some requests for payments before approving or denying them. These reviews were susceptible to human error, such as a reviewer’s overlooking a document in the case file or inaccurately interpreting CMS or MAO coverage rules.

System programming errors also contributed to payment denials. MAOs denied some payment requests because of inaccurate programming of claims processing systems. System errors can cause greater harm because they could generate large volumes of incorrect denials until the MAO notices and fixes the error.

OIG Recommends Additional Ways for CMS To Better Protect Enrollees and Providers From Inappropriate Denials

In addition to our recommendation that CMS issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews, our report included two recommendations that remain open. We continue to recommend that CMS:

- **incorporate the issues identified in our evaluation into its audits of MAOs, and**
- **direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.**

CMS agreed with each of these recommendations and indicated that it plans to implement them.

In addition, two of OIG’s recommendations remain open from our 2018 report on outcomes of Medicare Advantage appeals. These recommendations are that CMS:

¹⁰ For an annual context, if these MAOs denied the same number of payment requests each week of 2019, they would have denied 1.5 million payment requests that met Medicare coverage rules and MAO billing rules that year.

- **enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate; and**
- **provide enrollees with clear, easily accessible information about serious violations by MAOs.**

Although CMS agreed with these recommendations, it has not yet fully implemented them. CMS implemented our third recommendation from that 2018 report. In 2019, CMS revised its Civil Money Penalty calculation methodology to include a new aggravating factor for inappropriate delay or denial of medical services, drugs, and/or appeal rights, and new aggravating factors for prior offenses—all changes that better hold MAOs accountable for ensuring appropriate access to care.

LOOKING FORWARD: KEEPING PACE WITH FRAUD, WASTE, AND ABUSE IN HHS PROGRAMS

HHS-OIG's oversight portfolio is vital, vast, and varied. In fiscal year (FY) 2022, HHS-OIG was responsible for oversight of more than \$2.4 trillion in HHS expenditures. With a FY 2023 enacted budget of \$432.5 million, OIG has about 2 cents to oversee every \$100 of HHS spending. In particular, effective oversight of Medicare and Medicaid is complex, challenging, and resource intensive because of the intricacy and breadth of these programs. That is especially true in Medicare Advantage, which includes nearly 4,000 plans, 30 million enrollees, and more than \$350 billion in annual expenditures.

Despite extensive reviews and enforcement, our limited resources do not allow us to provide comprehensive oversight of Medicare and Medicaid. Notwithstanding rigorous efforts by OIG and support from Congress, the Administration, and HHS for OIG work and resources, serious fraud, waste, and abuse continue to threaten HHS programs and the people they serve. HHS-OIG lacks a sufficient number of agents to work cases and auditors, data scientists, and analysts to detect trends, outliers, and program vulnerabilities. OIG is turning down between 300 and 400 viable criminal and civil health care fraud cases each year. Each case means unaddressed potential fraud and missed opportunities for deterrence. This includes the growing trend of fraudsters targeting Medicare Advantage plans as the program continues to expand.

Every day we make tough choices on cases and issues to decline. OIG's Regional Offices reviewed and evaluated more than 1,780 hotline complaints in FY 2021 and more than 3,562 hotline complaints in FY 2022 that might have developed into viable cases, but we did not have resources to open additional cases. In addition to the cases noted above, last year OIG turned down 648 cases from the major case coordination effort we have with CMS, a nearly 10-percent increase in cases declined from the prior year. These uninvestigated cases represent real, potential unchecked fraud and the potential for patients to be put in harm's way. I do not want to give the impression that we are not addressing serious fraud and abuse. We are, and our

statistics and return on investment show it. However, with current resources we cannot keep up with the level of threat to HHS, patients, and taxpayer dollars.

The FY 2024 President's Budget requested resources for OIG that, if enacted, would go a long way toward addressing this shortfall, particularly with respect to combating fraud, waste, and abuse in Medicare and Medicaid, for which the President's Budget requests approximately \$52.5 million in additional funding. With additional resources, OIG would expand its work examining critical issues in Medicare Advantage, including additional work examining access to care issues, increased oversight of the billions in dollars in risk adjustment payments, and additional targeted efforts to root out fraud that threatens the integrity of the Medicare Advantage program.

CONCLUSION

As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare enrollees have appropriate access to needed care and that providers are reimbursed appropriately. However, our evaluations raise concerns about how MAOs fulfill these critical responsibilities that affect enrollee health and the value of taxpayer investments in the program.

Denied service requests that meet Medicare coverage rules may prevent or delay enrollees from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for enrollees, providers, and MAOs. Further, enrollees in Medicare Advantage may not be aware that they may face greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.

It is vital that CMS continue to take action to ensure that Medicare Advantage enrollees have timely access to all necessary health care services. We have recommended several ways for CMS to do this and will continue to push for progress. OIG will also continue to be vigilant in our oversight and enforcement work to promote payment integrity, enrollee access, and quality of care in Medicare Advantage.

We appreciate the attention that the Subcommittee is bringing to these important issues and the opportunity to testify before you today. I welcome your questions.