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Medicare Advantage Plan Practices Impede Beneficiary Access to Necessary Care

New OIG report raises concerns about plan denials

A new report issued by the U.S. Department of Health and Human Services' Office of Inspector General (OIG) has found that Medicare Advantage insurers often deny prior authorization requests and payment for covered Medicare services. The OIG says these practices can delay or prevent necessary care and create significant negative health outcomes for beneficiaries enrolled in Medicare Advantage plans.

The OIG indicates it undertook its review of these practices by Medicare Advantage Organizations (MAOs) because they recognize that the capitated payment model can provide an incentive for health insurers to deny services or payment in order to increase insurer profits. In addition, according to OIG, "…CMS's annual audits of MAOs have highlighted widespread problems related to inappropriate denials of services and payment."

To assess the level and type of problematic care and payment denials by MAOs, OIG reviewed case files from a one-week period in June 2019. It found that 13% of denied prior authorization requests for services should have been approved, causing concerns about beneficiary access to medically necessary care, unnecessary out-of-pocket payments and administrative burden. Further, OIG found that MAOs should have approved 18% of the payment requests they denied. OIG indicates if the 18% were applied over the course of a year, that would translate into about 1.5 million denials for payment. While the report does not indicate an average payment amount across all of the denied claims, it does provide examples of denied cases involving amounts that range from $5 to nearly $10,000, meaning millions or potentially hundreds of millions in denied payments annually. In addition, providers incur significant costs in dealing with the administrative burden of these practices, costs which are not reflected in the OIG report.

Imaging services were the most common health care services that met Medicare coverage and billing rules but were denied by MAOs. Prior authorization requests for post-acute care in skilled nursing and inpatient rehabilitation facilities for care needed after hospital stays were also commonly denied, with OIG finding that often the alternatives offered by the MAOs were not clinically sufficient to meet the needs of the patients.

The OIG report comes amid other reports of insurer prior authorization and payment denials in the commercial insurance market as well. (See articles from *Becker's ASC Review*, *Kaiser Medscape* and *RevCycle Intelligence*.) The report also builds on a previous OIG report from September 2018 in which the agency found that when beneficiaries and health care providers appeal denied requests, the Medicare Advantage organizations overturned about 75% of their prior authorization and payment denials. In that report, OIG recommended that the Centers for Medicare & Medicaid Services (CMS) enhance its oversight of MAO appeals data and provide beneficiaries with clear information about MAO violations. As of March 2022, OIG notes, CMS had not yet implemented those recommendations.

As health insurers have been aggressively pushing the envelope on these controversial practices to deny necessary patient care, WHA has been increasingly advocating for holding them accountable and protecting patients. WHA has recommended that Congress pass the Improving Seniors' Timely Access to Care Act of 2021, H.R.3173/S.3018. Currently, half of Wisconsin's congressional delegation and nearly 60% of Congress overall has signed onto this important legislation that would, among other things, streamline the prior authorization process for those covered by a Medicare Advantage plan.