

Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials

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WHY WE DID THIS STUDY

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for MAOs to inappropriately deny access to services and payment in an attempt to increase their profits. An MAO that inappropriately denies authorization of services for beneficiaries, or payments to health care providers, may contribute to physical or financial harm and also misuses Medicare Program dollars that CMS paid for beneficiary healthcare. Because Medicare Advantage covers so many beneficiaries (more than 20 million in 2018), even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers.

HOW WE DID THIS STUDY

We collected data on denials, appeals, and appeal outcomes for 2014-16 at each level of the Medicare Advantage appeals process. We calculated the volume and rate of appeals and overturned denials at each level. To examine CMS oversight, we analyzed CMS's 2015 audit results and the resulting enforcement actions, including Star Ratings data from 2016 to 2018.

WHAT WE FOUND

When beneficiaries and providers appealed preauthorization and payment denials, Medicare Advantage Organizations (MAOs) overturned 75 percent of their own denials during 2014-16, overturning approximately 216,000 denials each year. During the same period, independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers. The high number of overturned denials raises concerns that some Medicare Advantage beneficiaries and providers were initially denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers rarely used the appeals process, which is designed to ensure access to care and payment. During 2014-16, beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.

Centers for Medicare & Medicaid Services (CMS) audits highlight widespread and persistent MAO performance problems related to denials of care and payment. For example, in 2015, CMS cited 56 percent of audited contracts for making inappropriate denials. CMS also cited 45 percent of contracts for sending denial letters with incomplete or incorrect information, which may inhibit beneficiaries' and providers' ability to file a successful appeal. In response to these audit findings, CMS took enforcement actions against MAOs, including issuing penalties and imposing sanctions. Because CMS continues to see the same types of violations in its audits of different MAOs every year, however, more action is needed to address these critical issues.

WHAT WE RECOMMEND

We recommend that CMS (1) enhance its oversight of MAO contracts including those with extremely high overturn rates and/or low appeal rates and take corrective action as appropriate; (2) address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage; and (3) provide beneficiaries with clear, easily accessible information about serious violations by MAOs. CMS concurred with all three recommendations.