U.S. Department of Health and Human Services

Office of Inspector General

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

OEI-09-16-00410
September 2018

Daniel R. Levinson
Inspector General

Report in Brief
September 2018
OEI-09-16-00410

U.S. Department of Health and Human Services
Office of Inspector General

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

What OIG 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.

Key Takeaway
High numbers of overturned denials upon appeal, and persistent performance problems identified by CMS audits, raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs are required to provide.

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 OIG Recommends and How the Agency Responded

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.

Full report can be found at oig.hhs.gov/oei/reports/oei-09-16-00410.asp

Why OIG Did This Review

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 healthcare 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 OIG Did This Review

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.

TABLE OF CONTENTS

BACKGROUND 1

Methodology 5

FINDINGS

When Medicare Advantage beneficiaries and providers appealed, they were usually successful in getting denials overturned 7

Medicare Advantage beneficiaries and providers rarely used the appeals process designed to ensure access to services and payment 10

CMS audits found widespread and persistent problems related to denials of care and payment in Medicare Advantage 11

CMS has taken action to try to address MAO performance problems 12

MAO audit violations will no longer affect their contracts' quality ratings 14

CONCLUSION AND RECOMMENDATIONS

Enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate 17

Address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage 18

Provide beneficiaries with clear, easily accessible information about serious violations by MAOs 18

CMS COMMENTS AND OIG RESPONSE 19

APPENDICES

A: Medicare Advantage Appeals Process 20

B: Detailed Methodology 22

C: Volumes and Rates of MAO Appeal Outcomes, 2014–16 26

D: Volumes and Rates of Overturned Denials by Independent Reviewers, 2014–16 27

E: Volume and Rate of First-Level Appeals, 2014–16 28

F: CMS Comments 29

ACKNOWLEDGEMENTS 31

BACKGROUND

Objectives

1. To determine the extent of appeals and overturns of Medicare Advantage service and payment denials at each level of the appeals process during 2014–16.
2. To assess the Centers for Medicare & Medicaid Services' (CMS's) 2015 audit findings and enforcement actions related to denials and appeals.

A central concern about the capitated payment model used in Medicare Advantage (also known as Medicare Part C) is the potential incentive for insurers to inappropriately deny access to services and payment in an attempt to increase their profits. Under the capitated payment model, beneficiaries enroll in a managed care plan and Medicare pays the insurer (called a Medicare Advantage Organization, or MAO) a risk-adjusted payment each month for as long as the beneficiary is enrolled. In exchange for the monthly payment, the MAO agrees to authorize, and pay for, all medically necessary care for the beneficiary that falls within Medicare's benefits package.[1] MAOs that inappropriately deny the authorization of services for beneficiaries, or payments to healthcare providers who care for beneficiaries, may not only contribute to physical or financial harm, but they also misuse Medicare Program dollars that CMS pays for beneficiary healthcare. Because Medicare Advantage covers so many beneficiaries (more than 20 million in 2018),[2] even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers.

Medicare Advantage Appeals Process

Under managed care, MAOs need to balance managing healthcare costs and utilization while ensuring beneficiary access to quality care. MAOs must make millions of decisions each year about which requests for healthcare services and payment meet Medicare coverage criteria and, therefore,

[1] At a minimum, MAOs must cover the same services as in fee-for-service Medicare, although they may offer supplemental benefits. 42 CFR §§ 422.101(a) and (b); 422.102. MAOs are not responsible for paying hospice care costs for their beneficiaries—these costs are paid by Medicare fee-for-service.

[2] CMS, Medicare Part C Contract and Enrollment Data, *Monthly Contract and Enrollment Summary Report*, June 2018.

should be authorized and paid for.[3] The MAOs that we examined for this report collectively received 448 million requests in 2016: 24 million preauthorization requests for services that beneficiaries had not yet received, and 424 million payment requests for services already provided to beneficiaries. Although they approved the vast majority of these requests, the MAOs denied about 1 million preauthorization requests and 36 million payment requests, for denial rates of 4 percent and 8 percent, respectively.[4]

When beneficiaries or providers receive a notice that their request has been denied, they have the right to file an appeal to request that the denial be overturned.[5] Beneficiaries may submit the appeal themselves, or a designated representative may submit the appeal on their behalf. Although there are resources available to help beneficiaries navigate the appeals process, advocacy groups report that the process is often confusing and overwhelming for beneficiaries, particularly those struggling with critical medical issues.[6]

The Medicare Advantage appeals process includes four levels of administrative review by several entities. At the first level, most appeals are reviewed by the MAO that issued the denial, while appeals for certain types of services are independently reviewed by Quality Improvement Organizations. When appeals continue to the higher levels, they are reviewed by the Independent Review Entity, administrative law judges, and finally, the Medicare Appeals Council. Exhibit 1 on page 3 shows an overview of the Medicare Advantage appeals process. See appendix A for a detailed description of the process and the entities involved.

At each level of appeal, the denial may be overturned, partially overturned, or upheld. If the denial is overturned, then the MAO must authorize or pay for the service. If the denial is not fully overturned—either upheld or only partially overturned—the beneficiary or provider may appeal the decision to the next higher level.

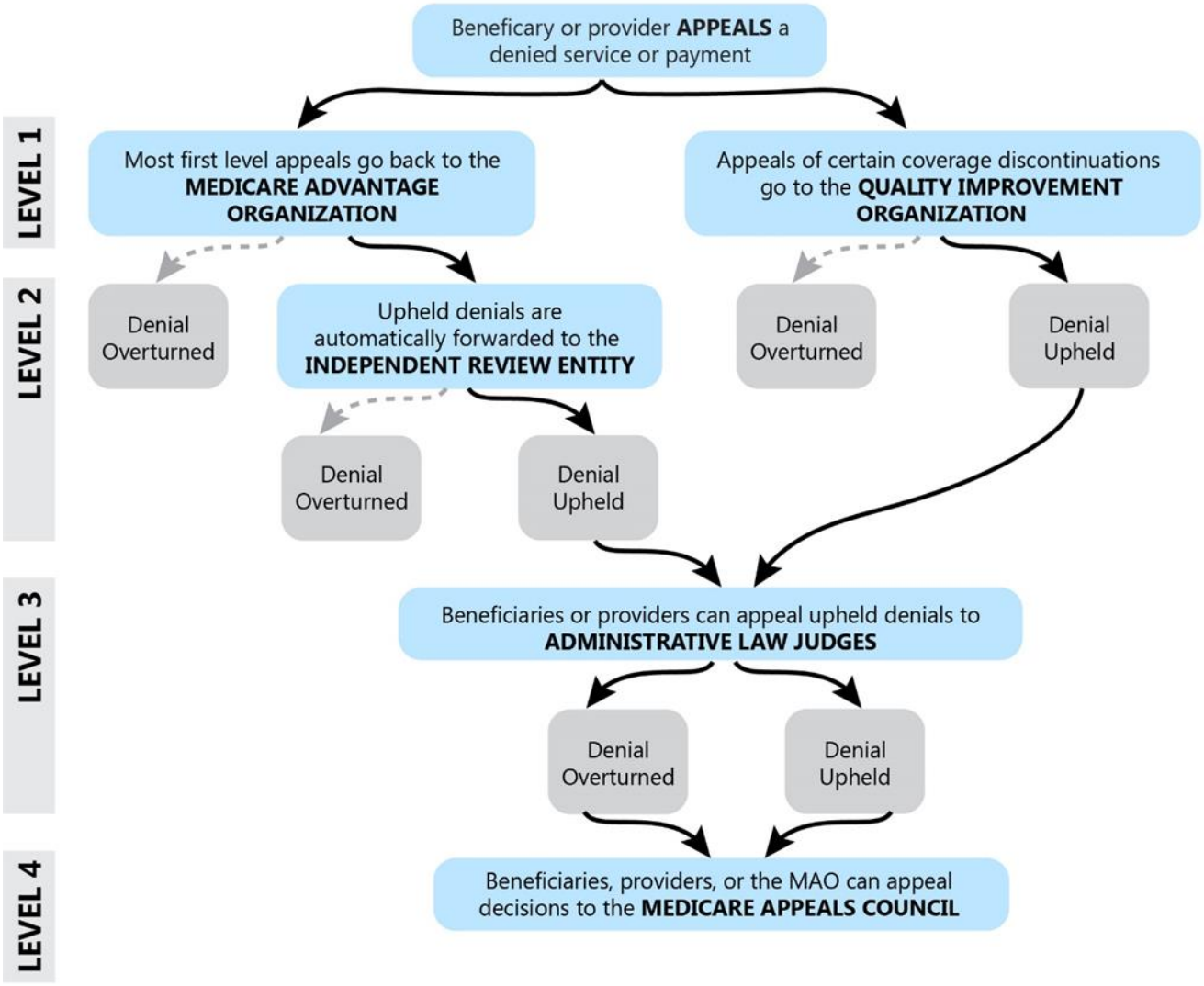
[3] MAOs may require that certain services receive approval before they are provided (called preauthorization).

[4] The numbers in this paragraph are based on our analysis of Medicare Advantage data for the 422 contracts that reported validated data for calendar year 2016. It does not include requests or denials processed by the 86 contracts whose data did not meet CMS's validation standards. See the methodology section for more information about our analysis and CMS's data validation process.

[5] MAOs review and resolve appeals from in-network and out-of-network providers through separate processes. Appeals from in-network providers are considered contractual disputes that are handled by the MAO directly and cannot be appealed to the higher levels of review. Appeals from out-of-network providers go through the same appeals process as beneficiary appeals.

[6] Medicare Rights Center, *2017 Transformation Ideas for the Medicare Advantage (MA) and Part D programs*, April 24, 2017. Kaiser Family Foundation, *Medical Debt among People with Health Insurance*, January 2014. Office of Inspector General (OIG) interview with the Center for Medicare Advocacy, 2016.

Exhibit 1: Beneficiaries and providers can appeal Medicare Advantage denials to multiple levels of review within the Department of Health and Human Services.



Source: OIG analysis of the Medicare Advantage appeals process, 2018

CMS Oversight of Denials and Appeals

CMS uses several tools to oversee the denial and appeal process in Medicare Advantage and to incentivize MAOs to improve their performance. These tools include program audits, compliance and enforcement actions, and quality ratings. CMS also assigns an account manager and lead caseworker for each MAO contract.[7] Among other duties, account managers monitor complaints from beneficiaries and work with MAOs to promote compliance with Medicare Program requirements.

[7] MAOs may enter into one or more contracts with CMS, and each contract may include multiple plans.

Program audits. Each year, CMS audits a sample of MAOs.[8] During the audits, CMS evaluates MAOs' compliance with requirements related to delivery of services and other beneficiary protections required by Medicare. CMS requires MAOs to implement corrective action plans to address any audit violations and to demonstrate that they have substantially corrected deficiencies before the audit is officially closed.

Enforcement actions. When CMS identifies noncompliance related to an MAO's healthcare delivery, it may take enforcement actions against the MAO.[9] Such actions may include issuing civil money penalties, imposing intermediate sanctions (i.e., suspension of marketing, enrollment, or payment), or terminating a contract.

Quality ratings. Every year, CMS publishes a quality rating, called a Star Rating, for each MAO contract. CMS bases the ratings on various quality measures related to MAOs' processes and patient health outcomes, experiences, and access to care. Star Ratings can affect MAOs' revenues—CMS awards bonus payments for high Star Ratings, while low Star Ratings may reduce MAO rebate payments and may deter beneficiaries from enrolling with an MAO.

Related Work

A previous OIG study examined the rates of denial, appeal, and appeal outcomes for Medicare Advantage preauthorization requests filed in 2007.[10] It also examined CMS audit findings from 2007 and 2008. OIG found that, at the time, beneficiaries appealed very few denials and that, upon appeal, MAOs overturned their own denial decisions more than half the time. The report did not contain recommendations. Over the last decade, the number of beneficiaries enrolled in Medicare Advantage has increased dramatically from 8 million in 2007 to 21 million in 2018. In light of the increase in the number of beneficiaries participating in Medicare Advantage, this report revisits similar issues.

In a more recent report, OIG examined CMS's validation and use of MAO performance data, which CMS collects annually.[11] Among other things, the annual performance data includes the volume of denials, appeals, and appeal outcomes (including overturned denials) that each MAO contract issued during the previous year. OIG recommended that CMS take steps to

[8] CMS selects the sample of MAOs based on several factors, including a yearly risk assessment, significant changes in enrollment, and whether the MAO has been recently audited. CMS, *2016 Part C and Part D Program Audit and Enforcement Report*, p. 5.
[9] 42 CFR § 422.752.
[10] OIG, *Beneficiary Appeals in Medicare Advantage* (OEI-01-08-00280), October 2009. Although the report was published in 2009, it analyzed data from October 1 to December 31, 2007.
[11] OIG, *CMS Regularly Reviews Part C Reporting Requirements Data, But Its Followup and Use of the Data Are Limited* (OEI-03-11-00720), March 2014.

ensure the accuracy of the data, make better use of the data in its oversight of MAO performance, and publicly release the data. As of October 2017, CMS had implemented one of OIG's three recommendations—to publicly release the data.

Methodology

To meet the objectives of this study, we analyzed data and documentation from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board. To ensure our understanding of the submitted data and documentation, we followed up in writing with officials knowledgeable about the program. This section provides a brief overview of the methodology. See appendix B for a detailed methodology.

Determining Volumes and Rates of Appeals and Overturned Denials During 2014–16

To determine the volumes and calculate the rates of appeals and denials overturned upon appeal at the MAO level, we analyzed annual performance data that MAOs reported to CMS for each of their contracts for 2014–16. We were unable to include in our analysis contracts that did not meet CMS's data validation standards in any one of the fields that we used in our calculations in a given year. Using the annual performance data for contracts that met CMS's data validation standards, we determined the total number of appealed denials that MAOs fully and partially overturned during the 3 years. To calculate the denial overturn rate, we divided the total number of overturned and partially overturned appealed denials by the total number of overturned, partially overturned, and upheld appealed denials. To calculate the national first-level appeal rate for the contracts with validated data, we divided the number of appeals received by the MAOs and the Quality Improvement Organization by the number of denials issued by those contracts during the 3 years. Using the 2016 performance data, we calculated contract-specific appeal and overturned denial rates.

To determine the volumes and calculate the rates of appeals and denials overturned upon appeal during 2014–16 for the independent reviewers, we analyzed Quality Improvement Organization and Independent Review Entity data from CMS, administrative law judge data from the Office of Medicare Hearings and Appeals, and Medicare Appeals Council data from the Departmental Appeals Board. To calculate the volume of denials overturned by each reviewer during 2014–16, we added the number of overturned denials to the number of partially overturned denials. To calculate the denial overturn rates for each reviewer, we divided the total number of overturned and partially overturned appealed denials by the total number of overturned, partially overturned, and upheld appealed denials.

Assessing CMS's 2015 Audit Findings and Enforcement Actions

To determine the number of contracts that CMS cited for each type of violation, we analyzed the final audit reports that CMS issued to MAOs that were audited for Part C Organization Determinations, Appeals, and Grievances during 2015. We reviewed the reports for the 19 audited MAOs that collectively administered 140 contracts.

To determine the amount of civil money penalties that were issued in response to the 2015 Medicare Advantage audit findings, and to examine the reasons for the penalties, we reviewed agency documentation for the nine MAOs that received a penalty. To describe the violations that led to sanctions for two MAOs, we reviewed the Notices of Imposition of Immediate Intermediate Sanctions that CMS issued to the MAOs. To examine the impact of the civil money penalties and sanctions on MAOs' Star Ratings, we reviewed Star Ratings data from 2016 to 2018 and requested clarifications from CMS about their process.

Limitations

For this study, we examined aggregate MAO data on denials, appeals, and appealed denials that were overturned. We did not conduct a medical record review to determine whether denials were appropriate according to medical or Medicare coverage standards. Because CMS does not require MAOs to report denials or appeals data by appellant type, we were unable to examine denial, appeal, or appeal overturn rates for in-network versus out-of-network providers. Additionally, because not all MAO contracts' data met CMS's data validation standards, we were unable to include some MAO contracts in our analysis of appeals and overturned denials at the MAO level. Therefore, the number of MAO denials overturned upon appeal presented in this report likely under-represents the actual number of overturned denials in the Medicare Advantage program.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

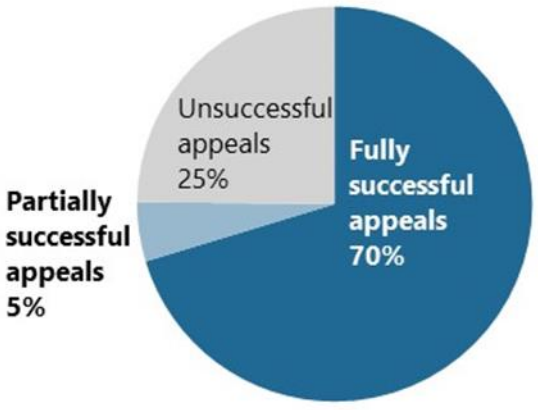
FINDINGS

High overturn rates of appealed denials, and widespread and persistent CMS audit findings about inappropriate denials, raise concerns that some Medicare Advantage beneficiaries and providers were denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers rarely used the appeals process designed to ensure access to care and payment, appealing only 1 percent of denials during 2014–16. Although CMS takes a variety of compliance and enforcement actions against MAOs when it identifies problems, more action is needed to address these critical issues.

When Medicare Advantage beneficiaries and providers appealed, they were usually successful in getting denials overturned

When beneficiaries and providers appealed denials for preauthorization or payment requests, they were usually successful in getting the denials overturned. During 2014–16, beneficiaries and providers appealed more than 863,000 denials to their MAOs.[12] Among the first-level appeals in this 3-year period, beneficiaries and providers were fully or partially successful in about 649,000 cases, getting approximately 216,000 denials overturned per year. The total number of overturned denials was even higher, as independent reviewers overturned additional denials in favor of beneficiaries and providers when they continued to appeal upheld denials to the higher levels of review.

Exhibit 2: During 2014–16, 75 percent of beneficiary and provider appeals to their MAOs were fully or partially successful.



Source: OIG analysis of 2014–16 MAO annual performance data, 2018.

MAOs overturned more than a half million preauthorization and payment denials at the first level of appeal

For the contracts we reviewed for 2014–16, beneficiaries and providers filed about 607,000 appeals for which denials were fully overturned and 42,000 appeals for which denials were partially overturned at the first level of appeal. This represents a 75 percent success rate (see exhibit 2). Most of these overturned denials (82 percent) were for payment to providers for services that the beneficiary already received.[13] The remaining overturned denials (18 percent) were for the preauthorization of services that the beneficiary had not yet received. See appendix C for the volumes and rates of MAO appeal outcomes by year.

[12] The appeal numbers on this page are rounded to the nearest thousand.

[13] Among all initial requests filed with MAOs during 2014–16, about 94 percent were requests for payment and 6 percent were for preauthorization of services.

An MAO may overturn its initial denial upon appeal for several reasons. In some cases, the MAO may determine that its original decision was incorrect, and therefore overturn the denial. In other cases, the MAO may determine that it made the correct initial denial decision based on the information available at the time, but find that the provider or beneficiary added new information in an appeal that demonstrates the denial should be overturned. For example, some MAOs do not pay for care provided out of network unless the beneficiary was referred by an in-network provider. In those cases, the MAO may deny the initial request if it did not include documentation of the referral, but then overturn the denial upon appeal after it receives additional documentation.

Although overturned denials do not necessarily mean that MAOs inappropriately denied the initial request, each overturned denial represents a case in which beneficiaries or providers had to file an appeal to receive services or payment that are covered by Medicare. This extra step creates friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. This may be especially burdensome for beneficiaries with urgent health conditions.[14] Further, although overturned payment denials do not affect access to services for the associated beneficiaries, the denials may impact future access. Providers may be discouraged from ordering services that are frequently denied—even when medically necessary—to avoid the appeals process.

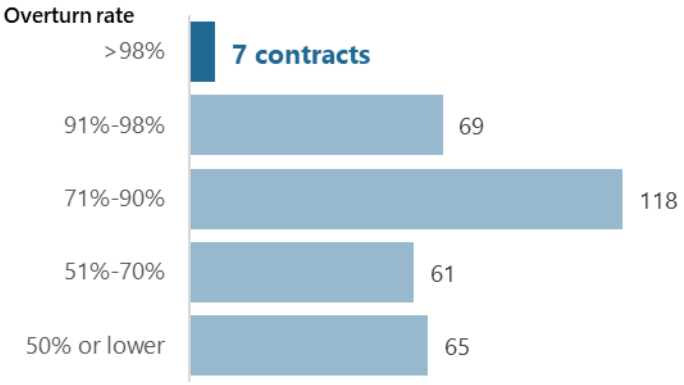
In 2016, MAO contract-specific overturn rates varied widely, ranging from 0 to 100 percent, with a median of 77 percent (see exhibit 3 on page 9).[15] On the high end, 76 MAO contracts overturned more than 90 percent of their own denials upon appeal, including 7 contracts that overturned more than 98 percent. Although data analysis alone is not sufficient to determine the reasons for this variation, extremely high overturn rates may indicate differences in MAO behavior and performance.

[14] Beneficiaries and providers may request an expedited review of appeals for urgently needed services. The required timeframes for MAOs to process appeals range from 72 hours to 60 days depending on whether the request is expedited or standard and whether it is for preauthorization or payment. 42 CFR § 422.590.

[15] We calculated the range and median of contract-specific appealed denial overturn rates for the 320 MAO contracts that reported validated data in 2016 and received at least 50 appeals.

Exhibit 3: MAO contracts' overturn rates varied widely in 2016.

Seven contracts overturned more than 98 percent of denials upon appeal.

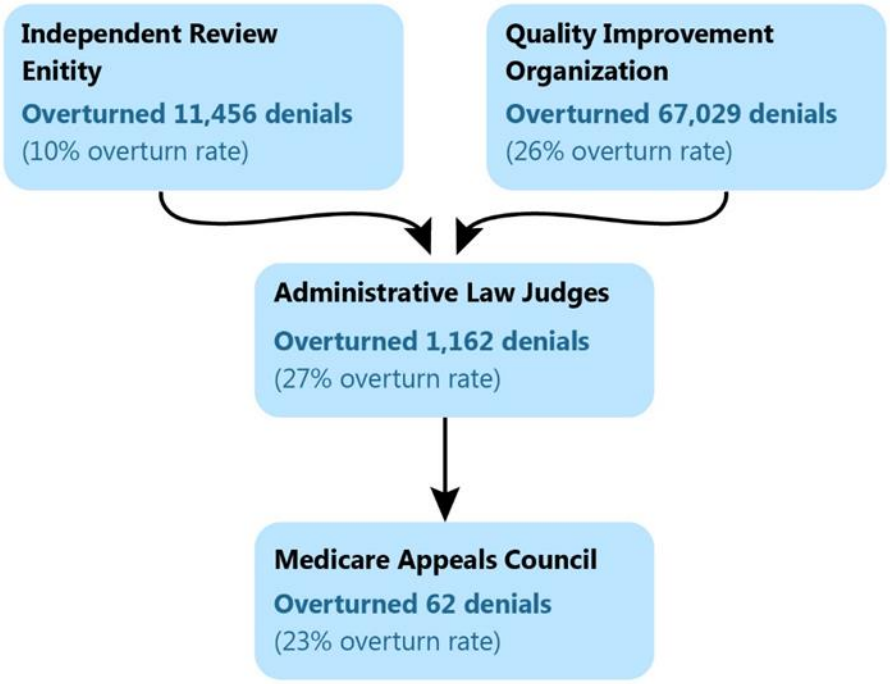


Source: OIG analysis of 2016 Medicare Advantage annual performance data for contracts that received at least 50 appeals, 2018.

Independent reviewers overturned additional denials in favor of beneficiaries and providers at four levels of appeal

During 2014–16, independent reviewers overturned an additional 80,000 denials in favor of beneficiaries and providers, or approximately 27,000 per year (see exhibit 4). There are two ways that appeals can get

Exhibit 4: During 2014–16, independent reviewers overturned nearly 80,000 denials in favor of beneficiaries and providers.



Source: OIG analysis of 2014–16 appeals data from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board, 2018.

routed to independent reviewers: some first-level appeals are reviewed by Quality Improvement Organizations rather than by MAOs,[16] and some first-level appeals that MAOs uphold are automatically forwarded to the Independent Review Entity for second-level review. If beneficiaries or providers decide to continue appealing to the higher levels of administrative review, the cases then go to administrative law judges and, finally, the Medicare Appeals Council. These independent reviewers overturned between 10 and 27 percent of the appealed denials that they reviewed. See appendix D for the volumes and rates of overturned denials for each of the independent reviewers by year.

Medicare Advantage beneficiaries and providers rarely used the appeals process designed to ensure access to services and payment

High rates of overturned denials upon appeal are especially concerning because beneficiaries and providers appealed relatively few of the total number of denials issued each year. The appeals process is one of the safeguards against inappropriate denials in Medicare Advantage and gives beneficiaries and providers the ability to appeal denials that they believe should be overturned. However, patient advocates have raised concerns that the appeals process can be confusing and overwhelming, particularly for critically ill beneficiaries. This may be one reason why beneficiaries and providers appealed only 1 percent of denials to the first level of appeal—reconsideration by their MAO or the Quality Improvement Organization—during 2014–16.[17] (See appendix E for the volume and rate of first-level appeals by year.) When beneficiaries and providers chose not to appeal denials, the beneficiary may have gone without the requested service, the beneficiary may have paid for the service out of pocket, or the provider may not have been paid for the service.[18]

In 2016, contract-specific appeal rates varied widely, ranging from 0 to 40.5 percent, with a median of 0.9 percent.[19] On the low end, 18 contracts had appeal rates lower than 0.1 percent. Those 18 contracts denied a combined 2.4 million preauthorization or payment requests in 2016, yet received only 1,838 appeals. Although data analysis alone is not sufficient to determine the reasons for variation in appeal rates, extremely low appeal rates may indicate differences in MAO behavior and performance, or

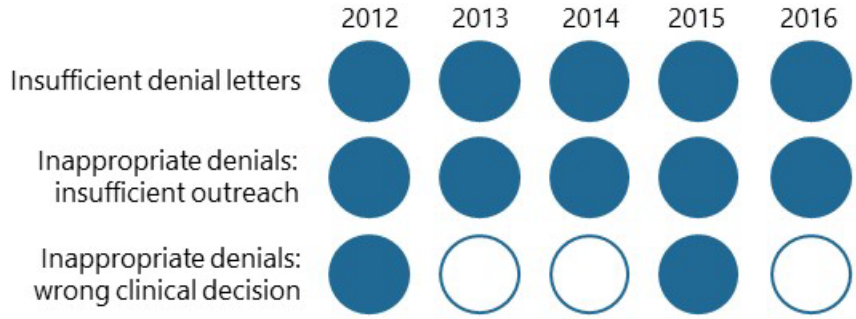
[16] Quality Improvement Organizations review and determine the outcome of appeals related to discharge and discontinuation notices from inpatient acute care, comprehensive outpatient rehab, home health, or skilled nursing facilities.
[17] During 2014–16, among the contracts in our review, beneficiaries and providers appealed 1.1 million out of the 101.1 million denials made by MAOs for a 1.1 percent appeal rate.
[18] In-network providers typically cannot bill beneficiaries when an MAO denies a payment request, but out-of-network providers can. However, if an out-of-network provider appeals the payment denial, they must agree to waive their right to bill the beneficiary.
[19] We calculated the range and median of contract-specific appeal rates for the 417 MAO contracts that reported validated data in 2016 and issued at least 50 denials.

differences in communication with beneficiaries and providers about the appeals process.

CMS audits found widespread and persistent problems related to denials of care and payment in Medicare Advantage

Despite CMS efforts to educate MAOs about persistent problems in Medicare Advantage, each year during its audits of different MAOs, CMS finds many of the same violations as in previous years. Among these violations, CMS audits have identified persistent problems related to denials of care and payment. Exhibit 5 shows three types of audit violations related to denials and the number of times they were among the five most common audit violations that CMS cited each year during 2012–16.[20] In 2015, the year we examined, of the 140 MAO contracts that CMS audited, it cited 56 percent for inappropriately denying requests and 45 percent for sending insufficient denial letters.

Exhibit 5: Violations related to denials were among the most common audit violations each year during 2012–16.



Note: solid circles indicate that the audit violation was among the five most common violations in that year.

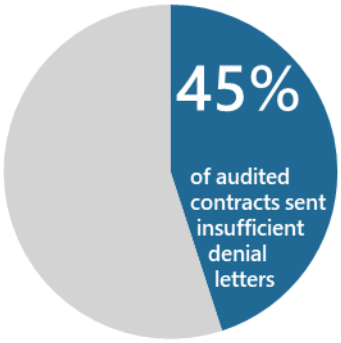
Source: CMS's 2012-16 Part C and Part D program audit and enforcement reports, 2018.

CMS cited more than half of audited MAO contracts for inappropriately denying requests for services or payment

In 2015, CMS cited 79 of the 140 audited MAO contracts (56 percent) for two types of violations related to inappropriately denying requests for preauthorization of services and/or payment. CMS cited some contracts for making the wrong clinical decision based on the information submitted by the provider or beneficiary. CMS also cited contracts for not conducting appropriate outreach before making clinical decisions, meaning that the MAO did not have all of the information needed to make a decision and did not take appropriate steps to gather information from the provider or

[20] Exhibit 5 presents the number of times that three types of audit violations were among the five most common for the Organization Determinations, Appeals, and Grievances audit program area, which is one of five program areas that CMS audits in Medicare Parts C and D.

beneficiary.[21] Failure by an MAO to make correct clinical decisions based on the information that it has, or failure to reach out to providers and beneficiaries for more information when needed, can result in beneficiary harm, financial hardship for beneficiaries and/or providers, and unnecessary use of the appeals process.



CMS cited nearly half of audited MAO contracts for sending incorrect or incomplete denial letters, which may inhibit beneficiaries' and providers' ability to appeal

In 2015, CMS cited 63 of the 140 audited MAO contracts (45 percent) for sending denial letters that did not contain important required information. MAOs must issue denial letters that clearly explain why requests were denied and how the beneficiary or provider can file an appeal. However, CMS found that some MAO denial letters did not clearly explain why a request was denied, contained incorrect or incomplete information, did not use approved language, and/or were written in a manner not easily understandable to beneficiaries. Failure to issue sufficient denial letters can impair a beneficiary's or provider's ability to mount a successful appeal and can result in delayed access to care, and/or financial hardship. Insufficient denial letters may be one reason that the appeal rate is so low in Medicare Advantage, especially when these letters go to beneficiaries who may be overwhelmed with medical issues or out-of-network providers who may be unfamiliar with the MAO's appeals process.

CMS has taken action to try to address MAO performance problems

When CMS identifies that an MAO has performance problems, it uses several compliance and enforcement tools to address the problems. As part of these efforts, CMS requires every MAO cited for an audit violation to develop and implement a corrective action plan. CMS does not officially close audits until MAOs demonstrate that violations are substantially corrected. CMS may also impose enforcement actions on MAOs that significantly fail to comply with program requirements. CMS has continued to make changes to its compliance and enforcement actions. Since 2014, CMS has fined MAOs additional penalty amounts for "aggravating factors" such as a history of prior offense, or if a violation had been previously identified in public audit reports as a common problem. For the 2017 audits, CMS raised the maximum possible penalty for a single violation for MAOs with more than 500,000 beneficiaries enrolled in their contracts.[22]

[21] Of the 79 contracts, 12 were cited for making the wrong clinical decision, 21 for not conducting appropriate outreach, and 46 for both violations.

[22] CMS, Medicare Parts C and D Oversight and Enforcement Group, *Civil Money Penalty Methodology*, December 15, 2016.

CMS suspended new enrollment for two MAOs because of serious threats to the health and safety of their beneficiaries; one of the MAOs had a longstanding history of noncompliance

After the 2015 audits, CMS imposed intermediate sanctions against two MAOs for violations that it deemed so systemic and harmful to beneficiaries that the MAOs should not market to or enroll any new beneficiaries until the problems were corrected.[23] CMS may impose sanctions when it identifies a "substantial failure" to comply with CMS requirements to provide medically necessary services, and it is the most serious enforcement action before contract termination.[24] CMS stated that the conduct of the MAOs, with a combined 22 contracts and nearly a half million beneficiaries, posed a "serious threat" to the health and safety of Medicare beneficiaries. Among other problems, CMS stated that MAO violations led to inappropriate delay and denial of services and increased out-of-pocket costs for beneficiaries.[25] CMS noted that one of the MAOs had a longstanding history of not meeting program requirements. In the several years leading up to the audit, CMS issued numerous notices of noncompliance, warning letters, and corrective action plans to the MAO. A number of the notices were for the same violations discovered during the audit, indicating that the MAO had not made changes to address the violations.

CMS fined nine MAOs a total of $1.9 million for violations related to denials and appeals; CMS had previously identified some of the violations as common problems

After the 2015 audits, CMS issued $1.9 million in civil money penalties to nine MAOs for violations related to processing requests for services and payment, appeals, and grievances.[26] CMS determined that these violations may have led to unnecessary delay or denial of services for beneficiaries, financial harm to beneficiaries, or preventing beneficiaries and providers from appealing.

CMS determines penalty amounts for each violation using a formula that takes into account the number of beneficiaries or contracts affected, and adjusts the amount for any aggravating or mitigating factors related to the violation.[27] For example, CMS fined one MAO $314,100 for inappropriately

[23] The sanctions for the two MAOs remained in place for 7–17 months until the MAOs submitted the results of an independent audit demonstrating that the violations were corrected.

[24] See 42 CFR § 422.752(a)(1).

[25] CMS also cited these MAOs for violations related to their delivery of the Medicare prescription drug benefit (Medicare Part D).

[26] This total does not include penalties issued to these MAOs for any Part D violations identified during the 2015 audits.

[27] CMS, Medicare Parts C and D Oversight and Enforcement Group, *Civil Money Penalty Methodology,* December 15, 2016.

denying 2,094 payment requests. CMS noted that because the MAO issued these inappropriate payment denials to out-of-network providers, the providers may have billed the beneficiaries for services that should have been paid by the MAO. Five MAOs each had one violation that CMS had previously warned MAOs about in its public audit reports, and so received an "aggravating factor" penalty for not correcting the problem. Including these added penalties, total civil money penalties for Medicare Advantage audit violations for the nine MAOs ranged from $3,300 to $1 million each.[28]

MAO audit violations will no longer affect their contracts' quality ratings

Although Medicare Advantage program audits are one of CMS's most direct methods for oversight of MAOs, at the time of our review, they had only a minimal and delayed impact on MAO quality ratings, called Star Ratings. Additionally, beginning in 2019, audit violations will no longer directly impact MAO Star Ratings. CMS posts MAOs' Star Ratings on the Medicare Plan Finder website, which allows beneficiaries to evaluate differences in MAO performance when deciding which plan to enroll in. Star Ratings are also intended to incentivize good MAO performance—MAOs that receive high Star Ratings receive bonus payments and higher rebates from CMS and may increase the number of beneficiaries enrolled in their plans. The lack of a strong relationship between performance problems revealed by CMS audits and MAO Star Ratings may diminish the usefulness of the Star Ratings system as a tool for beneficiaries to compare MAOs and a tool to incentivize good MAO performance.

At the time of our review, audit violations had only a minimal and delayed impact on Star Ratings

The 2015 MAO audit violations discussed in this report had very little, if any, impact on their contracts' 2017 and 2018 Star Ratings.[29] MAOs that received civil money penalties or sanctions following the 2015 audits also received a deduction on the Beneficiary Access and Performance Problems measure that fed into the Star Ratings for each of their contracts.[30] The measure was worth only about 3 percent of the Medicare Advantage (Part C) summary Star Rating, so even MAOs that received the maximum deduction were unlikely to see a change in their contracts' Star Ratings.

Another weakness of the Star Ratings deductions was a significant delay between when CMS discovered violations during an audit and any change in the Star Ratings (see exhibit 6 on page 15). Because there was not an

[28] The amounts of the nine MAO civil money penalties for Part C violations found during the 2015 audits, from lowest to highest, were $3,300, $15,000, $22,400, $30,000, $120,950, $125,450, $258,550, $329,350, and $1,000,000.

[29] Of the 11 MAOs that received an enforcement action following the 2015 audits, 3 received a deduction on their 2017 Star Ratings and 8 received a deduction on their 2018 Star Ratings.

[30] At the time, the Beneficiary Access and Performance Problems measure was 1 of 34 quality measures that made up the Medicare Advantage (Part C) summary Star Rating.

immediate impact on MAOs' Star Ratings, by the time the Star Ratings deductions went into effect, one-third of the contracts operated by MAOs that received an enforcement action because of 2015 audit results were no longer operational. Therefore, these contracts never received a Star Ratings deduction in response to the audit violations.

Exhibit 6: MAO violations discovered during program audits did not impact their Star Ratings until an average of 2 years later.

Example timelime for an audit conducted in September 2015:

Source: OIG analysis of CMS audit reports and enforcement action letters for the 2015 audits, and 2016–2017 Star Ratings releases, 2018.

Beginning in 2019, audit violations will no longer directly impact MAOs' Star Ratings

CMS will remove the direct link between audit results and Star Ratings beginning in 2019. CMS stated that it received mixed reactions to the removal of the Beneficiary Access and Performance Problem measure from the Star Ratings.[31] Beneficiary advocates strongly opposed the removal of the measure, stating that it will mask MAO behaviors that could pose a serious threat to the health and safety of beneficiaries. On the other hand, most MAOs supported the removal of the measure, in part because CMS does not have audit information for each contract each year.

Instead of having audits directly impact Star Ratings, CMS added an indicator on the Medicare Plan Finder website to alert beneficiaries if contracts are under sanction. The indicator links to the MAO's sanction notice, which outlines the violations that CMS identified. Contracts under sanction are also unable to enroll new beneficiaries. However, other performance problems revealed by CMS audits will not be reflected in the Star Rating of an MAO, which diminishes the usefulness of the Star Ratings system as a tool for beneficiaries to compare MAO performance.

The lack of a strong link between audit results and Star Ratings also means that MAOs that receive serious enforcement actions (including sanctions)

[31] CMS, *Announcement of Calendar Year (CY) 2019 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter,* p. 127, April 2, 2018.

can still receive high Star Ratings—and quality bonus payments—in the same year. Of the 22 contracts that were sanctioned in 2016 for 2015 audit violations, 6 contracts received overall Star Ratings of 4 or higher for 2016.

CONCLUSION AND RECOMMENDATIONS

MAOs may have an incentive to deny preauthorization of services for beneficiaries, and payments to providers, in order to increase profits. High overturn rates when beneficiaries and providers appeal denials, and CMS audit findings about inappropriate denials, raise concerns that some beneficiaries and providers may not be getting services and payment that MAOs are required to provide. These findings are particularly concerning because beneficiaries and providers rarely use the appeals process designed to ensure access to care and payment, and CMS has repeatedly cited MAOs for issuing incorrect or incomplete denials letters, which can impair a beneficiary's or provider's ability to mount a successful appeal. Additionally, because audit violations will no longer be reflected in Star Ratings, beneficiaries may be unaware of MAO performance problems when selecting a plan. Although CMS uses several compliance and enforcement tools to address MAO performance problems, more action is needed to address these widespread and persistent problems in Medicare Advantage.

We recommend that CMS:

Enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate

Given the persistent audit findings related to inappropriate denials and insufficient denial letters, CMS should conduct additional oversight of MAOs, including those with extremely high overturn rates or extremely low appeal rates. This report identified such MAO contracts for 2016, which we will provide to CMS in a separate memorandum. CMS should conduct a similar analysis for the 2017 annual performance data to identify additional MAOs that warrant enhanced oversight. In addition, CMS may want to analyze the annual performance data to identify other indicators of potential problems that go beyond this analysis, such as high denial rates or low rates of preauthorization requests.

Because there may be many reasons why these MAOs had extreme rates, CMS should engage with the MAOs to determine whether they are meeting program requirements and take corrective action as appropriate. Engagement could include having account managers meet with MAOs to determine why they had extreme rates, conducting a small probe review of denial or appeal cases, or other steps to determine the root causes of the rates. If through these efforts CMS identifies that an MAO is not meeting program requirements, it should take appropriate corrective action to improve compliance. These actions could include providing technical assistance, ongoing monitoring, or conducting additional audits. If this

analysis and enhanced oversight achieves positive results, CMS should continue it in future years.

Address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage

CMS audit results demonstrate that there are persistent problems related to denials of care and payment in Medicare Advantage, including (1) insufficient denial letters issued to beneficiaries and providers, (2) insufficient outreach before issuing denials, and (3) incorrect clinical decisions. Although CMS takes steps to address individual poor-performing MAOs, CMS should take program-level action to address these persistent problems. Actions could include a combination of technical assistance, training, education, and increased monitoring or enforcement actions for MAOs that exhibit these persistent problems. For example, CMS could apply additional aggravating factors to civil money penalties for these violations on top of the existing factors. CMS also could require individual MAOs with repeated violations to hire independent auditors to perform program audits more frequently than CMS is able to.

Provide beneficiaries with clear, easily accessible information about serious violations by MAOs

Because audit results no longer impact Star Ratings, CMS should develop another method for informing beneficiaries of serious violations identified by audits, including those that lead to civil money penalties. This information should be clear, meaningful, and easily accessible to beneficiaries in places where beneficiaries typically access information, such as on the Medicare Plan Finder website. CMS already includes information about MAO sanctions on the Medicare Plan Finder website, and could expand this effort to include civil money penalties, as it proposed in the 2019 draft call letter.[32] CMS could also consider including information about audit violations in addition to enforcement actions.

CMS could also revisit policy options for adjusting Star Ratings in response to audits and enforcement actions, such as adding a new Star Ratings measure that takes enforcement actions into account, or by directly adjusting an MAO's overall and summary Star Ratings in response to enforcement actions. This would help to ensure that Star Ratings serve as a "one-stop shop" for beneficiaries to evaluate differences in performance among MAOs.

[32] CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter*, February 1, 2018.

CMS COMMENTS AND OIG RESPONSE

In response to the draft report, CMS stated that it is strongly committed to oversight and enforcement of the Medicare Advantage program and it concurred with all three recommendations.

CMS concurred with the first recommendation to enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate. Although CMS noted that its current oversight and audit process already applies many of the oversight elements that we mentioned, it did not indicate how it planned to enhance oversight of MAOs with extremely high overturn rates or extremely low appeal rates.

CMS also concurred with the second recommendation to address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage. CMS noted that its audit process addresses individual poor-performing MAOs, but it did not indicate the actions that it plans at the program-level to address these persistent problems.

Lastly, CMS concurred with the third recommendation to provide beneficiaries with clear, easily accessible information about serious violations by MAOs. CMS noted that it is testing options to provide beneficiaries with clear, meaningful, and accessible information on MAO performance that will help them make the best decisions about their care.

For the full text of CMS's comments, see appendix F.

APPENDIX A: Medicare Advantage Appeals Process

The Medicare Advantage appeals process includes four levels of administrative review by several entities. At each level of review, the denial may be overturned, partially overturned, or upheld. If the denial is overturned, then the MAO must authorize or pay for the service.[33] If the denial is not fully overturned—either upheld or partially overturned—the beneficiary or provider may appeal the decision to the next higher level of review.

First-level appeals: MAO and Quality Improvement Organization. For most first-level appeals, the MAO itself must reconsider its decision to deny authorization or payment for a service. The MAO must review the evidence that led to the original decision and any additional evidence the beneficiary or provider may submit as part of the appeal. MAOs maintain separate processes to review and resolve appeals from in-network and out-of-network providers. Appeals from in-network providers generally are considered contractual disputes that are handled by the MAO directly and cannot be appealed to the higher levels of administrative review. Appeals from out-of-network providers who formally waive their right to bill a beneficiary for the service under appeal may go through the same appeal process as beneficiaries. If the MAO upholds its denial for appeals filed by beneficiaries, in-network providers filing on behalf of a beneficiary, or out-of-network providers, it must forward the appeal to the Independent Review Entity for review.

Beneficiary and Family Centered Care Quality Improvement Organizations review first-level appeals of discharge from a hospital or the discontinuation of certain types of services.[34] These Quality Improvement Organizations work under the direction of CMS and are staffed by doctors and other healthcare professionals trained to review medical care and help beneficiaries with complaints about the quality of care. If the Quality Improvement Organization upholds the MAO's decision to discharge the beneficiary or to discontinue services, beneficiaries may request that the Quality Improvement Organization reconsider its decision. If the Quality

[33] MAOs may also appeal overturned denials at the third and fourth levels of appeal.
[34] Beneficiary and Family Centered Care Quality Improvement Organizations review and determine the outcome of appeals related to discharge and discontinuation notices from inpatient acute care, comprehensive outpatient rehab, home health, or skilled nursing facilities.

Improvement Organization upholds its decision again, the beneficiary may appeal to administrative law judges at the third level of appeal.[35]

Second-level appeals: Independent Review Entity. The Independent Review Entity reviews appealed denials that MAOs uphold to determine whether MAOs made the correct decision. The Independent Review Entity is a CMS contractor that employs physicians and other consultants to review the denials and determine whether MAOs complied with relevant Medicare requirements. If the Independent Review Entity upholds or partially overturns the MAO's denial, beneficiaries and providers may choose to appeal to the next level.

Third-level appeals: administrative law judge. Administrative law judges, within the Office of Medicare Hearings and Appeals, review appeals of Independent Review Entity or Quality Improvement Organization decisions.[36] If the beneficiary, provider, or MAO is dissatisfied with the decision of the administrative law judge, they may choose to appeal to the next level.

Fourth-level appeals: Medicare Appeals Council. The Medicare Appeals Council, within the Departmental Appeals Board, reviews beneficiary, provider, and MAO appeals of decisions by an administrative law judge. The Council provides the last level of review within the Department of Health and Human Services' Medicare Advantage appeals process. If beneficiaries, providers, or MAOs are dissatisfied with the decision of the Council, they may appeal to Federal district court by filing a civil action.

[35] Under some circumstances, beneficiaries may appeal directly to administrative law judges when the Quality Improvement Organization upholds an MAO's decision. For additional details on Quality Improvement Organization appeals, see 42 CFR § 422.622 and CMS, *Medicare Managed Care Manual,* Chapter 13, sections 90.2 and 160.

[36] Beginning in March 2017, appeals at the third level of the administrative appeals process may be decided by an administrative law judge or, if a hearing is not necessary, by an attorney adjudicator. See 82 Fed. Reg. 4974, 4981-92 (2017).

APPENDIX B: Detailed Methodology

For this study, we analyzed data to examine (1) the volumes and rates of denied services and payments that were appealed and overturned at each level of review in Medicare Advantage during 2014–16, and (2) CMS's 2015 audit findings and enforcement actions related to denials and appeals in Medicare Advantage. To ensure our understanding of the submitted data and documentation, we followed up in writing with officials knowledgeable about the program.

Determining Volumes and Rates of Appeals and Overturned Denials During 2014–16

To determine the volumes and calculate the rates of appeals and overturned denials at each level of the Medicare Advantage appeals process for 2014–16, we analyzed data from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board.

MAOs. To calculate the volumes and rates of appeals and denials overturned upon appeal at the MAO level, we collected annual performance data from CMS for each MAO contract for 2014–16. CMS requires MAOs to report annual performance-related data for each contract that they administer.[37] Among other data, MAOs must report the numbers of determinations and their outcomes (i.e., the numbers of requests for preauthorization of services and payment that the MAO approved and denied) and the numbers of appeals and their outcomes.[38] These data go through two external reviews to verify the validity of the reported data.[39]

In the data sets that CMS provided to OIG, contract-specific data was missing from fields where the contract did not meet CMS's data validation standards. For example, some contracts passed data validation standards for the number of preauthorization denials overturned upon appeal, but not for the number of preauthorization denials upheld. This prevented us from calculating an overturn rate for those contracts. Therefore, we could not include in our analyses any contracts that had missing values in any fields that we used in our calculations in a given year. We analyzed data from a total of 581 contracts that submitted validated data in 1 or more of the 3 years. The numbers of contracts that were and were not included in our analysis for each year, and the numbers of beneficiaries associated with those contracts, are outlined in exhibit 7 on page 21. The contracts that we

[37] 42 CFR § 422.516(a).

[38] These data include requests and appeals received from in-network and out-of-network providers.

[39] For more information on CMS's data validation process, see CMS's *Part C and Part D data validation* website.

included in our analysis covered between 83 and 89 percent of beneficiaries each year.

Exhibit 7: OIG could not include between 86 and 106 contracts in each year of analysis because some of the data for those contracts did not meet CMS's validation standards.

Year	Contracts included in OIG analysis	Beneficiaries enrolled in contracts included in analysis	Contracts not included because of data validation issues	Beneficiaries enrolled in contracts not included in analysis
2014	409	12,612,173	106	1,992,547
2015	419	12,831,596	95	2,627,704
2016	422	15,083,075	86	1,825,944

Source: OIG analysis of 2014–16 Medicare Advantage annual performance data, 2018.

Using the annual performance data for contracts with validated data, we examined the outcomes of the 1.3 billion initial preauthorization and payment decisions and the 863,217 appeal decisions that MAOs issued during 2014–16. We calculated the total number of initial requests that MAOs denied during the 3 years. We also calculated the total number of appealed denials that MAOs fully and partially overturned during the 3 years. To calculate the overall overturn rate, we divided the total number of fully and partially overturned appealed denials by the total number of overturned, partially overturned, and upheld denials. See appendix C for the volumes and rates of MAO appeal outcomes by year.

Because first-level appeals are filed with either the MAO or the Quality Improvement Organization, to calculate the total number of first-level appeals and the overall appeal rate for the contracts with validated data, we analyzed appeals data from both sources. To calculate the total number of first-level appeals for contracts with validated data, we added the 863,217 first-level appeals filed with MAOs to the 257,852 appeals filed with the Quality Improvement Organization for those same contracts during 2014–16. To calculate the first-level appeal rate for the contracts in our analysis, we divided the total number of first-level appeals by the total number of denials issued by the contracts during 2014–16. This calculation did not include dismissed appeals because CMS did not require MAOs to report that data during 2014–15. See appendix E for the volume and rate of first-level appeals by year.

In the annual performance data, MAOs report the number of appeal decisions that they issued in each year, but not the dates the appeals were filed or denials were issued. Therefore, some of the appeal decisions made early in 2014 were likely for denials issued in 2013, which were not captured in our data. Similarly, some of the denials issued at the end of 2016 were likely not appealed until 2017, so those appeal decisions were also not captured in our data. We could not adjust the appeal rate based on when

denials were issued and appeals filed, so we calculated the first-level appeal rate by dividing the total number of appeal decisions issued during the 3 years by the number of denials issued during the same period.

To examine the contract-specific first-level appeal rates and the contract-specific MAO denial overturn rates, we analyzed the 2016 annual performance data for the 422 contracts that reported validated data. We calculated the ranges and medians and reviewed the distributions of the contract-specific rates. Because contract-specific rates can be skewed by low volumes, we did not include low-volume contracts in this analysis. For the contract-specific appeal rate, we analyzed data only for the 417 contracts that issued at least 50 denials. Similarly, for the contract-specific MAO overturn rate, we analyzed data only for the 320 contracts that received at least 50 MAO appeals.

Independent Reviewers. To calculate the volumes and rates of overturned denials for the independent reviewers, we collected data on appeals received by each entity during 2014–16 from CMS, the Office of Medicare Hearings and Appeals, or the Departmental Appeals Board. Because independent reviewers reported their own appeals data, we were able to examine higher level appeals for all MAO contracts, including contracts that we could not examine at the MAO-level because of data validation issues.

To calculate the volume of denials overturned by each reviewer during 2014–16, we added the number of overturned denials to the number of partially overturned denials. To calculate the denial overturn rates, we divided the number of overturned and partially overturned denials by the number of denials that were overturned, partially overturned, or upheld by the reviewer. We did not examine appeals for which the entity did not issue a decision based on the merits of the case, such as appeals that were dismissed, withdrawn, or still pending a decision. For appeals to the Medicare Appeals Council, we calculated the volumes and rates of overturned denials for cases filed by beneficiaries and providers only, and did not examine cases filed by MAOs. See appendix D for the volume and rate of overturned denials for each independent reviewer by year.

Assessing CMS's 2015 Audit Findings and Enforcement Actions

To determine the number of contracts that CMS cited for each type of violation, we analyzed the final audit reports that CMS issued to MAOs that were audited for Medicare Advantage Organization Determinations, Appeals, and Grievances during 2015. We reviewed the reports for the 19 audited MAOs that collectively administered 140 contracts.

To determine the amount of civil money penalties that were issued in response to the 2015 Medicare Advantage audit findings, and to examine the reasons for the penalties, we reviewed agency documentation for the nine MAOs that received a penalty. To describe the violations that led to

sanctions for two MAOs, we reviewed the Notices of Imposition of Immediate Intermediate Sanctions that CMS issued to the MAOs. To examine the impact of the civil money penalties and sanctions on MAOs' Star Ratings, we reviewed Star Ratings data from 2016 to 2018 and requested clarifications from CMS about their process.

APPENDIX C: Volumes and Rates of MAO Appeal Outcomes, 2014–16

	2014	2015	2016	Total
MAO contracts included in this analysis	**409**	**419**	**422**	**581***
Number of appeals filed with MAOs	277,098	279,824	306,295	863,217
Number of fully overturned denials	186,883	192,041	228,031	606,955
Number of partially overturned denials	20,495	18,858	2,594	41,947
Number of denials upheld	69,720	68,925	75,670	214,315
Rate of successful appeal (fully or partially overturned denials)	74.84%	75.37%	75.30%	75.17%
Rate of fully overturned denials	67.44%	68.63%	74.45%	70.31%
Rate of partially overturned denials	7.40%	6.74%	0.85%	4.86%
Rate of upheld denials	25.16%	24.63%	24.70%	24.83%

*This represents the total number of unique contracts included in our analyses.

Source: OIG analysis of 2014–16 annual performance data for contracts that reported validated data, 2018.

APPENDIX D: Volumes and Rates of Overturned Denials by Independent Reviewers, 2014–16

	2014	2015	2016	Total
Level 1: Quality Improvement Organization				
Number of appeal decisions issued	77,023	88,423	94,480	259,926
Number of denials overturned or partially overturned	*23,339*	*22,334*	*21,356*	*67,029*
Rate of denials overturned	**30.30%**	**25.26%**	**22.60%**	**25.79%**
Level 2: Independent Review Entity				
Number of appeal decisions issued	33,734	36,457	45,796	115,987
Number of denials overturned or partially overturned	*3,718*	*3,530*	*4,208*	*11,456*
Rate of denials overturned	**11.02%**	**9.68%**	**9.19%**	**9.88%**
Level 3: Administrative Law Judge				
Number of appeal decisions issued	1,145	1,515	1,632	4,292
Number of denials overturned or partially overturned	*251*	*481*	*430*	*1,162*
Rate of denials overturned	**21.92%**	**31.75%**	**26.35%**	**27.07%**
Level 4: Medicare Appeals Council				
Number of appeal decisions issued for cases brought by beneficiaries and providers	139	97	30	266
Number of denials overturned or partially overturned for these cases	*38*	*18*	*6*	*62*
Rate of denials overturned in favor of beneficiaries and providers	**27.34%**	**18.56%**	**20.00%**	**23.31%**

Source: OIG analysis of 2014–16 data from CMS, the Office of Medicare Hearings and Appeals, and the Departmental Appeals Board, 2018.

APPENDIX E: Volume and Rate of First–Level Appeals, 2014–16

	2014	2015	2016	Total
MAO contracts included in this analysis	**409**	**419**	**422**	**581***
Number of denials issued (full and partial)	28,907,329	35,662,934	36,565,990	101,136,253
Total number of first-level appeals	348,058	365,016	407,995	1,121,069
Number of appeals filed with MAOs for these contracts	*277,098*	*279,824*	*306,295*	*863,217*
Number of appeals filed with the Quality Improvement Organization for these contracts	*70,960*	*85,192*	*101,700*	*257,852*
Rate of first-level appeal	1.20%	1.02%	1.12%	1.11%

*This represents the total number of unique contracts included in our analyses.

Source: OIG analysis of 2014–16 annual performance data and Quality Improvement Organization data for contracts that reported validated data, 2018.

APPENDIX F: CMS Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: AUG 22 2018

TO: Daniel R. Levinson
Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Inappropriate Denials, OEI-09-16-00410

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to its oversight and enforcement of the Medicare Advantage program and appreciates OIG's recognition of CMS' efforts to address Medicare Advantage performance when necessary.

As OIG notes in its report, CMS uses several tools to oversee the Medicare Advantage program and help ensure enrollees have adequate access to health care services. CMS annually audits a select number of Medicare Advantage Organizations (MAOs) to evaluate the delivery of health care services to Medicare beneficiaries enrolled in the Medicare Advantage program. When program audits identify an issue, MAOs are required to implement a corrective action plan. If a MAO fails to correct an issue, CMS may impose enforcement actions such as civil money penalties, intermediate sanctions (suspension of payment, enrollment, and/or marketing activities), and contract terminations. In recent years, CMS has increased the transparency of audit findings by publishing them on the Medicare.gov website and developing a publicly available audit annual report with best practices MAOs can adopt to continue improving performance. Our oversight efforts are yielding positive results, with the average number of issues cited per audit declining almost 70 percent from 2012 to 2017. In addition, it is important to note that 82 percent of denials noted in this report were for payment to providers for services that the beneficiary had already received, which means the majority of denials do not impact beneficiary access to care and services.

OIG also notes CMS efforts to provide Medicare beneficiaries with meaningful information to evaluate differences in MAO performance when deciding which plan to enroll in. In recent years, CMS has populated information on the Medicare Plan Finder website to provide beneficiaries with information on MAO performance. In addition to the Star Ratings mentioned in this report, CMS has utilized the enrollment function in Medicare Plan Finder to cease enrollment to MAOs that fail to meet certain requirements. CMS is continually examining how to best inform beneficiaries of their Medicare enrollment options and is currently analyzing approaches to communicate civil money penalties information to beneficiaries.

However, it is important to note that the OIG did not conduct an examination of the universe of denials to determine whether MAOs were applying reasonable clinical criteria and adjudicate whether the MAOs' determinations were appropriate or not. If a claim is denied and that denial is overturned on appeal, the original denial may still have been appropriate, particularly when the denial was due to a lack of supporting documentation and the documentation is provided during the appeal. Lastly, the OIG's use of CMS annual audit reports limits determinations that can be made regarding the severity of certain conditions and overall MAO performance. CMS audits different organizations each year and the underlying causes for the conditions are often different between contracts and vary from year-to-year.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
Enhance its oversight of MAO contracts with extremely high overturn rates and/or low appeal rates and take corrective action as appropriate.

CMS Response
CMS concurs with this recommendation. CMS notes that the current oversight and audit process already applies many of the enhanced oversight elements the OIG mentions, including work with MAOs to take corrective action as appropriate. As noted above, the average number of issues cited per audit declined almost 70 percent from 2012 to 2017.

OIG Recommendation
Address persistent problems related to inappropriate denials and insufficient denial letters in Medicare Advantage.

CMS Response
CMS concurs with this recommendation. CMS notes that the current oversight and audit process examines inappropriate denial rationales and denial letters and CMS works with MAOs to take corrective action as appropriate. CMS does not close an audit until we are satisfied that the conditions have been substantially corrected.

OIG Recommendation
Provide beneficiaries with clear, easily accessible information about serious violations by MAOs.

CMS Response
CMS concurs with this recommendation. As this study notes, we recently proposed posting additional Medicare Advantage performance data to the Medicare Plan Finder website. CMS is testing this option, among others, with beneficiary focus groups in order to provide beneficiaries with clear, meaningful, and accessible information on MAO performance that will help them make the best decisions about their care.

ACKNOWLEDGMENTS

Rosemary Rawlins served as the team leader for this study, and Ivy Ngo served as the lead analyst. Others in the Office of Evaluation and Inspections who conducted the study include Sarah Ambrose. Office of Evaluation and Inspections staff who provided support include Clarence Arnold, Joe Chiarenzelli, Evan Godfrey, and Michael Novello. Other Office of Inspector General staff who provided support include Jessica Swanstrom.

This report was prepared under the direction of Blaine Collins, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Abby Amoroso and Michael Henry, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ABOUT THE OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.