

OIG REPORT ON PROBLEMS IN THE MEDICARE ADVANTAGE SPACE

**PREPARED FOR
AAHOMECARE
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President Johnson signed the Medicare Act into law in 1965. Medicare is primarily for the elderly. This precipitated the formation of the DME industry in the 1970s.

Up until about 10 years ago, the DME industry was almost exclusively a fee-for-service (“FFS”) industry. The supplier would sell a product, take assignment, and bill Medicare. The concept of “managed care” did not enter the supplier’s lexicon. And in any event, in the eyes of many, managed care was only for physicians and hospitals.

While the DME industry was focused on competitive bidding and audits, managed care snuck up on the industry. Fast forward to today: (i) approximately 47% of Medicare beneficiaries are covered by Medicare Advantage Plans (“MAPs”) and (ii) approximately 70% of Medicaid patients are covered by Medicaid Managed Care Plans (“MMCPs”). These percentages are increasing.

The challenge for DME suppliers is that if they have not signed contracts with MAPS, they will not be able to service about half of their Medicare patients ... and if they have not signed contracts with MMCPs, they will not be able to service about 3/4ths of their Medicaid patients.

A MAP and an MMCP essentially work the same way. In e.g., Ohio, a commercial insurer will set up a separate legal entity (e.g., “Buckeye Health Plan, Inc.” or “BHP”). BHP will sign a contract with CMS. Under the contract, BHP will (i) sign up Medicare beneficiaries and (ii) enter into contracts with hospitals, physicians, DME suppliers, etc. CMS will pay BHP and BHP will, in turn, handle the patients and providers/suppliers. BHP is the “middleman.” The same concept applies to an MMCP. Instead of being an MAP, assume that BHP is an MMCP. BHP will sign a contract with Ohio Medicaid. Ohio Medicaid will pay BHP and BHP will, in turn, work with the Medicaid patients and providers/suppliers. Again, BHP is the “middleman.”

There is a parallel concept in the pharmacy space. Pharmacy Benefit Managers (“PBMs”) serve as the middlemen between (i) commercial insurers on the one hand and (ii) patients/pharmacies on the other hand.

A goal of MAPs and MMCPs (collectively referred to as “Managed Care Organizations” or “MCOs”) is to generate a profit. They want to pay out less money than what they bring in from CMS and state Medicaid agencies. The MCO’s profit motive can cause problems for the DME supplier. At the end of the day, the MCO controls the DME supplier’s money. If the MCO pays nothing to the supplier or pays a reduced amount to the supplier, the harm to the supplier is obvious.

In dealing with MCOs, DME suppliers face a number of challenges, including the following:

- **Closed Panel** - A DME supplier will ask for a contract with an MCO but the MCO will say: “We have a sufficient number of DME suppliers on our panel. We don’t need any more.”

- **Sole Source** - The MCO will accept only one DME supplier on its panel. That supplier (the “sole source”) will be responsible for the DME needs for all of the MCO’s enrollees.
- **Low Reimbursement** - The DME supplier will be accepted onto the MCO’s panel...but unfortunately, the reimbursement is ridiculously low.

MAPs and MMCPs were established by Congress in 1997. The federal statutes and regulations governing MCOs are voluminous. Most of the statutes/regulations focus on rights of beneficiaries. There is little federal guidance on the rights of DME suppliers and other providers.

There has been little to no movement on the part of Congress and CMS to confront the practices of MCOs that are unfair to providers/suppliers. Through the efforts of AAHomecare’s Payer Relations Council and other industry stakeholders, there has been success on the state level. State legislatures are stepping in and passing laws designed to give protection to providers/suppliers. These state efforts may give political cover to Congress and CMS to become more assertive in exercising their oversight obligations of MCOs.

This brings us to the crux of this White Paper. We are *finally* beginning to see some federal governmental movement in addressing the problems being caused by MCOs. And coincidentally, we are also seeing federal movement designed to address PBM problems in the pharmacy space.

On April 27, 2022, the Office of Inspector General (“OIG”) issued a report addressing problems caused by MCOs (“Report”). The focus of the Report are the actions of MCOs to (i) reject prior authorizations and (ii) make it difficult for physicians to obtain prior authorizations. The Report points out that such actions cause harm to patients. The Report focuses on physicians and does not address the types of problems being faced by DME suppliers. But the Report, hopefully, will open the door for additional scrutiny of MCOs.

Here is what the Report says:

Why We Did This Study

A central concern about the capitated payment model used in Medicare Advantage is the potential incentive for Medicare Advantage Organizations (MAOs) to deny beneficiary access to services and deny payments to providers in an attempt to increase profits. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year, and CMS annual audits of MAOs have highlighted widespread and persistent problems related to inappropriate denials of services and payment. As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.

How We Did This Study

We selected a stratified random sample of 250 prior authorization denials and 250 payment denials issued by 15 of the largest MAOs during June 1-7, 2019. Health care coding experts conducted case file reviews of all cases, and physician reviewers examined medical records for a subset of cases. From these results, we estimated the rates at which MAOs denied prior authorization and payment requests that met Medicare coverage and MAO billing rules. We also examined the reasons that these denials occurred, and the types of services associated with these denials in our sample.

What We Found

Our case file reviews determined that MAOs sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules. MAOs also denied payments to providers for some services that met both Medicare coverage rules and MAO billing rules. Denied requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Although some of the denials that we reviewed were ultimately reversed by the MAOs, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Examples of health care services involved in denials that met Medicare coverage rules included advanced imaging services (e.g., MRIs) and post-acute facility stays (e.g., inpatient rehabilitation).

Prior authorization requests. We found that, among the prior authorization requests that MAOs denied, 13 percent met Medicare coverage rules; in other words, these services likely would have been approved for these beneficiaries under original Medicare (also known as Medicare fee-for-service). We identified two common causes of these denials. First, MAOs used clinical criteria that are not contained in Medicare coverage rules (e.g., requiring an x-ray before approving more advanced imaging), which led them to deny requests for services that our physician reviewers determined were medically necessary. Although our review determined that the requests in these cases did meet Medicare coverage rules, CMS guidance is not sufficiently detailed to determine whether MAOs may deny authorization based on internal MAO clinical criteria that go beyond Medicare coverage rules.

Second, MAOs indicated that some prior authorization requests did not have enough documentation to support approval, yet our reviewers found that the existing beneficiary medical records were sufficient to support the medical necessity of the services.

Payment requests. We found that, among the payment requests that MAOs denied, 18 percent of the requests met Medicare coverage rules and MAO billing rules. Most of these payment denials in our sample were caused by human error during manual claims processing reviews (e.g., overlooking a document) and

system processing errors (e.g., the MAO's system was not programmed or updated correctly).

We also found that MAOs reversed some of the denied prior authorization and payment requests that met Medicare coverage and MAO billing rules. Often the reversals occurred when a beneficiary or provider appealed or disputed the denial, and in some cases MAOs identified their own errors.

What We Recommend

Our findings about the causes and circumstances under which MAOs denied prior authorization or payment for requests that met Medicare coverage and MAO billing rules provide an opportunity for improvement to ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately. Therefore, we recommend that CMS:

- issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews;
- update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types; and
- direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

Coincidentally, on June 7, 2022, the Federal Trade Commission (“FTC”) issued a press release entitled “FTC Launches Inquiry into Prescription Drug Middleman Industry.” The inquiry focuses on the impact that vertically integrated PBMs has on drug access and affordability.

Conclusion

At this point in time, the primary avenue to address problems caused by MCOs is to work with state legislatures and state regulatory agencies. However, as indicated by the OIG Report and the FTC Inquiry, hopefully we will see federal movement as well.

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