



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

**Testimony Before the
United States House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations**

***“Protecting America’s Seniors: Oversight of
Private Sector Medicare Advantage Plans”***

Testimony of:
Erin Bliss
Assistant Inspector General
Office of Evaluation and Inspections
Office of Inspector General
Department of Health and Human Services

June 28, 2022

11 a.m.

2123 Rayburn House Office Building

Testimony of:
Erin Bliss

Assistant Inspector General for Evaluation and Inspections
Department of Health and Human Services, Office of Inspector General

Good morning, Chair DeGette, Ranking Member Griffith, and distinguished Members of the Subcommittee. I am Erin Bliss, Assistant Inspector General for Evaluation and Inspections, at the Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to appear before you today to discuss oversight of Medicare Advantage plans.

In 2021, approximately 26 million Medicare beneficiaries (more than 40 percent) were enrolled in Medicare Advantage plans, continuing a trend of significant growth in Medicare Advantage enrollment.¹ One of OIG's top priorities is ensuring that the Medicare Advantage program works effectively and provides quality care for enrollees and value for taxpayers. This priority includes ensuring that Medicare Advantage enrollees have access to appropriate and medically necessary care and that payments to Medicare Advantage organizations (MAOs) are based on accurate information about their enrollees' health conditions.

Today, I will focus my testimony on two lines of OIG evaluations aimed at advancing those goals. In summary, we have identified the following concerns:

- **MAOs sometimes delayed or denied beneficiaries' access to medical services, even though the requested care was medically necessary and met Medicare coverage rules.** In other words, these Medicare Advantage beneficiaries were denied access to needed services that likely would have been approved if the beneficiary had been enrolled in original Medicare. These denials likely prevented or delayed needed care for beneficiaries. In addition, MAOs sometimes denied payments to health care providers for services that they had already delivered to patients, even though the requests met Medicare coverage rules and MAO billing rules and should have been paid by the plan.
- **MAOs received an estimated \$9.2 billion in payments in 2017 for beneficiary diagnoses reported solely on chart reviews or health risk assessments, with no other records of services for those diagnoses in the encounter data.** This finding raises three concerns: (1) payment integrity—if the diagnoses were inaccurate, then MAOs received inappropriate payments; (2) quality of care—if the diagnoses were accurate, then beneficiaries may not have received appropriate care to treat these often serious conditions; and (3) data integrity—if the diagnoses were accurate and beneficiaries received care, then MAOs may not have reported all provided services in the encounter data as required.

¹ Kaiser Family Foundation, [Medicare Advantage in 2021: Enrollment Update and Key Trends](#), June 2021.

In my testimony, I will provide further details and context on these findings and highlight the actions that OIG has recommended the Centers for Medicare & Medicaid Services (CMS) take to better ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, that providers are paid appropriately, and that MAOs do not inappropriately inflate their risk-adjustment payments by reporting inaccurate diagnoses.

MEDICARE ADVANTAGE DENIALS OF SERVICES AND PAYMENTS

OIG's most recent report on Medicare Advantage examined MAO denials of requests for prior authorization, which is preapproval for a service or item before the beneficiary receives it, and denials of payment requests from a provider for a service already delivered to the beneficiary.²

Why Focus Oversight on Medicare Advantage Denials

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

Volume of Denials. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year. In 2018, MAOs denied 1.5 million prior authorization requests (5 percent of all prior authorization requests) and 56.2 million payment requests overall (9.5 percent of all payment requests) in the Medicare Advantage program.

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

How OIG Assessed Medicare Advantage Denials

For our most recent report, we selected a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs by enrollment during June 1–7, 2019.⁴ Health care coding experts reviewed case files for all cases, and

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

³ OIG, [*Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*](#), (OEI-09-16-00419), September 2018.

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

physician reviewers examined medical records for a subset of cases that warranted medical necessity review. From these results, we estimated the rates at which MAOs denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules.⁵ We also examined the reasons for these denials in our sample.

OIG Findings Raise Concerns About MAO Denials of Services

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

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

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

IMPACT: Denials likely prevented or delayed needed care

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

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

CMS guidance on the appropriate use of such criteria is insufficient. In several cases, we were unable to determine whether the prior authorization denials that met Medicare coverage rules would be considered appropriate by CMS because CMS’s guidance regarding MAO use of internal clinical criteria is not sufficiently detailed. The following example illustrates why more guidance and clarity is needed to apply this requirement.

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

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

⁷ CMS, [Medicare Managed Care Manual](#), chapter 4, section 10.16, p. 28.

Denial of CT Scan Illustrates Why More Guidance Is Needed on Use of MAO Clinical Criteria

An MAO denied a prior authorization request for a computed tomography (CT) scan that our physician reviewers determined was medically necessary to exclude a life-threatening diagnosis (aneurysm) based on the beneficiary's symptoms and comorbidities. The MAO stated that its clinical criteria required the beneficiary to have an x-ray first to prove that a CT scan was needed.

Medicare's coverage policy for CT scans states: "[T]here is no general rule that requires other diagnostic tests to be tried before CT scanning is used."

One might conclude that the MAO criteria in this case was "more restrictive" than the Medicare coverage policy and thus not allowable. However, CMS officials reported to OIG that MAOs may establish additional clinical criteria for Medicare-covered services, as long as the criteria are evidence-based and do not "contradict" the applicable Medicare coverage rules. In this example, the denial might be considered allowable if CMS judged that the MAO's x-ray requirement was evidence-based and did not contradict the Medicare coverage policy for CT scans.

Other prior authorization denials in our sample resulted from MAO requests for unnecessary documentation. In some of these cases, MAOs requested copies of documentation already contained in the case file.

OIG Findings Raise Concerns About MAO Denials of Payments

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

An estimated 18 percent of payment denials met Medicare coverage rules and MAO billing rules and therefore the provider payments should not have been denied by the MAOs. This projects to 28,949 payment denials that met Medicare coverage rules and MAO billing rules for these MAOs during the first week of June 2019.⁸ Denying payment requests that meet Medicare and MAO rules delays or prevents providers

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

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

Human errors during manual reviews contributed to these payment denials. MAOs rely on their staff to manually review some requests for payments before approving or denying them.

⁸ For an annual context, if these MAOs denied the same number of payment requests each week of 2019, they would have denied 1.5 million payment requests that met Medicare coverage rules and MAO billing rules that year.

These reviews are susceptible to human error, such as a reviewer's overlooking a document in the case file or inaccurately interpreting CMS or MAO coverage rules.

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

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

We have recommended that CMS take the following actions to ensure that beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately:

- **issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews,**
- **incorporate the issues identified in our evaluation into its audits of MAOs, and**
- **direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.**

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

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

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

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

USE OF CHART REVIEWS AND HEALTH RISK ASSESSMENTS

OIG has issued a series of evaluations examining the financial impacts of chart reviews and health risk assessments on Medicare Advantage risk-adjustment payments.⁹ Risk adjustment is a mechanism to increase payments to MAOs for covering sicker beneficiaries based on beneficiary diagnoses. Chart reviews and health risk assessments are ways that MAOs can identify and add diagnoses to the data they submit to CMS for their beneficiaries, which may increase the payments they receive.

Chart Reviews: Retrospective reviews of beneficiaries' medical record documentation to identify and add diagnoses that providers did not originally submit to the MAO and to delete any invalid diagnoses.

Health Risk Assessments: Health care professionals collect information from beneficiaries about their health status, health risks, and daily activities. Some MAOs contract with vendors to visit beneficiaries in their homes to conduct these assessments. Health risk assessments are meant to improve care and support care coordination.

Why Focus Oversight on Chart Reviews and Health Risk Assessments

Incentives. Although risk adjustment is an important mechanism to help ensure that beneficiaries who need a costlier level of care have continued access to MA plans, it may also create financial incentives for MAOs to make beneficiaries appear as sick as possible to increase these payments. Most beneficiary diagnoses are submitted by treating providers to MAOs. However, chart reviews and health risk assessments offer ways for MAOs to add diagnoses to the data CMS uses for risk adjustment more directly (i.e., through chart reviews) or indirectly (e.g., through a vendor conducting health risk assessments for the MAO).

Inappropriate Risk-Adjustment Payments. CMS reported a payment error rate of 10.3 percent for Medicare Advantage risk-adjustment payments in FY 2021, which resulted in net overpayments of almost \$7.2 billion.¹⁰ Through two series of compliance audits, OIG has questioned costs related to the diagnosis codes that MAOs submit to CMS. One OIG series of audits involves sampling from all diagnosis codes submitted by a plan, and OIG's completed audits of two plans have identified questioned costs of \$252 million.¹¹ The other OIG series is

⁹ OIG, [Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns](#), OEI-03-17-00470, December 2019; OIG, [Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns](#), OEI-03-17-00471, September 2020; OIG, [Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments](#), OEI-03-17-00474, September 2021.

¹⁰ CMS, [Part C Improper Payment Measure Fiscal Year 2021 Payment Error Rate Results](#).

¹¹ OIG, [Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., \(Contract H1036\) Submitted to CMS](#), A-07-16-01165, April 2021; OIG, [Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan \(Contract H5425\) Submitted to CMS](#), A-07-17-01169, January 2022.

targeting specific diagnosis codes. We have completed 8 targeted audits in this series with total questioned costs of \$37.4 million.¹² We have additional audits underway for both series. Finally, in a recent investigation of a provider that OIG conducted with the Department of Justice, Sutter Health and its affiliates agreed to pay \$90 million and enter into a corporate integrity agreement with OIG to settle False Claims Act allegations that it knowingly submitted unsupported diagnoses for beneficiaries in Medicare Advantage plans, resulting in inflated risk-adjustment payments.¹³

Prior Concerns About Chart Reviews and Health Risk Assessments. OIG’s work builds on concerns raised by other oversight entities. In 2016, the Government Accountability Office (GAO) raised concern that diagnoses collected from MAOs’ chart reviews may be less likely to be supported by medical records than diagnoses submitted to MAOs by providers.¹⁴ CMS and the Medicare Payment Advisory Commission (MedPAC) have questioned whether MAOs use health risk assessments primarily as a strategy to submit more diagnoses to increase payments rather than to improve the care provided to their beneficiaries. Since 2016, MedPAC has recommended that HHS eliminate health risk assessments as a source of diagnoses for risk-adjustment payments.¹⁵

How OIG Assessed the Financial Impact of Chart Reviews and Health Risk Assessments

We analyzed Medicare Advantage encounter data from 2016 to identify diagnoses that were included solely on chart reviews or health risk assessments and not on any other records of services for beneficiaries during that year. We then calculated how much these diagnoses increased the 2017 risk-adjustment payments to those MAOs. We also compared across MAOs to determine whether any MAO’s use of chart reviews and health risk assessments increased their risk-adjustment payments disproportionately relative to their size and their peers.

¹² [Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements](#), A-07-17-01170, April 2019; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan \(Contract H9572\) Submitted to CMS](#), A-02-18-01028, February 2021; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. \(Contract H3655\) Submitted to CMS](#), A-07-19-01187, May 2021; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. \(Contract H2663\) Submitted to CMS](#), A-07-17-01173, October 2021; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. \(Contract H3907\) Submitted to CMS](#), A-07-19-01188, November 2021; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., \(Contract H3359\) Submitted to CMS](#), A-02-18-01029, January 2022; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan \(Contract H2256\) Submitted to CMS](#), A-01-19-00500, February 2022; OIG, [Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network \(Contract H1961\) Submitted to CMS](#), A-06-18-05002, May 2022.

¹³ DOJ, [Sutter Health and Affiliates to Pay \\$90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program](#), August 30, 2021.

¹⁴ GAO, [Fundamental Improvements Needed in CMS’s Effort to Recover Substantial Amounts of Improper Payments](#), GAO-16-76, April 2016, p.13.

¹⁵ As part of this recommendation, MedPAC recommended that the Secretary develop a risk-adjustment model that uses 2 years of Medicare fee-for-service and MA diagnostic data. See MedPAC, Report to the Congress: Medicare Payment Policy, March 2016, p. 352.

OIG Findings Raise Concerns About MAOs' Use of Chart Reviews and Health Risk Assessments

\$6.7 Billion in payments to MAOs were generated by diagnoses only on **chart reviews** and not on any service records

For 16.8 million chart reviews (41 percent), there were no service records of visits, procedures, tests, or supplies that contained the diagnosis reported on the chart review. These 16.8 million chart reviews corresponded to 4.5 million beneficiaries (MAOs can submit multiple chart reviews for the

same beneficiaries). This means that, for the entire year, these beneficiaries may not have received any other services for the medical conditions indicated by the diagnoses. However, Medicare paid MAOs an estimated \$6.7 billion in risk-adjustment payments in 2017 arising from these chart review diagnoses to provide care for these beneficiaries.

Although chart reviews are intended to strengthen payment accuracy by both adding missing diagnoses and deleting invalid diagnoses, MAOs almost exclusively added diagnoses. Only 0.7 percent of chart reviews deleted diagnoses, while 99.3 percent added diagnoses.

Of these payments from chart reviews, an estimated \$2.7 billion were driven by “unlinked” chart reviews, which may be more vulnerable to misuse. To be eligible for risk-adjustment payments, a diagnosis must be documented based on a visit with an eligible health care provider.

Linked Chart Review: Points to a record of service that the beneficiary received from a health care provider as being the source of the medical documentation to support the newly added diagnosis.

Unlinked Chart Review: Does not indicate what health care visit or service was the source of the medical documentation that supports the newly added diagnosis.

Unlinked chart reviews do not indicate what visit or service the diagnosis came from and often contain default or “dummy” procedure codes, which would make it difficult to use encounter data to validate whether the diagnosis is eligible for payment.

Many of these unlinked charted reviews added diagnoses for serious and chronic conditions, despite the beneficiaries having no records for services indicating these conditions. Common conditions from these unlinked reviews were vascular disease; diabetes with chronic complications; chronic obstructive pulmonary disease; congestive heart failure; and major depressive, bipolar, and paranoid disorders.

\$2.6 Billion in payments to MAOs were generated by diagnoses only on **health risk assessments** and not on any other service records

MAOs reported diagnoses on health risk assessments for 3.5 million beneficiaries with no other encounter records of visits, procedures, tests, or supplies that contained the diagnosis reported on the assessment. These diagnoses resulted in an estimated \$2.6 billion in risk-adjustment payments for 2017.

For the entire year, these beneficiaries may not have received other services for the medical conditions indicated by the diagnoses from their health risk assessments. This raises questions about whether these assessments were administered as part of a care plan that included care coordination as intended. When health risk assessments lack care coordination, such as providing information to beneficiaries' primary care providers and ensuring that beneficiaries receive needed treatment, they could become vehicles for MAOs to collect diagnoses rather than function as tools to improve beneficiary health.

In-home health risk assessments, which may be more vulnerable to misuse, generated 80 percent of the estimated payments from diagnoses reported only on health risk assessments. Health risk assessments are often conducted in a doctor's office as part of a wellness visit but may be conducted in beneficiaries' homes. In-home health risk assessments represented only one-third of the assessments we reviewed but accounted for 80 percent of the increased payments from their resulting diagnoses. Most of these in-home health risk assessments that resulted in

In-home health risk assessments:

comprised **33%** of assessments

led to **80%** of risk-adjustment payments

increased payments were conducted by vendors on behalf of MAOs. The lack of other encounter records that contain the diagnoses identified by these vendors raises questions about whether the MAOs ensured that the results of these assessments were forwarded to beneficiaries' primary care providers; beneficiaries received appropriate followup care and treatment; and the diagnoses reported only on in-home health risk assessments were accurate.

Diagnoses from chart reviews or health risk assessments only—with no other service records—raise three important concerns.

Payment Integrity: Some of these diagnoses may have been inaccurate and resulted in improper payments.

Quality of Care: Some of these beneficiaries may have had these often-serious diagnoses and may not have received needed care.

Data Integrity: Some beneficiaries may have had these diagnoses and received care, but MAOs did not submit all service records as required, which hinders oversight.

20 of 162 MAOs:

Accounted for **54% of payments** (\$5 billion) solely from chart reviews or health risk assessments despite covering only **31% of beneficiaries** in MA

Of the 162 MAOs with any risk-adjustment payments resulting solely from chart reviews or health risk assessments, 20 had a share of payments that was disproportionately higher than their size (defined by their share of enrolled

beneficiaries). These 20 MAOs generated 54 percent (\$5.0 billion) of the estimated \$9.2 billion in total payments from diagnoses submitted solely on chart reviews and health risk assessments but enrolled only 31 percent of Medicare Advantage beneficiaries. Payments for 10 of these 20 MAOs were also disproportionately driven by unlinked chart reviews and in-home health risk assessments—each of which may be more vulnerable to misuse.

One MAO stood out from its peers in its use of chart reviews and health risk assessments to drive risk-adjustment payments. Among the top 20 MAOs, one MAO generated 40 percent (\$3.7 billion of \$9.2 billion) of all payments from diagnoses submitted solely on chart reviews and health risk assessments, yet it enrolled only 22 percent of all MA beneficiaries. Further, this MAO accounted for two-thirds of all payments resulting from in-home health risk assessments.

OIG Recommends Ways for CMS To Better Ensure Appropriate Payments to MAOs and Quality of Care for Enrollees

To better ensure appropriate MAO payments and patient quality of care, we have made several specific recommendations to CMS that address three key actions needed:

- **conduct targeted oversight of MAOs that are driving a high or disproportionate share of payments from chart reviews and/or health risk assessments,**
- **reassess the risks and benefits of allowing unlinked chart reviews and in-home health risk assessments to be used as sources of diagnoses for risk-adjustment payments, and**
- **require MAOs to implement best practices for care coordination for beneficiaries who receive health risk assessments.**

CMS has either implemented or taken steps to implement some of OIG's recommendations. CMS followed up with MAOs that had payments resulting from unlinked charts for beneficiaries who had no other service records in all of 2016. In addition, CMS has taken steps to include chart reviews in its audits that validate diagnoses for risk adjustment.

CMS has agreed to some additional recommendations but has not yet implemented them. These recommendations include providing targeted oversight of the MAOs that drove most of the risk-adjustment payments resulting from in-home health risk assessments.

CMS has disagreed with some of OIG's recommendations. These include recommendations to require MAOs to implement best practices for care coordination, to flag MAO-initiated health risk assessments in their MA encounter data, and to reassess the risks and benefits of allowing in-home health risk assessments to be used as the source of diagnoses for risk-adjustment payments.

OIG will continue to follow up with CMS on all our open recommendation to press for better safeguards over billions of dollars in Medicare Advantage risk-adjustment payments and to ensure that beneficiaries in Medicare Advantage receive the care that they need.

CONCLUSION

As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have appropriate access to needed care and that providers are reimbursed appropriately. It is also vital that MAOs submit accurate information about the diagnoses that drive billions of dollars in risk-adjustment payments. However, our evaluations raise concerns about how MAOs fulfill these critical responsibilities that affect beneficiary health and the value of taxpayer investments in the program.

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

At the same time, MAOs have the potential to inappropriately increase risk-adjustment payments—and thus, taxpayer costs—if they misuse chart reviews and health risk assessments. Diagnoses that show up solely on those reviews and assessments could also signal that some beneficiaries are not receiving services they may need to treat serious conditions.

It is critical that CMS take action to better ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, that providers are paid appropriately, and that MAOs do not inappropriately inflate their risk-adjustment payments. We have recommended several ways for CMS to do this and will continue to push for progress. OIG will also continue to be vigilant in our oversight work to promote payment integrity, beneficiary access, and quality of care in Medicare Advantage.

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