

COMMENTARY

Medicare Advantage: Growth Amidst Mounting Scrutiny

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The Medicare Advantage Program, home to nearly half of the eligible Medicare population, has recently come under increased scrutiny. The Government Accountability Office called on the Centers for Medicare & Medicaid Services to monitor “disenrollment of MA beneficiaries in the last year of life, validate MA-provided encounter data, and strengthen audits used to identify and recover improper payments to MA plans.” The House Subcommittee on Oversight and Investigations of the Committee on Energy & Commerce, dedicated a hearing to “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans.” In addition, a recently conducted audit of the Office of the Inspector General of the Department of Health and Human Services raised concerns over “denials of prior authorization requests” and “beneficiary access to medically necessary care.” In this article we consider the backdrop for the growing scrutiny of the MA program and the implications thereof to its future trajectory. (J Am Board Fam Med 2023;36:1062–1064.)

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Since Medicare’s inception in 1966 there has always been a role carved out for private plans – what had been called Medicare Part C plans but is now more commonly called Medicare Advantage (MA) plans.¹ These programs are designed to operate under a risk-based contracting scheme where the plan assumes liability for the health expenses of its covered beneficiaries in exchange for a capitated monthly sum. Proponents of these plans have long argued that they “could reduce government expenditures, improve quality, and provide additional benefits beyond those offered by traditional Medicare.”¹ The MA Program, now home to nearly half of the eligible Medicare population, has recently come under increased scrutiny. The *Government Accountability*

Office (GAO) called on the *Centers for Medicare & Medicaid Services* (CMS) to monitor “disenrollment of MA beneficiaries in the last year of life, validate MA-provided encounter data, and strengthen audits used to identify and recover improper payments to MA plans.”² The *House Subcommittee on Oversight and Investigations* of the *Committee on Energy & Commerce*, dedicated a hearing to “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans.”³ In addition, a recently conducted audit of the *Office of the Inspector General* (OIG) of the Department of *Health and Human Services* (HHS) raised concerns over “denials of prior authorization requests” and “beneficiary access to medically necessary care.”⁴ In this article we consider the backdrop for the growing scrutiny of the MA program and the implications thereof to its future trajectory.

The MA health insurance plan, an effort at introducing managed care principles to Medicare, traces its origins to the *Tax Equity and Fiscal Responsibility Act of 1982* wherein Medicare was authorized to contract with risk-based private-sector health insurers. This newly-earned authority, however, was not actualized until the enactment of the *Balanced Budget Act of 1997* which saw to the institution of the “Medicare+Choice” paradigm. Today’s MA program, the by-product of the *Medicare Prescription*

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Drug, Improvement, and Modernization of 2003, makes it possible for Medicare enrollees to receive their benefits through private capitated managed care plans rather than through the traditional fee-for-service Medicare construct. It is in the nature of MA programs to rely on contracted narrow physician networks the accessibility of which is constrained by utilization management policies and procedures (ie, prior authorization). At the time of this writing, the MA program, nearly 28 million enrollees strong, is home to 39 plans the annual receipts of which are estimated to account for 55% of the total annual spending of Medicare (\$427 billion net of premiums).⁵ A May 2023 analysis suggests that “spending per person in MA exceeds spending for comparable F[ee for service] Medicare beneficiaries, with estimates ranging from 4 to 10% higher spending in MA in 2021,” a differential that is expected to grow over time.⁶ A recent Kaiser Family Foundation analysis compared gross margins in the MA, Medicaid managed care, commercial individual (nongroup), and commercial group (employer) insurance markets from 2018 to 2020 and found that “gross margins per member per month (defined as the amount by which premium income exceeds claims costs per enrollee per month)” were highest in MA than the other 3 markets.⁶

The subject of GAO reviews since 2010, the MA program has long been deemed “High Risk” by the GAO by dint of its association with the Medicare program, which GAO views as susceptible to “mismanagement and improper payments.”² Recent GAO concerns revolve around the observation that “MA beneficiaries in the last year of life disenrolled to join traditional Medicare at more than twice the rate of all other beneficiaries.”² From GAO’s perspective, the “high rates of disenrollment from MA to join traditional Medicare fee-for-service” may reflect quality of care issues such as “potential limitations accessing specialized care under some MA organizations’ provider networks.”² Moreover, GAO notes that “disenrollments increase Medicare program costs” since “Medicare payments are generally based on the costs of services provided.”² GAO also expressed concern that because CMS auditors are using MA encounter data that “have not been fully validated for completeness and accuracy” and that this calls into question the “soundness of adjustments to MAP organization payments.”² It was the recommendation of the GAO that CMS “strengthen audits used to

identify and recover improper payments to MA organizations.”²

Congressional concerns over the MA program have centered on “MA enrollees’ access to medically necessary care and the fiscal sustainability of the MA program.”³ Citing the latest OIG audit of the MA program, the *Committee on Energy and Commerce* noted that “denying requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and treatment, resulting in direct harm to beneficiaries.”³ The Committee also made note of an earlier observation of the GAO according to which CMS “does little to assess the accuracy of the network data and reviews only 1% of all provider networks.”³ Drawing on the latest *Medicare Payment Advisory Commission* (MedPAC) report to Congress, the Committee concluded that the “data submitted by MA plans about beneficiaries’ health care encounters are incomplete, making it difficult to conduct appropriate program oversight.”³ Yet another concern raised by the Committee revolved around disparities of care in that “MA contracts with higher star ratings had larger racial and ethnic disparities than did those with lower star ratings.”³

As viewed by the office of the OIG of HHS, the capitated risk-adjusted payment model of MA must be carefully monitored to ensure that “Medicare beneficiaries have access to medically necessary covered services and that providers are reimbursed appropriately.”⁴ Special attention must be paid to prior authorization and payment denial errors.⁴ The OIG observed that MA plans “sometimes delayed or denied Medicare Advantage beneficiaries’ access to services, even though the requests met Medicare coverage rules.”⁴ The OIG also made note of the fact that MA “denied payments to providers for some services that met both Medicare coverage rules and MA billing rules.”⁴ Examples of denied health care services that met Medicare coverage rules included “advanced imaging services (eg, MRIs) and post-acute facility stays (eg, inpatient rehabilitation).”⁴ It was the recommendation of OIG that CMS issue additional guidance on the comparability of the clinical criteria of Medicare and MA as well as scrutinize noncompliant MA plans and work with those plans to prevent the types of errors identified in the report.

Taken together, one cannot escape the fact that the growing MA program comprises an ever more costly endeavor which threatens the solvency of the

Medicare trust funds.⁷ This state of affairs may be attributable, at least in part, to the reality of augmented coding intensity (“up-coding”) by MA plans. Two recent lawsuits alleging up-coding filed against 2 MA plans by the Department of Justice under the “False Claims Act” led to the recovery of nearly \$100 million.⁸ Viewed in hindsight, concerns over alleged “up-coding” by MA plans are hardly novel. It was against this backdrop that the *Deficit Reduction Act of 2005* was enacted with an eye toward directing CMS to implement an annual “coding intensity adjustment.” CMS currently maintains the “coding intensity adjustment” at the statutory minimum of 5.9%.⁷ Absent additional corrective Congressional action, the status quo is bound to accelerate the prospect of insolvency of the Medicare trust funds.⁷

Currently, only a small contingent of progressive lawmakers is seeking to address the matter of augmented MA coding intensity.⁹ Comparable calls by the American Hospital Association to “take swift action to hold Medicare Advantage plans accountable” seem to have gained limited traction as well.¹⁰ Today’s Congressional efforts are focused on simplifying the prior authorization process used by MA programs via the *Improving Seniors’ Timely Access to Care Act of 2022*. The Medicare Part A Trust Fund could become insolvent as early as 2028. Congress would do well to consider reigning in the MA plan payments at this time. Inaction will all but guarantee the unthinkable.

To see this article online, please go to: <http://jabfm.org/content/36/6/1062.full>.

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