Title: Inappropriate Denials or Delays of Care or Medications by Medicare Advantage Organizations

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Introduction

Medicare Advantage organizations (MAOs) receive hundreds of billions of dollars in annual federal payments and use care management tools such as prior authorization and formulary restrictions to control costs and promote appropriate care.[1] However, a 2022 Office of Inspector General (OIG) report found that 13% of prior authorization denials by MAOs met Medicare coverage rules and were determined to be medically necessary by three physician reviewers, raising concerns about inappropriate denials.[2] The Centers for Medicare & Medicaid Services (CMS), which oversees MAOs, conducts scheduled audits of MAO operations, including on denials of care. Yet, little is known about the types of violations identified through this oversight, particularly those resulting in enforcement actions. This study systematically characterized violations cited in CMS enforcement actions. We focused on inappropriate denials or delays of care or medications, as these may have the most severe consequences for enrollees' health and financial well-being.

Methods

We analyzed textual data from CMS enforcement actions issued between 2021 and 2026, which included detailed information on associated violations by MAOs.[3] All available enforcement action documents published by CMS were included in the study. First, we categorized violations into four groups: 1) inappropriate denials or delays of care or medications, 2) errors in premium, cost-sharing, and out-of-pocket maximum, 3) low star ratings, and 4) other violations (Appendix). For each type of violation, we summarized the total penalty amounts among violations that resulted in monetary

penalties, and the median, minimum, and maximum penalties. Second, we conducted a qualitative content analysis on inappropriate denials or delays to identify themes, subthemes, and patterns of denials-related violations (Appendix).[4] Specifically, one researcher developed an inductive codebook. Two researchers independently applied the codebook to the data and reconciled coding differences. Throughout analysis and reconciliation, the first author identified themes. Finally, we summarized the frequency of each subtheme.

This qualitative study was exempt from institutional review board approval or informed consent because the data were publicly available and reported at the organization level.

Results

From September 2021 to March 2026, CMS reported 66 violations resulting in enforcement actions (Table 1). Of these, 22 violations involved inappropriate denials or delays of care or medications, resulting in $616,366 in penalties (median, $15,080; range, $5,336 – $285,476). Median penalties per violation for the other two categories of violations were $33,988 (errors in premiums and etc.) and $47,596 (others). For inappropriate denials or delays, there were 16 violations for Part D medications and 4 for Part C services (Table 2).

Two main themes emerged through qualitative content analysis: types of violations and their underlying causes. We identified five specific types of violations under inappropriate denials or delays. Most commonly, MAOs inappropriately

rejected/administered formulary medications (9 violations) and inappropriately denied, dismissed, or processed coverage requests, determinations, or complaints (7 violations). We also identified five underlying causes. The most frequent were internal procedural or workflow deficiencies that led to inappropriate denials or delays (7 cases), followed by staff mistakes (5 cases), and incorrect data used for plan enrollment determination (4 cases).

Discussion

Over four and a half years, CMS imposed sanctions on 22 violations by MAOs involving inappropriate denials or delays of care or medications; these violations received lower median fines than other types of violations. Most denials or delays involved Part D medications, with relatively few involving other services. Moreover, all violations were attributed to procedural deficiencies and human or system processing errors.

There were no citations of denials related to medically necessary care. Observed violations likely reflect the interaction of legislations and regulations, CMS audit priorities, and underlying MAO behaviors. Current CMS program audits of MAOs appear to focus on procedural adherence.[5,6] These audits may not capture denials that are procedurally compliant but clinically inappropriate, as medical necessity is determined on an individual basis. Since the OIG report found some prior authorization denials were medically necessary for beneficiaries,[2] expanding oversight to include medical necessity reviews may strengthen beneficiary protections.

The OIG report also suggests that applications of MAOs' internal coverage criteria partially explained denials of prior authorizations for medically necessary care.[2] Since 2024, CMS has issued regulations clarifying permissible use of internal criteria and initiated audits of MAOs' adherence, although we did not observe corresponding violations during the study period.[7,8]

This study has limitations. We analyzed recent violations that led to CMS enforcement actions and were publicly reported, which may not reflect the full scope of oversight activities. We could not determine the number of beneficiaries affected by these violations based on CMS reports.

This study found that MAOs only received CMS sanctions for inappropriate denials or delays of care due to nonadherence to procedural requirements rather than explicit determinations of medical necessity. Incorporating medical necessity reviews into routine oversight may enhance CMS' ability to identify and address inappropriate denials and better protect MA beneficiaries' access to care.

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Disclaimer: The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs or the US government.

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Table 1. Medicare Advantage Organizations' Violations that Lead to Sanctions, 2021– 2026

Types	No. of Violations	Total Monetary penalties [a]	Median (Minimum, Maximum)
All	66	3,890,210	
Inappropriate denials or delays of care or medications	22[b]	$616,366 (22)	$15,080 (5,336 – 285,476)
Errors in premium, cost-sharing, and out-of-pocket maximum	24	$3,014,768 (24)	$33,988 (5,336 – 2,000,000)
Low star rating	5	Not Applicable	Not Applicable
Others (e.g., financial insolvency, medical loss ratio violations)	15	$259,076 (4)	$47,596 (47,596 – 116,288)

[a] Numbers in parentheses represent the number of violations resulting in monetary penalties. In addition to monetary penalties, violations may also lead to suspensions of marketing and enrollment, as well as contract terminations.

[b] Twenty-one violations related to inappropriate denials or delays were initially identified. Upon further review, we split one violation into two distinct violations, resulting in a total of 22 violations. Two violations of Program of All-Inclusive Care for the Elderly (PACE) requirements also involved inappropriate denial of care but were described in a substantially different way from other violations related to inappropriate denials or delays. Therefore, they were categorized as "Others".

Table 2. Contents of Violations Related to Inappropriate Denials or Delays of Care or Medications that Lead to Enforcement Actions, 2021- 2026

Categories/ Subthemes	No. of Violations	Examples
	Program Type	
Part C [a]	4	
Part D	16	
Medicare-Medicaid Plans	2	
	Theme 1: Specific Violations	
Inappropriately rejected/administered formulary medications	9	CMS determined that the MAO violated Part D formulary and benefit administration requirements because the sponsor inappropriately rejected formulary medications.
Inappropriately denied, dismissed, or processed coverage requests, determinations, or complaints	7	CMS determined that the MAO violated Part C requirements because the sponsor inappropriately dismissed valid organization determination requests for Part B drugs.
Improper denial notice	3	CMS determined that the MAO failed to provide non-contract provider denial notices with the applicable appeal rights.
Failed to effectuate approved prior authorizations	2	CMS determined that the MAO failed to properly effectuate approved prior authorizations because it denied opioid medications when the beneficiary already had an approved prior authorization for the opioid medication.
Other	1	
	Theme 2: Underlying Causes	
Internal procedural or workflow deficiencies	7	The organization's workflow document did not clearly require call center agents to initiate a coverage determination or appeal on behalf of an enrollee when received as part of a grievance.
Staff mistakes	5	Staff misrouted coverage requests to the incorrect department.
Incorrect data used for plan enrollment determination	4	An incorrect “Individual Start Date” was loaded into its pharmacy benefit manager’s’ adjudication system.
Claims processing logic or configuration errors	3	Pharmacy benefit manager’s system incorrectly applied out of sequence member records in its eligibility files, which caused enrollees’ active coverage to be voided.
None listed	2	
Misinterpretation of CMS requirement	1	The organization misinterpreted CMS requirements by treating the receipt of an exception request from a prescriber as the receipt of a supporting statement.

Note: Names for Medicare Advantage Organizations were redacted in these examples.

[a] Part C includes Part A and Part B services.