Medicare Paid Insurers Billions for Questionable Home Diagnoses, Watchdog Finds

Nurse visits said to be worth $1,869 each for Medicare Advantage companies

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Private Medicare insurers got about $4.2 billion in extra federal payments in 2023 for diagnoses from home visits the companies initiated, even though they led to no treatment, a new inspector general's report says.

The extra payments were triggered by diagnoses documented based on the visits, including potentially inaccurate ones, for which patients received no other medical services, the report says. Insurers offering private plans under Medicare, known as Medicare Advantage, are paid more when patients have costly conditions.

Each visit was worth $1,869 on average to the insurers, according to the Office of Inspector General for the Department of Health and Human Services. The findings are similar to those of a Wall Street Journal investigation published in August. It showed that insurers between 2019 and 2021 pocketed an average of $1,818 for each visit based on diagnoses for which people received no other treatment.

The OIG recommended in Thursday's report for the first time that Medicare restrict or even cut off payments for diagnoses from these visits.

The Medicare agency disagreed with the recommendation to restrict home visit payments, citing limitations of the study, according to the report. In a statement to the Journal, the Medicare agency said it is committed to ensuring that diagnoses, including those from home visits, are accurate.

Medicare Advantage was conceived as a way to lower costs and improve care in the program for seniors and disabled people. But researchers and the Medicare Payment Advisory Commission, a nonpartisan watchdog agency known as MedPAC, have found that it has wound

up costing more than traditional Medicare, in part because insurers have found ways to draw ever-greater payments from the pay-for-diagnoses system.

The home visits, also called health risk assessments, are an important part of that effort. During visits, nurse practitioners, or sometimes doctors, take medical histories, review medications and run simple diagnostic tests, sometimes coming up with novel diagnoses that the patients' regular doctors had never documented.

"We're seeing that some Medicare Advantage companies are making billions from the health risk assessment diagnoses without providing care for the conditions that they identify," said Erin Bliss, assistant inspector general for evaluation and inspections.

That could mean some of the diagnoses are false, she said. Or, if they are accurate, the insurers making them aren't connecting patients to the care they need, even as the companies are paid extra based on the supposed cost of treating the conditions. "Profiting off enrollees' medical conditions without providing treatment for those conditions is wrong," she said.

Bliss said the OIG's latest findings and the conclusions of the Journal investigation are "highly consistent and pointing in the same direction."

The diagnoses that triggered home-visit payments documented in the OIG report were often for illnesses that might be difficult to confirm without a laboratory or other equipment. Two of the top diagnoses driving the payments were a form of rheumatoid arthritis, which might require lab work and X-rays to diagnose, along with secondary hyperaldosteronism, a condition that can be confirmed with blood work.

"There are definitely conditions where you might wonder, 'Can they really, you know, identify that by a visit to someone's home?' " said Jacqualine Reid, an OIG analyst and the lead author of the report.

Another Journal article, from July, found that insurers received about $50 billion in payments from diagnoses they themselves added to patients' records, including many that were demonstrably false, such as diabetic cataract cases that had already been cured.

The OIG analysis also examined health risk assessments at doctors' offices, worth about $365 a visit to insurers, as well as those done through telehealth. The report also included diagnoses insurers added following so-called chart reviews of home, telehealth or office assessments. In total, Medicare paid insurers $7.5 billion in 2023 for diagnoses recorded just through those practices.

One major Medicare Advantage insurer received about two-thirds of the total payments stemming from home visits and chart reviews, despite accounting for only 28% of the program's enrollment, the report said, without naming the company. An OIG official confirmed to the Journal that the company was UnitedHealth Group, the Medicare Advantage market leader.

UnitedHealth didn't immediately respond to a request for comment Wednesday. In an earlier statement, UnitedHealth told the Journal that in 2023, three million "gaps in care" were identified during such home visits, which typically last 45 to 60 minutes. It said the visits had a 99% customer satisfaction rate.

The Journal's recent analysis showed that UnitedHealth extracted far higher payments for diagnoses tied to home visits than other large insurers—$2,735 on average over the three years ending in 2021—and accounted for most of the payments.

In a statement on its corporate website following the Journal's reports, UnitedHealth said that its home visits are valuable for patients, and that the finding that diagnoses are questionable or wrong "is unsubstantiated, and the WSJ presented no credible evidence to support this claim."

In all, UnitedHealth received $3.7 billion from all types of health risk assessments activities in 2023, the OIG report said. Humana, the No. 2 Medicare Advantage insurer, generated $1.7 billion from health risk assessments and associated chart reviews.

A Humana spokesman said that health risk assessments help improve patient outcomes and that findings are always referred back to patients' own physicians for follow-up. He said Humana would continue to work with Medicare to improve the assessments' transparency and accuracy.

The Justice Department has pursued a number of cases that accused Medicare insurers of inflating payments based on diagnoses. Last year Cigna Group agreed to pay $172 million to settle such allegations. The company admitted to adding diagnoses that weren't supported by patients' medical records. An OIG official declined to comment on any ongoing investigations.

The report is the latest in a series by OIG pointing to the potential for Medicare Advantage overpayments due to insurer-driven diagnoses, such as those from home visits.

The newest findings propelled the oversight agency's strongest recommendations to rein in the tactics yet. In addition to restricting or cutting off payments based solely on home visit diagnoses, the inspector general recommended targeted audits of such diagnoses to determine whether they are accurate.

MedPAC has previously called for the Medicare agency, the Centers for Medicare and Medicaid Services, to stop allowing diagnoses drawn from health risk assessments to affect insurers' payments.

The Medicare agency disagreed with that recommendation. It argued that OIG's report hadn't fully proved problems with the home visit diagnoses because the investigators didn't have access to patients' medical records, and that data made it difficult to identify the home visits definitively. The Medicare agency said it would consider targeted audits after further analysis.

The agency said it believed recent changes to which diagnoses trigger payments—now being phased in—had already addressed a third recommendation to study diagnoses detected at high rates through health risk assessments.