29 June 2022

Energy and Commerce Subcommittee Hearing on Oversight of Medicare Advantage Plans

On Tuesday (June 28), the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce held a hearing entitled, "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage (MA) Plans," aimed at addressing concerns raised by recent reports surrounding MA enrollees' access to medically necessary care and the fiscal sustainability of the MA program.

Witnesses from the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) provided an overview of their findings and recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding addressing issues with the MA program, as well as status updates. The witnesses discussed potentially inappropriate payment denials from MA organizations for services that would have likely been approved under fee-for-service (FFS) Medicare; the use of chart reviews or health risk assessments for beneficiary diagnoses unsubstantiated by encounter data; concerns regarding beneficiary disenrollment in MA plans in the last year of life; and other concerns regarding inflationary coding practices, incomplete data submission, and more. The witnesses discussed several recommendations aimed at enhancing payment and data integrity and urged CMS to enhance their oversight of the MA program.

Bipartisan members of the subcommittee expressed general support for the MA program, many citing large enrollment numbers in their districts and general satisfaction from constituents; however, many also expressed a desire to enhance program efficiency, ensure appropriate and timely access to care, and keep costs and spending down. Several committee members expressed support for the Improving Seniors' Timely Access to Care Act of 2021 (H.R.3173/S.3018), aimed at streamlining prior authorization requirements under MA plans. Others focused on findings of improper payments due to coding intensity, CMS's lack of action in response to suggestions to improve timeliness of MA audits, ways to improve collection and validation of encounter data, and more. Several committee members also expressed their disapproval that CMS was not present at the hearing.

- *For more information*: https://energycommerce.house.gov/committee-activity/hearings/hearing-on-protecting-americas-seniors-oversight-of-private-sector

Opening Remarks

Subcommittee Chairman Diana DeGette (D-CO): In her statement, Rep. DeGette said that while beneficiaries with MA plans are entitled to the same services as those on traditional Medicare, recent reports indicate that they are not always receiving the care they need, saying some are facing "serious impediments" and that our seniors and doctors should not be required to "jump through hoops" to get them the care they need. She said that we "need to understand better why this is happening." She also cited reports that MA enrollees disenroll from MA in their last years of life, saying that when care is most critical, MA plans are perhaps not providing what beneficiaries need. She also cited "concerning disparities" in care based on racial demographics and location. In closing she said that we need better information and oversight to drill down into these issues and ensure beneficiaries are being provided high quality care, adding that "MA is an important tool" and that "we want it to succeed" but that we must "ensure seniors and taxpayers are protected."

Subcommittee Ranking Member Morgan Griffith (R-VA): "Millions of our constituents depend on Medicare Advantage to provide comprehensive and affordable health care as they age… Medicare Advantage offers a range of services to enrollees. This includes care coordination, disease management programs, out-of-pocket spending limits and access to community-based programs. Further, these plans offer supplemental benefits—such as vision, dental, prescription drug coverage, telehealth services, and fitness benefits… Medicare Advantage's success and increasing popularity can be traced directly to its critical features, which distinguish the program from the fee-for-service structure… Medicare patients who choose Medicare Advantage are able to cap their personal financial liability and enjoy a wide range of supplemental and personalized benefits in exchange for some utilization management and network controls… As Medicare Advantage takes on an even larger presence in the Medicare program, and as the Medicare Hospital Insurance Trust Fund is projected to be insolvent by 2028, it will continue to be important to assess how well Medicare's current payment methodology for Medicare Advantage is working to enhance efficiency and keep beneficiary costs and Medicare spending down." Full statement.

Committee Chairman Frank Pallone (D-NJ): "I am deeply concerned with recent reports that seniors in private sector Medicare Advantage plans are facing unwarranted barriers to accessing timely, medically necessary care… Studies have repeatedly found that some Medicare Advantage plans, particularly the largest plans, receive greater compensation from Medicare without necessarily providing better health care services to beneficiaries. In short, some insurance companies appear to have figured out a way to game the system… This allows the plans to claim that beneficiaries are in riskier health and therefore the plans receive more funding from Medicare. But, as today's witnesses will help explain, those new diagnoses do not always reflect reality… One benefit to enrollees under the Medicare Advantage program is that plans can use portions of their funding to provide supplemental benefits beyond what traditional Medicare offers… As Medicare payments for these supplemental benefits continue to increase, we must better understand if they are helping seniors and whether they are being delivered at a reasonable cost." Full statement.

Committee Ranking Member Cathy McMorris Rodgers (R-WA): "For seniors on a fixed-income — those who are especially pinched by inflation and surging energy costs — these savings make a huge difference in their lives. Medicare Advantage gives them more choices too… Recently, I have heard at my town halls about counties losing their Medicare Advantage plans. I have also met Washingtonians who have moved so that they can stay enrolled in Medicare Advantage… Rather than limit seniors' choices, we should take this opportunity to think creatively about how to expand greater Medicare Advantage availability, improve care, and lower costs, particularly in rural parts of the country… I remain extremely concerned by proposals from my colleagues across the aisle that would ban Medicare Advantage plans and move everyone to a one-size-fits all government run plan… We should be exploring solutions to improve Medicare Advantage, not dismantle it… This reflects a pattern from the Biden administration of not participating in necessary oversight over our government's entitlement and mandatory spending programs." Full statement.

Witness Testimony

Erin Bliss, Assistant Inspector General, Office of Evaluation and Inspection, Office of Inspector General, Department of Health and Human Services: "[Medicare Advantage organizations (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… 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." Full Testimony

Leslie Gordon, Acting Director, Health Care, Government Accountability Office: "Due to our concerns about the program's susceptibility to mismanagement and improper payments as well as its size and complexity, we have designated Medicare, including Medicare Advantage, as a high-risk program. We—along with the Department of Health and Human Services Office of Inspector General and others— have identified significant concerns with CMS's oversight of the MA program. As a part of our work, we have made a number of recommendations to prompt CMS action to improve MA monitoring and oversight, including recommendations related to beneficiary disenrollment, the validity of MA encounter data, and audits to identify and recover improper payments to MAOs… CMS has begun monitoring MA disenrollment in the last year of life, as GAO recommended… CMS has not fully validated encounter data needed to accurately adjust payments to MAOs… CMS has not implemented GAO recommendations to improve timeliness of MA audits and appeals to recover improper payments." Full Testimony

James E. Mathews, Ph.D., Executive Director, Medicare Payment Advisory Commission: "Despite its growing popularity, the expansion of MA is also a cause for concern. Private plans that accept full risk have been available in Medicare since the mid-1980s, but they have never generated aggregate savings for the program, at least in part because of how they are paid, among other factors… The Commission contends that under the right policies, MA plans could serve as vehicles to manage spending and quality of care more effectively than the fragmented FFS system. Although MA plans have the potential to provide good value for the program, the policies that govern how MA plans are paid and administered are deeply flawed and prevent that value from materializing… Three areas where the Commission contends current MA policy is falling short and needs to be changed: (1) how MA plans' diagnostic coding practices inflate their Medicare payments; (2) the program to incentivize and reward plan quality increases plan payments for nearly all enrollees but does not provide the Medicare program, policy makers, or beneficiaries with the necessary information to evaluate plan quality; and (3) plan-submitted data about beneficiaries' health care encounters are incomplete." Full Testimony

Q&A

Rep. Dianna DeGette (D-CA) asked what the most important recommendation was to improve seniors' quality of care and cost. Ms. Bliss said for CMS to update and clarify guidance on how they can use internal clinical criteria that goes beyond Medicare coverage rules to determine coverage approvals/denials and for CMS to reassess whether to allow unlinked chart reviews and health risk assessments to be sole sources of diagnosis for MA payments. Mrs. Gordon said that complete and accurate encounter data is necessary to substantiate risk adjusted payments and quality care and stressed the timeliness around contract level Risk Adjustment Data Validation (RADV) audits to assess MA plans for improper payments. Mr. Mathews said they should address excess payments due to coding intensity, completely overhaul the quality bonus program and change their approach on MA benchmarking. All the witnesses said that CMS needs to take action to course correct.

Rep. Morgan Griffith (R-VA) asked the witnesses if they recommended getting rid of MA, to which all said no. He said he agrees health risk assessments should not be the sole source for diagnosis but thinks they are helpful due to their insight into the home environment. Ms. Bliss agreed that they can be an important tool in care coordination, but CMS only recommends this and does not require that as best practice, noting that many beneficiaries do not have appropriate follow-up care after these are carried out. She said CMS's final action plans are due in October, but they did not agree with all their recommendations regarding health risk assessments. Ms. Gordon added that CMS has not yet fully implemented recommendations to improve the timeliness of RADV audits

and appeals, noting they CMS has not yet issued final contract-level audit findings for payments made in 2011 through 2014.

Rep. Frank Pallone (D-NJ) said that despite the promise of efficiency, MA has not yet resulted in savings. When asked why spending is higher, Mr. Mathews said that payments are calculated based on FFS benchmarks – and some in excess of FFS to induce entry – and that MA plans are provided a rebate when they bid below, so Medicare is not able to benefit fully from the savings. He suggested changes that bring down benchmarks and improve the completeness of encounter data to ensure program integrity. When questioned about it, Ms. Bliss said that a small number of MA companies drive a disproportionate share of risk adjustment payments coming solely from chart reviews and health risk assessments, suggesting a targeted approach to oversight.

Rep. Cathy McMorris Rodgers (R-WA) discussed the high rates of satisfaction with MA and beneficiary preference over supplemental or Medigap plans. She asked if they have explored the financial and other trade-offs between MA and supplemental and Medigap plans and between managed care and FFS plans. Ms. Gordon agreed that MA plans can offer additional services, provide specialized care needs plans, and have additional flexibilities which is beneficial.

Rep. Kim Schrier (D-WA) cited OIG findings that among prior authorization requests that MAOs denied, 13 percent were for requests that met Medicare coverage rules. She also noted that additional staffing is required for providers to handle all of these prior authorization requests and asked how it impacts the beneficiary. Ms. Bliss said they are concerned with patients receiving care in a timely manner and they should be receiving the same benefits as FFS, noting that some denials leverage clinical criteria not leveraged for original Medicare. Rep. Schrier also expressed support as a sponsor of the Improving Seniors Timely Access to Care Act to ensure real-time decisions around prior authorization. Mr. Mathews said that MedPAC recognizes the value of appropriate use of prior authorization to manage costs but they are unable to determine if it's being used appropriately due to quality of data.

Rep. Michael Burgess (R-TX) asked about the feasibility of using electronic medical records to facilitate prior authorization. Ms. Bliss said some prior authorization requests are denied because the plan requested a document that may be contained in the record, so that it holds promise. When asked about redundant requests, Ms. Bliss said they are looking into a risk-based approach at the provider level. Rep. Burgess said we should facilitate and make the process less burdensome for providers and patients, to which Ms. Bliss agreed and said we should streamline and avoiding unnecessary requirements while also ensuring appropriate data. Rep. Burgess asked if there is a way to remove requirements based on historic requests from providers who have always done it in a way that is accurate and asked about costs resulting from care delays. Ms. Bliss said they are also concerned about those costs, but it was not part of their analysis.

Rep. Kathleen Rice (D-NY) asked about the prevalence of prior authorization denials and asked how detailed new guidance should be to remove ambiguity. Mr. Mathews said they have not weighed in on the level of guidance and Ms. Bliss said they leave it to program officials on where to draw the line regarding the level of detail and guidance needed. When asked why pain management injections are subject to additional scrutiny, Ms. Bliss said it is due to a history of fraud.

Gary Palmer (R-AL) asked what percent of improper payments come from FFS vs. MA, to which Ms. Gordon said that 6-7% come from FFS and 10% from MA. When asked what areas they recommended CMS to follow up on, Ms. Gordon said that RADV audits on improper payments need to be a greater area of focus due to the increased enrolment in MA. When asked if the change to ICD-19 and increase in codes led to additional complexity, Ms. Gordon said that there is an open recommendation for CMS to re-evaluate documentation requirements in both Medicare and Medicaid to ensure they are appropriate.

Janice Schakowsky (D-IL) expressed her concern with tactics to increase profits such as coding intensity, noting a MedPAC report that found MA plans' higher coding resulted in an estimated $12 billion in unwarranted payments. When asked how widespread this is, Mr. Mathews said that to the extent diagnoses are collected, MedPAC is not saying they are erroneous but that heath risk assessments in particular should not be used for risk adjustment and that other changes should be made to fully mitigate the impact of MA plan coding practices on Medicare spending. He added that CMS has the statutory authority to do this.

Rep. Raul Ruiz (D-CA) said that MA disproportionally serves minorities, and they need to ensure the program serves the populations in the way it is intended. He expressed the need for verified data and absence of quality data on encounters. Ms. Gordon said that without accurate encounter data it is difficult to assess the quality of care and that CMS needs to hold plans accountable for completing all data requirements including demographics, services provided, and diagnoses. When asked about similar improper denials due to step therapy, Ms. Bliss said that they have not included step therapy in their review but some of the same incentives are in place and they are happy to investigate it.

Rep. John Joyce (R-PA) discussed the virtues of MA and need to cut red tape around prior authorization and step therapy, which he said can lead to unnecessary delays in care. When asked about oversight of this and similar utilization management techniques, she said they are looking at prior authorization for other services and that it comes with the risk of inappropriate use and detrimental outcomes. Rep. Joyce said he has heard from hospitals that MA plans delay necessary care and Ms. Bliss said that denials for post-acute care were prominent.

Rep. Scott Peters (D-CA) expressed the need to bolster better access to data and asked about disenrollment in MA in the final years of life. Ms. Gordon said some disenrollment is expected but that it is important to monitor levels because it would be due to issues accessing specialized care. When asked what changes CMS should put in place, she said additional scrutiny of MA plans and benefit packages, changes to star ratings, and more.

Rep. Paul Tonko (D-NY) asked Ms. Bliss to discuss health risk assessments how they drive billions in additional payments due to coding intensity. Ms. Bliss said that the intent is to improve coordination and outcomes for those patients and that sometimes the MA plan contracts out to have these done in a patient's home. She said that when they generate diagnoses but there is no treatment to follow those up, they are worried if the information made it back to the provider or if it is even supported. She said CMS should implement best practices around these and consider if home risk assessments should be the sole source of information around risk assessment. Mr. Mathews said that the use of health risk assessments and chart reviews where those are the exclusive source of diagnoses account for about 2/3 of overpayments that stem from coding intensity.

Rep. Ann Kuster (D-NH) said prior authorization can be a barrier to care and asked how MA plans can better support beneficiaries in appeals. Ms. Bliss said that beneficiaries and providers appeal only about 1% of payment denials and they typically work with their provider to go through that process, but that it often leads to delays in care and contributes to administrative burden. When asked how many are overturned and the reasons, Ms. Bliss said that 75% are overturned and it could be due to a lack of necessary information. When asked if electronic submission would reduce burden, Ms. Bliss said anything to reduce burden is a consideration.

Rep. Tom O'Halleran (D-AZ) expressed his disappointment that CMS was not at the hearing and that they have not responded to recommendations from years earlier. He said that while there is a lot of room for improvement, it is also important to spend time getting it right due to the large proportions of beneficiaries with MA. He said that the quality program should also ensure people in underserved areas can access care and noted that lack of access to data is not a new issue, saying it is critical CMS can give people information around the quality of their plan. Ms. Gordon said that CMS has a responsibility to ensure MA plans are submitting all necessary data and to

review and validate it in addition to ensuring they are meeting coverage requirements and that it is done equitably.

Rep. Larry Bucshon (R-IN). Rep. Bucshon waived on to the subcommittee, first expressing his support for MA and commitment to ensuring it succeeds and works for patients. He expressed support for Improving Seniors' Timely Access to Care Act to facilitate electronic prior authorization and enable real-time decisions for items and services routinely approved. When asked, Mr. Mathews expressed support for considering ways encounter data can be submitted will less burden and in a timelier fashion.

Rep. Gus Bilirakis (R-FL). Rep. Bilirakis waived on to the subcommittee and expressed his support for MA, saying that not only is it very popular but that the federal government gets "more for its dollar" and provides additional value to beneficiaries. When asked if they evaluated overall outcomes, Ms. Bliss said they did not. Rep. Bilirakis said risk adjustment ensures adequate resources for those who may need more complex and costly care, but that it is possible that actual patient need is not reported. When asked how to improve validation, Ms. Gordon said that complete and accurate encounter data is necessary.

If you have questions, please contact Heather Meade or Laura Dillon.