



**MEMORANDUM**

**June 24, 2022**

**To: Subcommittee on Oversight and Investigations Members and Staff**

**Fr: Committee on Energy and Commerce Staff**

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

On **Tuesday, June 28, 2022, at 11:00 a.m. (EDT), in the John D. Dingell Room, 2123 of the Rayburn House Office Building, and via Cisco WebEx online video conferencing**, the Subcommittee on Oversight and Investigations will hold a hearing entitled, “Protecting America’s Seniors: Oversight of Private Sector Medicare Advantage Plans.” The hearing will examine the quality of care that America’s seniors are receiving through Medicare Advantage plans and the fiscal sustainability of the Medicare Advantage program.

**I. BACKGROUND**

Medicare beneficiaries can choose to receive their benefits under the traditional fee-for-service (FFS) Medicare program or through the Medicare Advantage (MA) program, a private-plan alternative. While traditional Medicare offers an unconstrained choice of health care providers, MA plans offer alternative delivery systems with a more limited provider network, employ care and utilization management techniques, and develop robust information systems that provide timely feedback to providers.<sup>1</sup>

Enrollment in MA has more than doubled in the last 10 years. For 2021, the MA program enrolled nearly 27 million beneficiaries—or 46 percent of all Medicare beneficiaries with both Parts A and B—at a cost of approximately \$350 billion (not including Part D drug plan payments).<sup>2</sup> While the MA program’s popularity among seniors has grown, recent reports have raised concerns about MA enrollees’ access to medically necessary care and the fiscal sustainability of the MA program.<sup>3</sup>

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<sup>1</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>2</sup> *Id.*

<sup>3</sup> *Medicare Advantage Plans Often Deny Needed Care, Federal Report Finds*, New York Times (Apr. 29, 2022); *Medicare Advantage’s Cost to Taxpayers Has Soared in Recent Years, Research Finds*, NPR (Nov. 11, 2021); *Medicare Advantage Plans Have Great Promise but They Are Not Delivering*, Forbes (June 15, 2022).

## II. MEDICARE PAYMENTS TO MA PLANS

Traditional Medicare pays on an FFS basis each time a beneficiary accesses services and supplies. By contrast, the MA program pays insurance plans a monthly capitated payment for each enrollee. The amount paid to each MA plan is risk adjusted based on the medical history and demographics of the enrollees.<sup>4</sup> MA plans are required to provide all Medicare Part A and Part B services, excluding hospice.<sup>5</sup>

MA plans submit annual bids—i.e., estimated costs of providing Medicare-covered services, administration, and profit—and are paid depending on how these bids compare to benchmarks established by the Centers for Medicare & Medicaid Services (CMS).<sup>6</sup> If an MA plan's bid is higher than the benchmark, then the plan is paid the benchmark amount and enrollees must pay the difference between the bid and the benchmark in the form of premiums. If an MA plan's bid is lower than the benchmark, then the Medicare payment to the plan equals the bid plus a rebate, which ranges from 50 to 70 percent of the difference between the bid and the benchmark and is frequently used by MA plans to offer supplemental benefits to enrollees.

CMS calculates the benchmarks using payment data from the traditional Medicare program and risk adjusts the benchmarks to reflect the demographic and health history of MA plans' enrollees. CMS relies on a diagnosis-driven model to determine enrollees' relative level of medical need—more diagnosis codes for a plan's enrollees generally leads to higher risk-adjustment payments to that plan. MA plans have several mechanisms that do not exist under traditional Medicare to document diagnoses for their enrollees, including chart reviews of previous provider encounters and health risk assessments (HRAs).<sup>7</sup> CMS also increases the risk-adjusted benchmarks for MA plans with a higher star rating, which is a score calculated using more than 40 measures of clinical quality, patient experience, and administrative performance.<sup>8</sup>

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<sup>4</sup> Congressional Research Service, *Medicare Advantage (MA)—Proposed Benchmark Update and Other Adjustment for CY2020: In Brief* (Feb. 7, 2019) (R45494); Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>5</sup> Congressional Research Service, *Medicare Advantage (MA)—Proposed Benchmark Update and Other Adjustment for CY2020: In Brief* (Feb. 7, 2019) (R45494).

<sup>6</sup> Medicare Payment Access Commission, *Medicare Advantage Program Payment System* (Nov. 2021).

<sup>7</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns* (Dec. 2019) (OEI-03-17-00470); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns* (Sept. 2020) (OEI-03-17-00471); Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Companies Leverage Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments* (Sept. 2021) (OEI-03-17-00474).

<sup>8</sup> Medicare Payment Access Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2020).

### III. BENEFICIARY EXPERIENCE UNDER MA PLANS

#### A. Improper Delays or Denials of Medically Necessary Care

Several studies have raised concerns that some beneficiaries enrolled in MA plans are not receiving timely, medically necessary care and that delayed care can negatively impact beneficiaries' health. Specifically, in April 2022, the Department of Health and Human Services Office of Inspector General (OIG) reported that MA plans sometimes delayed or denied beneficiaries' access to medically necessary services such as advanced imaging services, radiation therapy, and stays in post-acute facilities, despite those requests meeting Medicare coverage rules.<sup>9</sup> For instance, OIG found that an MA plan initially denied a request for radiation therapy for a patient with prostate cancer and a computerized tomography (CT) scan for a patient with endometrial cancer.<sup>10</sup> OIG found that 13 percent of MA plans' prior authorization denials that OIG examined met Medicare coverage rules and would have been approved under traditional Medicare. In addition, OIG examined payment denials and found that 18 percent of the provider payment requests denied by MA plans met both Medicare coverage rules and MA plan billing rules.<sup>11</sup>

CMS audits have also highlighted widespread and persistent MA organization performance problems related to denials of care and payment. CMS's 2015 audit of a portion of MA contracts resulted in 56 percent of those contracts being cited for inappropriate denials.<sup>12</sup> As OIG stated, CMS' findings are concerning because 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.<sup>13</sup>

A September 2018 OIG report also raised concerns about the validity of MA plans' denials of prior authorizations and payments. Specifically, that report found that while beneficiaries and providers appealed only one percent of denials to the first level of appeal, MA organizations overturned 75 percent of the preauthorization and payment denials.<sup>14</sup>

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<sup>9</sup> Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (Apr. 2022) (OEI-09-18-00260).

<sup>10</sup> MA plans subsequently reversed the denials and authorized the requested services.

<sup>11</sup> Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (Apr. 2022) (OEI-09-18-00260).

<sup>12</sup> Department of Health and Human Services, Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018) (OEI-09-16-00410).

<sup>13</sup> Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (Apr. 2022) (OEI-09-18-00260).

<sup>14</sup> Department of Health and Human Services, Office of Inspector General, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (Sept. 2018) (OEI-09-16-00410).

## **B. Beneficiaries' Access to Specialized Care**

While traditional Medicare offers beneficiaries an unconstrained choice of health care providers, beneficiaries enrolled in MA plans are incentivized to stay within the MA plan's provider network, which may limit access to certain specialists. This phenomenon may be more acute for rural beneficiaries as MA market concentration is higher in rural areas than urban areas, suggesting less choice for rural beneficiaries.<sup>15</sup>

A Government Accountability Office (GAO) report in June 2021 also found that beneficiaries in the last year of life disenrolled from MA plans to join traditional Medicare at more than twice the rate of all other MA beneficiaries.<sup>16</sup> Since beneficiaries in their last year of life may need access to specialized care and require more services than those newly eligible for Medicare, the high rate of disenrollment raises concerns about whether these beneficiaries are able to access medically necessary care while enrolled in an MA plan.<sup>17</sup>

## **IV. FINANCIAL SUSTAINABILITY OF THE MA PROGRAM**

Although at its inception the MA program was expected to reduce Medicare spending, MA plans in the aggregate have never produced savings for Medicare due to the MA program's payment policies.<sup>18</sup> The Medicare Payment Advisory Commission (MedPAC) identified a number of payment-related policies that are flawed and result in increased spending.<sup>19</sup> Additionally, MedPAC found that the data submitted by MA plans about beneficiaries' health care encounters are incomplete, making it difficult to conduct appropriate program oversight. MedPAC concluded that these payment-related policies will further worsen Medicare's long term fiscal sustainability.

## **A. MA Continues to Cost More Than Traditional Medicare**

Since 2004, MedPAC has found that MA spending has been consistently higher than FFS spending.<sup>20</sup> In 2022, MedPAC found that Medicare spent four percent *more* for MA enrollees than it would have spent if those enrollees remained in traditional Medicare.<sup>21</sup> An analysis by

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<sup>15</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>16</sup> Government Accountability Office, *Medicare Advantage: Beneficiary Disenrollment to Fee-for-Service in Last Year of Life Increase Medicare Spending* (June 2021) (GAO-21-482).

<sup>17</sup> Government Accountability Office, *Medicare Advantage: Beneficiary Disenrollment to Fee-for-Service in Last Year of Life Increase Medicare Spending* (June 2021) (GAO-21-482); Centers for Medicare & Medicaid Services, *Demographic Factors Used to Project Medicare Expenditures—Incorporation of Time-to-Death to Account for Increasing Longevity on the Age-Sex Distribution of Spending* (Apr. 22, 2020) (<https://www.cms.gov/files/document/incorporation-time-death-medicare-demographic-assumptions.pdf>).

<sup>18</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>19</sup> *Id.*

<sup>20</sup> Medicare Payment Access Commission, *For the Record: MedPAC's Response to AHIP's Recent "Correcting the Record" Blog Post* (Mar. 3, 2021) (<https://www.medpac.gov/for-the-record-medpacs-response-to-ahips-recent-correcting-the-record-blog-post/>).

<sup>21</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

the Kaiser Family Foundation also found that spending for MA enrollees was \$321 higher per person than if those individuals had instead been covered by traditional Medicare.<sup>22</sup> Medicare spending for supplemental benefits in the MA program accounts for 15 percent of payments to MA plans.<sup>23</sup> While Medicare payments for supplemental benefits have increased by 53 percent from 2019 to 2022, there is no data on their utilization by beneficiaries or information about their value including its impact on health outcomes.<sup>24</sup>

## **B. Impact of Coding on the MA Program**

The purpose of the risk adjustment program is to ensure MA plans are adequately compensated for enrollees who are older or sicker as well as those with less health care utilization. CMS determines an MA plan's risk-adjusted benchmark, in part, by examining the diagnosis codes associated with the plan's enrollees. Thus, the more diagnosis codes associated with the enrollees in an MA plan will generally lead to higher risk adjustment payments to that plan. In its most recent report to Congress, MedPAC found that beneficiary risk scores have grown faster under MA than traditional Medicare.<sup>25</sup>

In 2020, MedPAC found that coding intensity, the difference in risk scores caused by additional diagnoses or upcoded diagnoses by MA plans, resulted in MA risk scores that were 9.5 percent higher than scores for similar beneficiaries in traditional Medicare,<sup>26</sup> and has resulted in inflated payments to MA plans.<sup>27</sup> In 2020, the differences in diagnostic coding resulted in \$12 billion more in payments to MA plans than Medicare would have spent if the same beneficiaries were enrolled in traditional Medicare.<sup>28</sup>

According to MedPAC and OIG, MA plans have used tools such as HRAs and chart reviews to increase diagnosis coding.<sup>29</sup> Specifically, MedPAC found in 2022 that nearly two-thirds of the MA coding intensity could be due to HRAs and chart reviews.<sup>30</sup> OIG found in

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<sup>22</sup> Kaiser Family Foundation, *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges* (Aug. 17, 2021) (<https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>).

<sup>23</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*; Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Companies Leverage Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments* (Sept. 2021) (OEI-03-17-00474); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns* (Sept. 2020) (OEI-03-17-00471); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns* (Dec. 2019) (OEI-03-17-00470).

<sup>30</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

2019, 2020, and 2021 that some MA companies drove billions of dollars in payments by reporting diagnosis codes found only on HRAs and chart reviews, not in actual service records. These findings raise concerns about the validity of the diagnoses that were only reported on the HRAs, the quality of care coordination for beneficiaries, and that beneficiaries are not receiving the medical services needed for these additional diagnoses.<sup>31</sup> Additionally, inflated payments due to increased coding intensity undermines quality in the MA program<sup>32</sup> and negatively impacts Medicare’s fiscal sustainability.<sup>33</sup>

Risk Adjustment Data Validation (RADV) audits are an essential tool for CMS to examine whether the diagnosis data submitted by MA plans are supported by patients’ medical records and ensure proper payments to MA plans. GAO has found that CMS can improve the criterion used to select contracts for audit and take steps to improve the timeliness of the RADV audit process.<sup>34</sup>

## **V. OTHER ISSUES IN THE MA PROGRAM**

### **A. Disparities of Care**

A June 2021 JAMA Health Forum article found that MA contracts with higher star ratings had larger racial and ethnic disparities than did those with lower star ratings.<sup>35</sup> Furthermore, MA contracts with lower concentrations of individuals of low socioeconomic status and Black or Hispanic individuals had larger disparities and worse quality for these individuals.<sup>36</sup> An April 2021 CMS and Rand report also found that, with one exception, racial and ethnic minority MA beneficiaries reported experiences with care that were either worse than or similar to the experiences reported by White beneficiaries.<sup>37</sup>

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<sup>31</sup> Department of Health and Human Services, Office of Inspector General, *Some Medicare Advantage Companies Leverage Chart Reviews and Health Risk Assessments to Disproportionately Drive Payments* (Sept. 2021) (OEI-03-17-00474); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns* (Sept. 2020) (OEI-03-17-00471); Department of Health and Human Services, Office of Inspector General, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns* (Dec. 2019) (OEI-03-17-00470).

<sup>32</sup> Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

<sup>33</sup> Kaiser Family Foundation, *Higher and Faster Growing Spending Per Medicare Advantage Enrollee Adds to Medicare’s Solvency and Affordability Challenges* (Aug. 17, 2021) (<https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>).

<sup>34</sup> Government Accountability Office, *Medicare Advantage: Fundamental Improvements Needed in CMS’s Effort to Recover Substantial Amounts of Improper Payments* (Apr. 2016) (GAO-16-76); Government Accountability Office, *Medicare Advantage Program Integrity: CMS’s Efforts to Ensure Proper Payments and Identify and Recover Improper Payments* (July 19, 2017) (GAO-17-761T).

<sup>35</sup> David J. Meyers et al., *Association of Medicare Advantage Star Ratings with Racial, Ethnic, and Socioeconomic Disparities in Quality of Care*, JAMA Health Forum (June 11, 2021).

<sup>36</sup> *Id.*

<sup>37</sup> Centers for Medicare & Medicaid Services and the Rand Corporation, *Racial, Ethnic, & Gender Disparities in Health Care in Medicare Advantage* (Apr. 2021).

## **B. Quality Bonus Program**

The quality bonus program with its star rating system is intended to be a source of information about the quality of MA plans for beneficiaries. However, MedPAC has found that the program, which cost \$6 billion in 2019 and is projected to cost \$94 billion over 10 years, is flawed.<sup>38</sup> MedPAC found that the way that measures are examined and reported are not particularly useful as an indicator of quality of care provided in a beneficiary's local area.<sup>39</sup> Additional studies also suggest that the MA quality bonus program has not improved plan quality.<sup>40</sup>

## **C. Network Adequacy**

A 2015 GAO report found that CMS' criteria for network adequacy—a minimum number of providers and maximum travel time and distance to those providers—do not reflect provider availability and MA provider networks may appear to be more robust than they are.<sup>41</sup> In addition, although CMS requires MA plans entering a market to submit standardized data via an automated system, GAO found that the agency does little to assess the accuracy of the network data and reviews only one percent of all provider networks.<sup>42</sup>

## **VI. WITNESSES**

The following witnesses have been invited to testify:

### **Erin Bliss**

Assistant Inspector General  
Office of Evaluation and Inspection  
Office of Inspector General  
Department of Health and Human Services

### **Leslie Gordon**

Acting Director  
Health Care  
Government Accountability Office

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<sup>38</sup> Medicare Payment Access Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2020); Congressional Budget Office, *Reduce Quality Bonus Payments to Medicare Advantage Plans* (Dec. 13, 2018).

<sup>39</sup> Medicare Payment Access Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2020).

<sup>40</sup> Adam A. Markovitz et al., *The Medicare Advantage Quality Bonus Program Has Not Improved Plan Quality*, Health Affairs (Dec. 2021); Adam A. Markovitz et al., *Medicare Advantage Plan Double Bonuses Drive Racial Disparity in Payments, Yield No Quality or Enrollment Improvements*, Health Affairs (Sept. 2021).

<sup>41</sup> Government Accountability Office, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy* (Aug. 2015) (GAO-15-710).

<sup>42</sup> *Id.*

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