HANDOUT 1

MEMORANDUM

To: ALC-Employee Benefits Division Oversight Subcommittee

From: Winston F. Simpson, Public School Retiree

Subject: Medicare Advantage Health Insurance Implementation Oversight

Date: July 20, 2022

I ask that this committee and Employee Benefits Director Bleed oversee implementation of the United Healthcare Medicare Advantage plan designed for Arkansas State and Public School retirees in a manner that makes sure that (1) retirees receive timely, medically necessary care to which they are entitled under Medicare coverage rules, and (2) retirees and providers are not negatively impacted by unnecessary, burdensome preauthorization requests, data submission, and appeals of denials of service.

This request is based on recent reports that seniors enrolled in private sector Medicare Advantage plans are facing unwarranted barriers to accessing timely, medically necessary care and that enrollees in Medicare Advantage plans cost Medicare more per enrollee than Original Medicare enrollees thereby increasing the threat to solvency of Medicare. The attachments to this memo are statements presented June 28, 2022 before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives. Additional statements presented to the Subcommittee may be found at https://energycommerce.house.gov/committee-activity/hearings/hearing-on-protecting-americas-seniors-oversight-of-private-sector.

The handwritten page numbers are provided to assist reference to the few issues listed below.

1. **The US Department of Health and Human Services Office of Inspector General, in an April 2022 study, found that 13% of Medicare Advantage plans' preauthorization denials examined by OIG met Medicare rules and would have been approved under traditional Medicare. Additionally, OIG examined payment denials and found that 18% of provider payment requests denied by Medicare Advantage plans met both Medicare coverage rules and Medicare Advantage plan billing rules. Further, a September 2018 OIG report found that Medicare Advantage plans reversed 75% of their own preauthorization and payment denials. But that report found that beneficiaries and providers appealed only 1% of denials to the first level of the appeal process. So, almost all those denials for preauthorization and payment for services represent denial of access to health services or payment for health services to which seniors were entitled to under Medicare rules. (page 3)**

2. **A Government Accountability Office report in June 2021 found that beneficiaries in the last year of life disenrolled from Medicare Advantage plans to join traditional Medicare at more than twice the rate of all other Medicare Advantage beneficiaries. The rate of disenrollment raises concerns about whether these beneficiaries are able to access medically necessary care while enrolled in Medicare Advantage plan. (page 4)**

3. **In 2022, the Medicare Payment Advisory Commission found that Medicare spent 4% more for Medicare Advantage enrollees than it would have spent if those enrollees remained in traditional Medicare (page 4).**
   Note: Traditional Medicare pays on a Fee For Service basis each time a beneficiary accesses services and supplies. By contrast, Medicare pays Medicare Advantage plans a monthly capitulated payment for each enrollee. The amount Medicare pays to a Medicare Advantage plan for an enrollee is paid on a risk adjusted basis (page 2). In its most recent report to Congress, MedPAC found beneficiary risk scores have grown faster under Medicare Advantage plans than traditional Medicare. In 2020, the difference in diagnostic coding resulted in $12 billion more in payments to Medicare Advantage plans than Medicare would have spent if the same beneficiaries were enrolled in traditional Medicare (page 5).

4. **The US Department of Health and Human Services Office of Inspector General, in an April 2022 study, found that Medicare Advantage plans denied many preauthorization requests that met Medicare coverage rules by applying Medicare Advantage clinical criteria that are not required by Medicare. (page 12)**

Suggested Oversight Actions:

1. **Director Bleed and staff should work with CMS to obtain, on an as-reported, United Healthcare plan "Organization Determinations & Reconsiderations" and "Enrollment and Disenrollment" as reported to CMS by the plan. These reports will include denials of preauthorization requests, denials of requests for payment for services and supplies, and appeals and the plan's actions on same.**

2. **Director Bleed and staff should require United Healthcare to provide copies of their clinical criteria United Healthcare used in assessment of requests for preauthorization and payment for services and supplies. With the aid of CMS, Director Bleed and staff should compare the criteria supplied with traditional Medicare coverage criteria to assure that the plan's clinical criteria are "no more restrictive than original Medicare's national and local coverage policies."**

3. **Director Bleed and staff should undertake such other oversight actions as they deem necessary to assure members of the plan access to timely, medically necessary health care services that meet Medicare's national and local coverage policies.**

4. **Director Bleed and staff should report their findings to and make any appropriate recommendations to the ALC-Employee Benefits Division Oversight Subcommittee based on their review of these data.**

COMMITTEE ON
ENERGY & COMMERCE

CHAIRMAN FRANK PALLONE, JR.

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.[1]

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).[2] 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.[3]

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[1] Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

[2] *Id.*

[3] *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.[4] MA plans are required to provide all Medicare Part A and Part B services, excluding hospice.[5]

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).[6] 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).[7] 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.[8]

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[4] 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).

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

[6] Medicare Payment Access Commission, *Medicare Advantage Program Payment System* (Nov. 2021).

[7] 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).

[8] 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.[9] 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.[10] 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.[11]

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.[12] 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.[13]

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.[14]

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[9] 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).

[10] MA plans subsequently reversed the denials and authorized the requested services.

[11] 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).

[12] 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).

[13] 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).

[14] 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.[15]

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.[16] 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.[17]

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.[18] The Medicare Payment Advisory Commission (MedPAC) identified a number of payment-related policies that are flawed and result in increased spending.[19] 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.[20] 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.[21] An analysis by

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[15] Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

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

[17] 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).

[18] Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

[19] *Id.*

[20] 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/).

[21] 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.[22] Medicare spending for supplemental benefits in the MA program accounts for 15 percent of payments to MA plans.[23] 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.[24]

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.[25]

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,[26] and has resulted in inflated payments to MA plans.[27] 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.[28]

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

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[22] 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-medicares-solvency-and-affordability-challenges/).

[23] Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] *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).

[30] 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.[31] Additionally, inflated payments due to increased coding intensity undermines quality in the MA program[32] and negatively impacts Medicare's fiscal sustainability.[33]

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.[34]

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.[35] 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.[36] 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.[37]

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[31] 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).

[32] Medicare Payment Access Commission, *Report to Congress: Medicare Payment Policy* (Mar. 2022).

[33] 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-medicares-solvency-and-affordability-challenges/).

[34] 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).

[35] 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).

[36] *Id.*

[37] 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.[38] 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.[39] Additional studies also suggest that the MA quality bonus program has not improved plan quality.[40]

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.[41] 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.[42]

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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[38] 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).

[39] Medicare Payment Access Commission, *Report to Congress: Medicare and the Health Care Delivery System* (June 2020).

[40] 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).

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

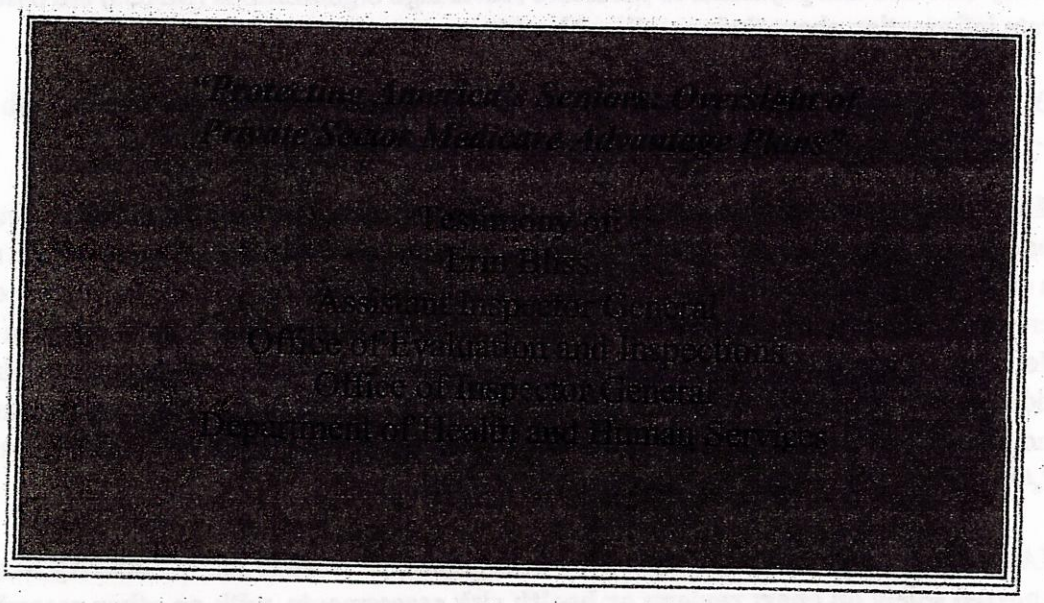
[42] *Id.*

James E. Mathews, Ph.D.
Executive Director
Medicare Payment Advisory Commission

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Testimony Before the
United States House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations



June 28, 2022

11 a.m.

2123 Rayburn House Office Building

Testimony of:
Erin Bliss
Assistant Inspector General for Evaluation and Inspections
Department of Health and Human Services, Office of Inspector General

Good morning, Chair DeGette, Ranking Member Griffith, and distinguished Members of the Subcommittee. I am Erin Bliss, Assistant Inspector General for Evaluation and Inspections, at the Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to appear before you today to discuss oversight of Medicare Advantage plans.

In 2021, approximately 26 million Medicare beneficiaries (more than 40 percent) were enrolled in Medicare Advantage plans, continuing a trend of significant growth in Medicare Advantage enrollment.[1] One of OIG's top priorities is ensuring that the Medicare Advantage program works effectively and provides quality care for enrollees and value for taxpayers. This priority includes ensuring that Medicare Advantage enrollees have access to appropriate and medically necessary care and that payments to Medicare Advantage organizations (MAOs) are based on accurate information about their enrollees' health conditions.

Today, I will focus my testimony on two lines of OIG evaluations aimed at advancing those goals. In summary, we have identified the following concerns:

- **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. These denials likely prevented or delayed needed care for beneficiaries. 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.

[1] Kaiser Family Foundation, *Medicare Advantage in 2021: Enrollment Update and Key Trends*, June 2021.

In my testimony, I will provide further details and context on these findings and highlight the actions that OIG has recommended the Centers for Medicare & Medicaid Services (CMS) take to better ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, that providers are paid appropriately, and that MAOs do not inappropriately inflate their risk-adjustment payments by reporting inaccurate diagnoses.

MEDICARE ADVANTAGE DENIALS OF SERVICES AND PAYMENTS

OIG's most recent report on Medicare Advantage examined MAO denials of requests for prior authorization, which is preapproval for a service or item before the beneficiary receives it, and denials of payment requests from a provider for a service already delivered to the beneficiary.[2]

Why Focus Oversight on Medicare Advantage Denials

Incentives. A central concern about capitated payment models, including Medicare Advantage, is the potential incentive for insurers to deny access to services for enrollees and deny payments to providers to increase profits. MAOs are paid a fixed amount of money each month for each enrollee, regardless of the number or cost of services they pay for on behalf of that enrollee.

Volume of Denials. Although MAOs approve the vast majority of requests for services and payment, they issue millions of denials each year. In 2018, MAOs denied 1.5 million prior authorization requests (5 percent of all prior authorization requests) and 56.2 million payment requests overall (9.5 percent of all payment requests) in the Medicare Advantage program.

Prior Evidence of Problems. OIG's previous analysis of Medicare Advantage appeals outcomes raised concerns about MAO denials.[3] When beneficiaries and providers appealed service and payment denials, MAOs overturned 75 percent of their own denials during 2014–2016. Independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers. The high rate of overturned denials raises concerns that some beneficiaries and providers were initially denied services and payments that should have been provided. This is especially concerning because beneficiaries and providers appealed only 1 percent of denials. In addition, OIG found that CMS's annual audits of MAOs from 2012 through 2016 commonly identified problems related to denials.

How OIG Assessed Medicare Advantage Denials

For our most recent report, we selected a stratified random sample of 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs by enrollment during June 1–7, 2019.[4] Health care coding experts reviewed case files for all cases, and

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[2] OIG, *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*, (OEI-09-19-00260), April 2022.
[3] OIG, *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns about Service and Payment Denials*, (OEI-09-16-00419), September 2018.
[4] These 15 MAOs accounted for nearly 80 percent of Medicare Advantage enrollees.

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physician reviewers examined medical records for a subset of cases that warranted medical necessity review. From these results, we estimated the rates at which MAOs denied prior authorization and payment requests that met Medicare coverage rules and MAO billing rules.[5] We also examined the reasons for these denials in our sample.

OIG Findings Raise Concerns About MAO Denials of Services

13% of prior authorization denials were for services that met Medicare coverage rules

Among prior authorization requests that MAOs denied, 13 percent were for requests that met Medicare coverage rules. In other words, these services likely would have been approved in original Medicare. This rate projects to 1,631 prior authorization denials for requests that met Medicare coverage rules for these MAOs during the first week of June 2019.[6] Such denials can have a range of negative impacts, such as beneficiaries not receiving needed care, delays in receiving needed care, beneficiaries receiving an alternative service that may be less effective for their needs, beneficiaries paying out-of-pocket for care, and/or administrative burden for beneficiaries or their providers who choose to appeal the denial.

IMPACT: Denials likely prevented or delayed needed care

MAO use of internal clinical criteria contributed to many of these denials in our sample. For many of the denials of prior authorization requests in our sample for services that met Medicare coverage rules, MAOs denied the requests by applying MAO clinical criteria that are not required by Medicare. MAOs must follow Medicare coverage rules, which specify what items and services are covered and under what circumstances. However, they are also permitted to use additional clinical criteria that were not developed by Medicare, as long as such criteria are "no more restrictive than original Medicare's national and local coverage policies."[7]

CMS guidance on the appropriate use of such criteria is insufficient. In several cases, we were unable to determine whether the prior authorization denials that met Medicare coverage rules would be considered appropriate by CMS because CMS's guidance regarding MAO use of internal clinical criteria is not sufficiently detailed. The following example illustrates why more guidance and clarity is needed to apply this requirement.

[5] Our sampling method enables us to project these rates to the universe of all denials by the 15 largest MAOs during this time period. However, it does not enable us to estimate MAO-specific rates or to project the reasons for denials from our sampled cases to the universe of denials.

[6] For an annual context, if these MAOs denied the same number of prior authorization requests in each week of 2019, they would have denied 84,812 beneficiary requests for services that met Medicare coverage rules that year.

[7] CMS, *Medicare Managed Care Manual*, chapter 4, section 10.16, p. 28.

Denial of CT Scan Illustrates Why More Guidance Is Needed on Use of MAO Clinical Criteria

An MAO denied a prior authorization request for a computed tomography (CT) scan that our physician reviewers determined was medically necessary to exclude a life-threatening diagnosis (aneurysm) based on the beneficiary's symptoms and comorbidities. The MAO stated that its clinical criteria required the beneficiary to have an x-ray first to prove that a CT scan was needed.

Medicare's coverage policy for CT scans states: "[T]here is no general rule that requires other diagnostic tests to be tried before CT scanning is used."

One might conclude that the MAO criteria in this case was "more restrictive" than the Medicare coverage policy and thus not allowable. However, CMS officials reported to OIG that MAOs may establish additional clinical criteria for Medicare-covered services, as long as the criteria are evidence-based and do not "contradict" the applicable Medicare coverage rules. In this example, the denial might be considered allowable if CMS judged that the MAO's x-ray requirement was evidence-based and did not contradict the Medicare coverage policy for CT scans.

Other prior authorization denials in our sample resulted from MAO requests for unnecessary documentation. In some of these cases, MAOs requested copies of documentation already contained in the case file.

OIG Findings Raise Concerns About MAO Denials of Payments

18% of payment denials were for claims that met Medicare coverage rules and MAO billing rules

An estimated 18 percent of payment denials met Medicare coverage rules and MAO billing rules and therefore the provider payments should not have been denied by the MAOs. This projects to 28,949 payment denials that met Medicare coverage rules and MAO billing rules for these MAOs during the first week of June 2019.[8] Denying payment requests that meet Medicare and MAO rules delays or prevents providers from receiving payment for services that they have already delivered to beneficiaries.

IMPACT: Denials prevented or delayed payments to providers for services already delivered

Human errors during manual reviews contributed to these payment denials. MAOs rely on their staff to manually review some requests for payments before approving or denying them.

[8] For an annual context, if these MAOs denied the same number of payment requests each week of 2019, they would have denied 1.5 million payment requests that met Medicare coverage rules and MAO billing rules that year.

These reviews are susceptible to human error, such as a reviewer's overlooking a document in the case file or inaccurately interpreting CMS or MAO coverage rules.

System programming errors also contributed to payment denials. MAOs denied some payment requests because of inaccurate programming of claims processing systems. System errors can cause greater harm because they could generate large volumes of incorrect denials until the MAO notices and fixes the error.

OIG Recommends Ways for CMS To Better Protect Beneficiaries and Providers From Inappropriate Denials

We have recommended that CMS take the following actions to ensure that beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately:

- **issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews,**
- **incorporate the issues identified in our evaluation into its audits of MAOs, and**
- **direct MAOs to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.**

CMS agreed with each of these recommendations and indicated that it plans to implement them.

In addition, two of OIG's recommendations remain open from our 2018 report on outcomes of Medicare Advantage appeals. These recommendations are that CMS:

- **enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate, and**
- **provide beneficiaries with clear, easily accessible information about serious violations by MAOs.**

Although CMS agreed with these recommendations, it has not yet fully implemented them. CMS implemented our third recommendation from that 2018 report. In 2019, CMS revised its Civil Money Penalty Calculation Methodology to include a new aggravating factor for inappropriate delay or denial of medical services, drugs, and/or appeal rights, and new aggravating factors for prior offenses—all changes that better hold MAOs accountable for ensuring appropriate access to care.

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USE OF CHART REVIEWS AND HEALTH RISK ASSESSMENTS

OIG has issued a series of evaluations examining the financial impacts of chart reviews and health risk assessments on Medicare Advantage risk-adjustment payments.[9] Risk adjustment is a mechanism to increase payments to MAOs for covering sicker beneficiaries based on beneficiary diagnoses. Chart reviews and health risk assessments are ways that MAOs can identify and add diagnoses to the data they submit to CMS for their beneficiaries, which may increase the payments they receive.

> Chart Reviews: Retrospective reviews of beneficiaries' medical record documentation to identify and add diagnoses that providers did not originally submit to the MAO and to delete any invalid diagnoses.
>
> Health Risk Assessments: Health care professionals collect information from beneficiaries about their health status, health risks, and daily activities. Some MAOs contract with vendors to visit beneficiaries in their homes to conduct these assessments. Health risk assessments are meant to improve care and support care coordination.

Why Focus Oversight on Chart Reviews and Health Risk Assessments

Incentives. Although risk adjustment is an important mechanism to help ensure that beneficiaries who need a costlier level of care have continued access to MA plans, it may also create financial incentives for MAOs to make beneficiaries appear as sick as possible to increase these payments. Most beneficiary diagnoses are submitted by treating providers to MAOs. However, chart reviews and health risk assessments offer ways for MAOs to add diagnoses to the data CMS uses for risk adjustment more directly (i.e., through chart reviews) or indirectly (e.g., through a vendor conducting health risk assessments for the MAO).

Inappropriate Risk-Adjustment Payments. CMS reported a payment error rate of 10.3 percent for Medicare Advantage risk-adjustment payments in FY 2021, which resulted in net overpayments of almost $7.2 billion.[10] Through two series of compliance audits, OIG has questioned costs related to the diagnosis codes that MAOs submit to CMS. One OIG series of audits involves sampling from all diagnosis codes submitted by a plan, and OIG's completed audits of two plans have identified questioned costs of $252 million.[11] The other OIG series is

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[9] OIG, *Billions in Estimated Medicare Advantage Payments From Chart Reviews Raise Concerns*, OEI-03-17-00470, December 2019; OIG, *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on Health Risk Assessments Raise Concerns*, OEI-03-17-00471, September 2020; OIG, *Some Medicare Advantage Companies Leveraged Chart Reviews and Health Risk Assessments To Disproportionately Drive Payments*, OEI-03-17-00474, September 2021.

[10] CMS, Part C Improper Payment Measure Fiscal Year 2021 Payment Error Rate Results.

[11] OIG, *Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS*, A-07-16-01165, April 2021; OIG, *Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS*, A-07-17-01169, January 2022.

targeting specific diagnosis codes. We have completed 8 targeted audits in this series with total questioned costs of $37.4 million.[12] We have additional audits underway for both series. Finally, in a recent investigation of a provider that OIG conducted with the Department of Justice, Sutter Health and its affiliates agreed to pay $90 million and enter into a corporate integrity agreement with OIG to settle False Claims Act allegations that it knowingly submitted unsupported diagnoses for beneficiaries in Medicare Advantage plans, resulting in inflated risk-adjustment payments.[13]

Prior Concerns About Chart Reviews and Health Risk Assessments. OIG's work builds on concerns raised by other oversight entities. In 2016, the Government Accountability Office (GAO) raised concern that diagnoses collected from MAOs' chart reviews may be less likely to be supported by medical records than diagnoses submitted to MAOs by providers.[14] CMS and the Medicare Payment Advisory Commission (MedPAC) have questioned whether MAOs use health risk assessments primarily as a strategy to submit more diagnoses to increase payments rather than to improve the care provided to their beneficiaries. Since 2016, MedPAC has recommended that HHS eliminate health risk assessments as a source of diagnoses for risk-adjustment payments.[15]

How OIG Assessed the Financial Impact of Chart Reviews and Health Risk Assessments

We analyzed Medicare Advantage encounter data from 2016 to identify diagnoses that were included solely on chart reviews or health risk assessments and not on any other records of services for beneficiaries during that year. We then calculated how much these diagnoses increased the 2017 risk-adjustment payments to those MAOs. We also compared across MAOs to determine whether any MAO's use of chart reviews and health risk assessments increased their risk-adjustment payments disproportionately relative to their size and their peers.

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[12] *Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements*, A-07-17-01170, April 2019; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS*, A-02-18-01028, February 2021; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS*, A-07-19-01187, May 2021; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS*, A-07-17-01173, October 2021; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS*, A-07-19-01188, November 2021; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS*, A-02-18-01029, January 2022; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS*, A-01-19-00500, February 2022; OIG, *Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS*, A-06-18-05002, May 2022.

[13] DOJ, Sutter Health and Affiliates to Pay $90 Million to Settle False Claims Act Allegations of Mischarging the Medicare Advantage Program, August 30, 2021.

[14] GAO, *Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, GAO-16-76, April 2016, p.13.

[15] As part of this recommendation, MedPAC recommended that the Secretary develop a risk-adjustment model that uses 2 years of Medicare fee-for-service and MA diagnostic data. See MedPAC, Report to the Congress: Medicare Payment Policy, March 2016, p. 352.

OIG Findings Raise Concerns About MAOs' Use of Chart Reviews and Health Risk Assessments

$6.7 Billion in payments to MAOs were generated by diagnoses only on chart reviews and not on any service records

For 16.8 million chart reviews (41 percent), there were no service records of visits, procedures, tests, or supplies that contained the diagnosis reported on the chart review. These 16.8 million chart reviews corresponded to 4.5 million beneficiaries (MAOs can submit multiple chart reviews for the same beneficiaries). This means that, for the entire year, these beneficiaries may not have received any other services for the medical conditions indicated by the diagnoses. However, Medicare paid MAOs an estimated $6.7 billion in risk-adjustment payments in 2017 arising from these chart review diagnoses to provide care for these beneficiaries.

Although chart reviews are intended to strengthen payment accuracy by both adding missing diagnoses and deleting invalid diagnoses, MAOs almost exclusively added diagnoses. Only 0.7 percent of chart reviews deleted diagnoses, while 99.3 percent added diagnoses.

Of these payments from chart reviews, an estimated $2.7 billion were driven by "unlinked" chart reviews, which may be more vulnerable to misuse. To be eligible for risk-adjustment payments, a diagnosis must be documented based on a visit with an eligible health care provider.

> Linked Chart Review: Points to a record of service that the beneficiary received from a health care provider as being the source of the medical documentation to support the newly added diagnosis.
>
> Unlinked Chart Review: Does not indicate what health care visit or service was the source of the medical documentation that supports the newly added diagnosis.

Unlinked chart reviews do not indicate what visit or service the diagnosis came from and often contain default or "dummy" procedure codes, which would make it difficult to use encounter data to validate whether the diagnosis is eligible for payment.

Many of these unlinked charted reviews added diagnoses for serious and chronic conditions, despite the beneficiaries having no records for services indicating these conditions. Common conditions from these unlinked reviews were vascular disease; diabetes with chronic complications; chronic obstructive pulmonary disease; congestive heart failure; and major depressive, bipolar, and paranoid disorders.

$2.6 Billion in payments to MAOs were generated by diagnoses only on health risk assessments and not on any other service records

MAOs reported diagnoses on health risk assessments for 3.5 million beneficiaries with no other encounter records of visits, procedures, tests, or supplies that contained the diagnosis reported on the assessment. These diagnoses resulted in an estimated $2.6 billion in risk-adjustment payments for 2017.

For the entire year, these beneficiaries may not have received other services for the medical conditions indicated by the diagnoses from their health risk assessments. This raises questions about whether these assessments were administered as part of a care plan that included care coordination as intended. When health risk assessments lack care coordination, such as providing information to beneficiaries' primary care providers and ensuring that beneficiaries receive needed treatment, they could become vehicles for MAOs to collect diagnoses rather than function as tools to improve beneficiary health.

In-home health risk assessments, which may be more vulnerable to misuse, generated 80 percent of the estimated payments from diagnoses reported only on health risk assessments. Health risk assessments are often conducted in a doctor's office as part of a wellness visit but may be conducted in beneficiaries' homes. In-home health risk assessments represented only one-third of the assessments we reviewed but accounted for 80 percent of the increased payments from their resulting diagnoses. Most of these in-home health risk assessments that resulted in increased payments were conducted by vendors on behalf of MAOs. The lack of other encounter records that contain the diagnoses identified by these vendors raises questions about whether the MAOs ensured that the results of these assessments were forwarded to beneficiaries' primary care providers; beneficiaries received appropriate followup care and treatment; and the diagnoses reported only on in-home health risk assessments were accurate.

In-home health risk assessments:

comprised 33% of assessments

led to 80% of risk-adjustment payments

Diagnoses from chart reviews or health risk assessments only—with no othe service records—raise three important concerns.

Payment Integrity: Some of these diagnoses may have been inaccurate and resulted in improper payments.

Quality of Care: Some of these beneficiaries may have had these often-serious diagnoses and may not have received needed care.

Data Integrity: Some beneficiaries may have had these diagnoses and received care, bu MAOs did not submit all service records as required, which hinders oversight.

20 of 162 MAOs:

Accounted for 54% of payments ($5 billion) solely from chart reviews or health risk assessments despite covering only 31% of beneficiaries in MA

Of the 162 MAOs with any risk-adjustment payments resulting solely from chart reviews or health risk assessments, 20 had a share of payments that was disproportionally higher than their size (defined by their share of enrolled beneficiaries). These 20 MAOs generated 54 percent ($5.0 billion) of the estimated $9.2 billion in total payments from diagnoses submitted solely on chart reviews and health risk assessments but enrolled only 31 percent of Medicare Advantage beneficiaries. Payments for 10 of these 20 MAOs were also disproportionately driven by unlinked chart reviews and in-home health risk assessments—each of which may be more vulnerable to misuse.

One MAO stood out from its peers in its use of chart reviews and health risk assessments to drive risk-adjustment payments. Among the top 20 MAOs, one MAO generated 40 percent ($3.7 billion of $9.2 billion) of all payments from diagnoses submitted solely on chart reviews and health risk assessments, yet it enrolled only 22 percent of all MA beneficiaries. Further, this MAO accounted for two-thirds of all payments resulting from in-home health risk assessments.

OIG Recommends Ways for CMS To Better Ensure Appropriate Payments to MAOs and Quality of Care for Enrollees

To better ensure appropriate MAO payments and patient quality of care, we have made several specific recommendations to CMS that address three key actions needed:

- **conduct targeted oversight of MAOs that are driving a high or disproportionate share of payments from chart reviews and/or health risk assessments,**
- **reassess the risks and benefits of allowing unlinked chart reviews and in-home health risk assessments to be used as sources of diagnoses for risk-adjustment payments, and**
- **require MAOs to implement best practices for care coordination for beneficiaries who receive health risk assessments.**

CMS has either implemented or taken steps to implement some of OIG's recommendations. CMS followed up with MAOs that had payments resulting from unlinked charts for beneficiaries who had no other service records in all of 2016. In addition, CMS has taken steps to include chart reviews in its audits that validate diagnoses for risk adjustment.

CMS has agreed to some additional recommendations but has not yet implemented them. These recommendations include providing targeted oversight of the MAOs that drove most of the risk-adjustment payments resulting from in-home health risk assessments.

CMS has disagreed with some of OIG's recommendations. These include recommendations to require MAOs to implement best practices for care coordination, to flag MAO-initiated health risk assessments in their MA encounter data, and to reassess the risks and benefits of allowing in-home health risk assessments to be used as the source of diagnoses for risk-adjustment payments.

OIG will continue to follow up with CMS on all our open recommendation to press for better safeguards over billions of dollars in Medicare Advantage risk-adjustment payments and to ensure that beneficiaries in Medicare Advantage receive the care that they need.

CONCLUSION

As Medicare Advantage enrollment continues to grow, MAOs play an increasingly critical role in ensuring that Medicare beneficiaries have appropriate access to needed care and that providers are reimbursed appropriately. It is also vital that MAOs submit accurate information about the diagnoses that drive billions of dollars in risk-adjustment payments. However, our evaluations raise concerns about how MAOs fulfill these critical responsibilities that affect beneficiary health and the value of taxpayer investments in the program.

Denied service requests that meet Medicare coverage rules may prevent or delay beneficiaries from receiving medically necessary care and can burden providers. Even when denials are reversed, avoidable delays and extra steps create friction in the program and may create an administrative burden for beneficiaries, providers, and MAOs. Further, beneficiaries enrolled in Medicare Advantage may not be aware that they may face greater barriers to accessing certain types of health care services in Medicare Advantage than in original Medicare.

At the same time, MAOs have the potential to inappropriately increase risk-adjustment payments—and thus, taxpayer costs—if they misuse chart reviews and health risk assessments. Diagnoses that show up solely on those reviews and assessments could also signal that some beneficiaries are not receiving services they may need to treat serious conditions.

It is critical that CMS take action to better ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, that providers are paid appropriately, and that MAOs do not inappropriately inflate their risk-adjustment payments. We have recommended several ways for CMS to do this and will continue to push for progress. OIG will also continue to be vigilant in our oversight work to promote payment integrity, beneficiary access, and quality of care in Medicare Advantage.

We appreciate the attention that the Subcommittee is bringing to these important issues and the opportunity to testify before you today. I welcome your questions.