

RPTR SCHOETTLE

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PROTECTING AMERICA'S SENIORS:

OVERSIGHT OF PRIVATE SECTOR

MEDICARE ADVANTAGE PLANS

MONDAY, JUNE 28, 2022

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 11:01 a.m., in Room 2123, Rayburn House Office Building, Hon. Diana DeGette [chairman of the subcommittee] presiding.

Present: Representatives DeGette, Kuster, Rice, Schakowsky, Tonko, Ruiz, Peters, O'Halleran, Schrier, Pallone (ex officio), Griffith, Burgess, Palmer, Dunn, Joyce, and Rodgers (ex officio).

Also Present: Representatives Buschon, and Bilirakis.

Staff Present: Austin Flack, Junior Professional Staff Member; Waverly Gordon, Deputy Staff Director and General Counsel; Tiffany Guarascio, Staff Director; Perry

Hamilton, Clerk; Xiaoyi Huang, GAO Detailee; Rebekah Jones, Oversight Counsel; Mackenzie Kuhl, Digital Assistant; Will McAuliffe, Counsel; Kaitlyn Peel, Digital Director; Chloe Rodriguez, Clerk; Harry Samuels, Professional Staff Member; Caroline Wood, Research Assistant; C.J. Young, Deputy Communications Director; Alec Aramanda, Minority Professional Staff Member, Health; Kate Arey, Minority Content Manager & Digital Assistant; Sarah Burke, Minority Deputy Staff Director; Marissa Gervasi, Minority Counsel, O&I; Brittany Havens, Minority Professional Staff Member, O&I; Nate Hodson, Minority Staff Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Clare Paoletta, Minority Policy Analyst, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Olivia Shields, Minority Communications Director; Alan Slobodin, Minority Chief Investigative Counsel, O&I; and Michael Taggart Minority Policy Director.

Ms. DeGette. The subcommittee on oversight and investigations hearing will now come to order.

Today, the Committee's having a hearing entitled "Protecting America's Seniors, Oversight of Private Medicare Advantage Plans." Today's 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.

Due to the COVID 19 public health emergency, Members and witnesses can participate in today's hearing, either in person or remotely via online video conferencing. In accordance with the updated guidance issued by the attending physician, Member's staff and members of the press present in the hearing room are not required to wear a mask.

For Members participating remotely, your microphones are set on mute for purposes of eliminating inadvertent background noise. Members participating remotely will need to unmute your microphone each time you wish to speak. Please note that once you unmute your microphone, anything that is said in Webex will be held over the loud speakers in the committee room and are also subject to being picked up by live stream and C-SPAN.

Because members are participating from different locations at today's hearing, all recognition of members, such as for questions, will be in order of subcommittee seniority. This may vary a little bit today because some of our members are going to go a little out of order because of their schedules in their district. Documents for the record can be sent to Austin Flack at the email address we provided to staff. All documents will be entered into the record at the conclusion of the hearing.

And the Chair will now recognize herself for purposes of an opening statement.

Ensuring that our seniors, one of our most vulnerable populations, have access to

flexible, affordable, high quality healthcare is of critical importance to everyone on this committee. That was the intent behind the creation of Medicare Advantage, the program that we're discussing here today, and we are conducting this regular oversight hearing to determine whether the program is fulfilling that intent.

Medicare Advantage programs offer an alternative to traditional Medicare. Nearly 64 million Americans are enrolled in Medicare. An increasing number of them are choosing Medicare Advantage plans each year. Enrollment in these privately run plans has more than doubled over the last decade. Today, nearly 27 million Americans are enrolled in a Medicare Advantage plan. Federal spending for these plans is about \$350 billion annually, and it's expected to grow. Given the tremendous size and growth of the Medicare Advantage program, it's important to the American people and also the U.S. Congress to see how these plans work, the quality of services that are being delivered to beneficiaries, and the value added to American taxpayers.

Beneficiaries on Medicare Advantage plans are entitled to the same health services as those on traditional Medicare, but reports by the watchdog agencies represented here today indicate that folks are not always receiving that care. A recent report by the HHS, Office of the Inspector General, indicated that some beneficiaries on Medicare Advantage plans are facing serious impediments to the care that they're entitled to.

Eighteen percent were outright denied care that they should have received. Another 13 percent were required to seek prior authorization and were still improperly denied care. While Medicare Advantage plans are permitted to require prior authorization for certain health services, organizations have raised concerns that they are now being required for relatively standard medical services. Our seniors and their doctors should not be required to jump through numerous hoops to ensure coverage for

straightforward and medically necessary procedures.

In one example, OIG found that a patient with prostate cancer had been denied coverage for routine cancer treatment services. In another, a patient with endometrial cancer was denied a CT scan. While those denials were ultimately reversed when appealed, seniors who are dealing with serious health issues, should not be forced to spend their precious time and energy fighting needless bureaucracy to receive the care that they're entitled to.

Unfortunately, too many of them are required to do just exactly that. OIG found that when appealed, planned denials of payment or prior authorizations were reversed 75 percent of the time. That's an alarmingly high rate, and we need to understand better why this is happening. And to be clear, the administrative challenges have real -- [audio malfunction] advantage may be encountering challenges --

And that's in their last year of life. GAO found that individuals dis-enroll from their Medicare Advantage programs and switch to original Medicare at twice the normal rate in the final year of life. This suggests that when care is most critical, Medicare Advantage plans may not be delivering. While this is encouraging, I was happy to see that the -- while it's concerning, I was happy to see that the centers for Medicare and Medicaid services has started to more closely monitor why beneficiaries dis-enrolling from Medicare Advantage plans in their last year of life. So hopefully we will have answers to that soon as well.

It's not just access that's of concern under these plans, but also the quality of the care itself. For example, studies indicated there are concerning disparities in the quality of care that individuals on Medicare Advantage plans receive based on racial demographics or where they live. Unfortunately, data on the services that are actually provided to Medicare Advantage enrollees and the quality of that care has been

historically inadequate or difficult to substantiate without burdensome audits. We need good information for good oversight, and we look forward to hearing from that today.

And so today, we're going to hear directly from the government organizations that scrutinize how Medicare Advantage plans are being administered and what steps are necessary to ensure that the plans are providing high quality healthcare to seniors. The HHS, Office of the IG, the GAO and the Medicare payment Advisory Commission have been vigilant observers of the growth of Medicare Advantage and they're assisted CMS in ways to improve the program.

I want to emphasize, Medicare Advantage is an important tool for helping seniors, and we want it to succeed. We're going to continue to conduct the oversight necessary to make sure this program provides the services they need in a cost effective way so that seniors are protected and taxpayers are protected too.

With that, I'm happy to recognize the Ranking Member, Mr. Griffith, for five minutes.

[The prepared statement of Ms. DeGette follows:]

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Mr. Griffith. Thank you very much, Chair DeGette, for holding this hearing, and we welcome the opportunity to review the Medicare Advantage program so this program may continue to serve Medicare beneficiaries and taxpayers alike.

I got to say, I was a little bit amused when you were talking because you were talking about how there is more disenrollment in the last year of life, and my 92-year-old mother reports to me that she loves her Medicare Advantage program. And I'm glad to hear that she's not probably in her last year of life since she's continuing to enroll. I know that's not really the point, but I couldn't help being amused thinking about my mom.

Medicare Advantage is a private plan supplement to Medicare's fee for service program. Medicare pays Medicare Advantage plans and monthly capitated amount per beneficiary, and this amount is adjusted based on a beneficiary's health status. Millions of our constituents depend on Medicare Advantage to provide comprehensive and affordable healthcare as they age. Among the Medicare eligible seniors in my district, just shy 39 percent of them are enrolled in a Medicare Advantage plan. A constituent enrolled in a Medicare Advantage plan continues to pay a Medicare Part B premium and may pay an additional premium for Medicare Advantage. The insured determines the Medicare Advantage premium, which can vary from one Medicare Advantage plan to another.

Some Medicare Advantage plans have premiums as low as zero dollars. 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. My mom's not taking Advantage of any fitness benefits.

In 2022, the average Medicare Advantage plan enrollee has access to nearly \$2,000 in extra benefits annually that Medicare fee for service enrollees cannot access without purchasing additional health insurance coverage. Among other things, this comprehensive care can improve healthcare for seniors by offering individually targeted programs, such as to prevent falls, transportation to primary care visits, and in-home nursing visits.

Medicare Advantage enrollment has grown steadily over the past decade. In 2003, there were 5 million people enrolled in Medicare Advantage. Fast forward to 2022, there are now 28 million people enrolled. That means about 45 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans. The growth rate of enrollment in Medicare Advantage programs speaks for itself. If this trend continues, the Congressional Budget Office estimates 51 percent of eligible Medicare beneficiaries will be enrolled in Medicare Advantage plans by 2030.

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 offered by Medicare. 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.

The Medicare Advantage program was built with foundational tools to not only provide quality care, but also provide that care at a lower cost. For example, the Medicare Advantage program uses a benchmark and bidding system to induce plans to provide benefits at lower costs. Another tool is prior authorization, which can control costs and ensure the most cost effective, clinically appropriate treatment is provided to enrollees. This tool can help reduce inappropriate service use. Additionally, the risk

adjusted capitated payment structure creates a built in incentive for health plans to coordinate with a patient's providers and communities to help beneficiaries become healthier and control costs. Conversely, in Medicare fee for service, there is a pay for volume system in which an unlimited number of services could be delivered without any incentives and find a good deal for patients or taxpayers.

In addition to these built in tools, multiple entities provide oversight with the Medicare Advantage program, including the witnesses here today. Ultimately, however, the Centers for Medicare and Medicaid Services, commonly known as CMS oversees the Medicare Advantage program. Multiple reports authored by the witnesses before us today include recommended actions for CMS to refine their methodology or operations in the Medicare Advantage program. Specifically, CMS needs to issue clear guidelines to Medicare Advantage insurers.

It's a shame CMS could not agree to testify at this hearing to speak to the work the agency is doing to improve this program. As Medicare Advantage takes on an even larger presence in the Medicare program, that is the Medicare Hospital Insurance Trust Fund is projected to be insolvent by 2028, it would 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.

I look forward to discussing the Medicare Advantage program with our witnesses here today, and ensure program integrity so that our constituents can continue to access comprehensive affordable health coverage choices and benefits.

Thank you. I yield back.

[The prepared statement of Mr. Griffiths follows:]

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Ms. DeGette. I thank the gentleman.

Chair now recognizes the chairman of the full committee, Mr. Pallone for 5 minutes for an opening statement.

The Chairman. Thank you, Chairwoman DeGette.

We're here today to conduct oversight of the Medicare Advantage program. Nearly 27 million seniors are enrolled in Medicare Advantage plans, which is run by private health insurance companies. And while the program offers seniors flexibility in the way that they receive their medical care, it's important that we ensure that Medicare remains financially viable and that seniors are receiving the high quality care that they deserve.

Now, 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. Several studies have raised concerns that insurance companies are denying beneficiaries access to treatment and imposing burdensome requirements that delay care, improper claim denials and increased use of prior authorizations are preventing beneficiaries from receiving the care that they need.

Now, while most plans appear to be acting responsibly, some are not. And these bad actors are costing taxpayers money and more importantly jeopardizing the healthcare of seniors. This oversight hearing is critical to ensure that we're protecting the health and wellbeing of Medicare beneficiaries. It's also important to determine whether Medicare Advantage is providing good value for our federal dollar. When Medicare Advantage was created, the hope was that private sector efficiencies would reduce the cost of care for seniors.

Unfortunately, that has not been the case. In fact, the Medicare Payment Advisory Commission, one of today's witnesses, has consistently found that providing

care under Medicare Advantage has cost more than other traditional Medicare. Studies have repeatedly found that some Medicare Advantage plans, particularly the larger ones, received greater compensation for Medicare without necessarily providing better healthcare services to beneficiaries. In short, some insurance companies have appeared to have figured out a way to game the system.

Now, this is in large part due to the way we reimburse Medicare Advantage plans. Those plans receive more money from the federal government based on various factors, including the underlying medical risks of the individual enrolled in the plan. To ensure they receive more money, insurance companies use tools like in-home health risk assessments to claim that individuals on those plans have additional health conditions that their provider has not formally diagnosed them with. And this allows the plans to claim that beneficiaries are in riskier health, and therefore, the plans receive more funding for Medicare.

But as today's witnesses will help explain, those new diagnoses do not always reflect reality. Additionally, seniors that receive these new diagnoses from insurance companies rather than their doctors do not always then receive the healthcare services for those diagnoses. So this if phenomenon is called coding intensity, and it suggests that some plans are focussing their efforts on finding ways to pad their profits rather than ensure seniors are receiving appropriate care.

So we'll hear a great deal today about coding intensity and what can be done to put a stop to it. One benefit to enrollees under the Medicare Advantage program is the plans use portions of their funding to provide supplemental benefits beyond what traditional Medicare offers. And these supplemental benefits can include transportation to and from appointments, nutrition planning, memberships for fitness centers, or dental coverage. These supplemental benefits can certainly provide real

positive impacts for seniors, but there has not been any meaningful accounting about whether or not seniors are actually using these services and if their usage correlates to the additional money insurance companies being paid.

So as Medicare payments to these supplemental benefits continue to increase, we must better understand that they're helping seniors, and whether they're being delivered at a reasonable cost, we simply need more transparency and reliable data from the insurers to make sure that taxpayer funds are benefiting seniors and not the insurers. America's seniors expect and deserve high quality healthcare. We must ensure that is what they're receiving.

I thank witnesses for being here today as we conduct important oversight of the Medicare Advantage program. I know many of us, both Democrats and Republicans, that are part of this subcommittee today, Madam Chair, including yourself, have always been trying to expand services for seniors, and, you know, looking out for seniors. Some of you are on the task force. I think that's Jan and also Doris Montsuey that is constantly bringing to my attention and to the Congress' attention, you know, what we need to do to protect seniors. So this is an important part of that, and I thank you, Madam Chair, for doing this today.

I yield back.

[The prepared statement of The Chairman follows:]

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Ms. DeGette. I thank the gentleman.

Chair now recognizes the Ranking Member, Congresswoman McMorris Rodgers, for 5 minutes for her opening statement.

Mrs. Rodgers. Thank you, Madam Chair.

Medicare Advantage is a very popular and successful program. For example, according to an E-health poll, 88 percent of Medicare Advantage enrollees expressed satisfaction with their Medicare Advantage plan. And 86 percent would recommend it to family and friends. Other surveys suggest that 61 percent of MA enrollees who were previously enrolled in another form of Medicare are more satisfied with MA, while 24 percent say they are equally satisfied.

Medicare Advantage is popular because these plans offer supplemental benefits to its enrollees, including hearing, vision, dental, and fitness benefits. Many of these benefits are only available to Medicare fee for service enrollees through additional insurance. And we know that many patients continue to switch over to Medicare Advantage for more savings and better options and benefits. Moreover, the growth of zero premium Medicare Advantage plans and the peace of mind of a cap on their financial liability stands in stark contrast to the outdated structure of fee for service Medicare, which can be confusing and more expensive.

On average, MA patients report spending nearly \$2,000 less on their out-of-pocket costs and premiums compared to Medicare fee for service. For seniors on a fixed income who are especially pinched by inflation and surging energy costs, these savings make a huge difference in their lives.

Medicare Advantage plans gives them more choices too. In 2022, the average Medicare beneficiary had access to 39 Medicare Advantage plans. That's more than double the number of plans per person in 2017, and the largest number of options

available in more than a decade. Still there is improvements to be made. Today's hearing is a welcomed opportunity to conduct oversight of the Medicare Advantage program to ensure that it is providing adequate coverage and quality care.

Large areas of the country, including areas in my home state in Washington, had fewer Medicare Advantage plans for people to choose and enroll in. Recently, I had heard at my town halls about counties losing their Medicare Advantage plans. And I've also met with Washingtonians who have moved so that they can stay enrolled in Medicare Advantage. People shouldn't have to move to stay enrolled in the plan they want and that works for them.

Rather than limit senior's choices, we should take this opportunity to think creatively about how to expand greater Medicare Advantage availability, improve care, lower costs especially in the rural parts of the country. I remain extremely concerned by proposals by 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. These include ideas to harmonize the prior authorization process, like the private sector led Davinci project and solutions our Members are working on to modernize the prior authorization process so it better serves patients and doctors. We should be leading with solutions that ensure patients and their doctors can access treatments through improved user friendly electronic interface. Proper oversight should inform this policy work.

I hope this hearing signals a genuine effort to make a successful program even stronger. Any savings that are to be realized from this oversight and enhancing program integrity should be used to improve Medicare Advantage today and in the future, and not towards a government run healthcare system that won't meet the needs of seniors and

hurt their quality of live.

I'll close by registering disappointment that the Centers for Medicare and Medicaid Services declined their invitation to participate in today's subcommittee hearing. It reflects a pattern from the Biden administration of not participating in necessary oversight of our government's entitlement and mandatory spending programs. As the federal agency that administers the Medicare program, CMS is best positioned to speak to the details on the operations of this program. It's a missed opportunity for CMS to be a partner in conducting oversight of an important program and helping the committee develop solutions to strengthen Medicare Advantage.

While CMS is not here to provide their expertise and perspective, I do look forward to today's witnesses and hearing from them about how we can strengthen Medicare Advantage to improve the program and serve its beneficiaries.

Thank you, and I yield back.

[The prepared statement of Mrs. Rodgers follows:]

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Ms. DeGette. I thank the gentlelady, and just note that we're going to continue to work on the investigation on this. And I expect that we will be interfacing with CMS directly. I thank the gentlelady and also the Ranking Member of the subcommittee for their comments.

And now, the Chair would ask unanimous consent that the Members' written opening statements be made part of the record.

Without objection, so ordered.

I now want to introduce the witnesses for today's hearing. Ms. Erin Bliss the Assistant Inspector General, Office of Evaluation and Inspection, Office of Inspector General, Department of Health and Human Services; Ms. Leslie Gordon, acting director of healthcare of the GAO; Dr. James E. Mathews, executive director, Medicare Payment Advisory Commission. I want to thank all of you appearing here today in front of the subcommittee, and as you're aware, we're holding an investigative hearing. When we do so, we have a practice of taking testimony under oath.

Do any of our witnesses object to testifying under oath today?

Let the record reflect the witness responded "no."

The Chair then advises you that under the rules of House and the rules of the Committee, you are entitled to be accompanied by counsel.

Does any of our witnesses request counsel today?

Let the record reflect the witnesses responded "no."

It you would then, if you could please raise your right hand so you may be sworn in.

Do you swear the testimony that you're about to give is the truth, the whole truth, and nothing but the truth?

Let the record reflect that the witnesses have responded affirmatively.

And you're now under oath and subject to the penalties set forth in Title 18 Section 1001 of the U.S. Code.

At this time, the Chair will recognize each witness for 5 minutes to provide an opening statement. And I would like to remind all of you there's a timer on your screen that will count down your remaining time.

I would like to recognize Ms. Bliss first for 5 minutes thank you for being with us, and you're recognized.

TESTIMONY OF 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; AND JAMES E. MATHEWS,
PH.D.,
EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION**

TESTIMONY OF ERIN BLISS

Ms. Bliss. Thank you. Good morning, Chair DeGette Ranking Member Griffith and other distinguished Members of the subcommittee.

I'm pleased to join you to discuss two critical issues in Medicare Advantage. One is ensuring that enrollees have access to the medical care they need. The other is protecting American taxpayers from overpayment of the Medicare Advantage plan. More than 26 million beneficiaries were enrolled in Medicare Advantage in 2021. That's a lot of lives relying on these organizations to authorize and pay for the care they need. And as noted, that number continues to grow.

In a recent evaluation, OIG found that Medicare Advantage organizations sometimes delayed or denied enrollees access to medical care even though the care was needed and met Medicare coverage rules. In other words, these services likely would have been approved by original Medicare. For many of these denials in our review, Medicare Advantage plans used internal clinical criteria that are not required by Medicare. For example, a Medicare Advantage plan denied a request for a CT scan that was medically necessary to rule out a life-threatening aneurism.

The denial was because beneficiary did not have an x-ray first, but Medicare has no such requirement. Medicare Advantage plans' internal criteria are supposed to be no more restrictive than original Medicare. But CMS guidance on this is not detailed enough for us to tell whether it would consider certain denials to be inappropriate. OIG recommends that CMS issue new guidance on the appropriate use of clinical criteria and that CMS assess the use of these criteria in its audits of Medicare Advantage plans.

Another risk in Medicare Advantage is that plans will make their patients appear sicker than they really are to get extra payments. One way they might do this is through chart reviews, which review beneficiaries' medical documentation to identify and add diagnoses not included on the service record. OIG found that Medicare paid an estimated \$6.7 billion in 2017 for diagnoses arising only from chart reviews. Another way is through health risk assessments, which collect information about beneficiaries' health status. The intent is to improve care coordination.

Some Medicare Advantage organizations contract with vendors to visit beneficiaries' homes to conduct these assessments. OIG found that Medicare paid an estimated \$2.6 billion in 2017 for diagnoses arising only from health risk assessments. These three and a half million beneficiaries did not have records for any other visits, procedures, tests, or supplies for the diagnoses from these assessments.

OIG is concerned when we see chart reviews or health risk assessments as the sole source of diagnoses that led to extra payments. If these diagnoses were inaccurate, then Medicare Advantage organizations may have received inappropriate overpayment. If these diagnoses were accurate, then beneficiaries may not have gotten needed care to treat these often serious conditions. OIG recommends that CMS conduct targeted oversight of Medicare Advantage organizations that are outliers in using these tools, that they reassess whether to allow certain chart reviews in health assessments to be sole

sources for extra payment, and that CMS require Medicare Advantage organizations to improve their care coordination for enrollees who receive health risk assessments.

OIG appreciates and shares your interest in ensuring that Medicare enrollees get the medical care they need and that payments to Medicare Advantage organizations are appropriate. Thank you, and I'll be happy to answer any questions.

[The prepared statement of Ms. Bliss follows:]

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Ms. DeGette. Thank you so much.

Ms. Gordon, you're now recognized for 5 minutes.

TESTIMONY OF LESLIE GORDON

Ms. Gordon. Good morning, Chair DeGette, Ranking Member Griffith, Chair Pallone, Ranking Member McMorris Rodgers, distinguished Members of the subcommittee.

I'm pleased to be here with you today to discuss the oversight of the Medicare Advantage program. My testimony summarizes key findings and recommendations in three areas related to oversight in the Medicare Advantage program and the status of CMS' efforts to address GAO's recommendations. First, I'll discuss monitoring of disenrollment by beneficiaries in the last year of life. Second, validating encounter data. And third, strengthening audits to identify and recover improper payments.

First, monitoring disenrollments. Medicare Advantage beneficiaries in the last year of life are generally in poor health and often require high costs and specialized care. High rates of disenrollment from Medicare Advantage to join traditional Medicare may indicate issues with the quality of care, such as potential limitations accessing specialized care. In 2021, we reported that Medicare Advantage beneficiaries in the last year of life dis-enrolled to join traditional Medicare at more than twice the rate of other Medicare beneficiaries in both 2016 and 2017.

We recommended, and CMS implemented, reviews of the Medicare Advantage disenrollments by beneficiaries in the last year of life and CMS also found higher disenrollment rates in the last year of life under certain Medicare Advantage contracts for 2019 through 2021. These findings underscore the value of continued monitoring, and

according to the CMS, the agency plans to conduct these analyses annually.

Second, validating encounter data. The encounter data submitted by Medicare Advantage organizations on services provided to beneficiaries contain beneficiaries' clinical diagnoses and are used by CMS to adjust payments to reflect beneficiaries' projected health costs. In 2014, we recommended that CMS complete six actions necessary to validate encounter data for completeness and accuracy before using the encounter data to risk adjust payments. However, CMS is using the data to risk adjust payments, and as of this month CMS has not yet implemented all the steps necessary to validate the encounter data.

In particular, CMS has not completed medical record reviews to help ensure the accuracy of encounter data. Without such reviews, CMS cannot determine whether the diagnoses that are used to risk adjust payments are supported by beneficiary medical records and the soundness of adjustments made to billions of dollars in payments remain unsubstantiated.

My third area of oversight, strengthening audits that identify improper payments. In 2016, we reported on several factors that hampered CMS' risk adjustment data validation, RADV audit program, and recovery of improper payments in Medicare Advantage. We made two recommendations related to improving the timeliness of RADV audits and appeals processes. In 2016, we found that the contract level RADV audits were subject to years' long delays. We recommended and CMS -- we recommended CMS take several actions to improve the timeliness audit processes. As of this month, the agency has completed some of these actions, but has not yet issued final contract level audit findings for payments made in 2011 through 2014.

CMS has, however, established specific timeframes that allow the agency to complete the national RADV audits on an annual basis, which are used to estimate

improper payments for the year. In 2021, improper payments were estimated to be about 10 percent. Until CMS improves the timeliness of the contract level RADV audits, the agency may miss out on recovering hundreds of millions of dollars in improper payments.

I thank you for your time and the ability to contribute to this hearing. Chair DeGette, Ranking Member Griffith, and other Members of the Committee, this concludes my prepared statement, and I would be pleased to respond to any questions you may have.

[The prepared statement of Ms. Gordon follows:]

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Ms. DeGette. Thank you so much.

I'm now very pleased to recognize Dr. Mathews for 5 minutes. Doctor.

TESTIMONY OF JAMES E. MATHEWS, PH.D.

Dr. Mathews. Good morning.

Chair DeGette, Ranking Member Griffiths, and distinguished Members, I appreciate the opportunity to discuss MPAC's perspectives on the Medicare Advantage program or MA. By many measures, MA has been successful. Soon, the majority of eligible Medicare beneficiaries will be enrolled in MA. MA is less costly to beneficiaries than traditional fee for service and by law protects them against catastrophic costs. 99 percent of beneficiaries have access to an MA plan, and the average beneficiary has around 30 plans to choose from. Lastly, rebates, which fund extra benefits under MA, are at record high levels in 2022.

However, there is a downside to this robust growth. The average plan bid to provide the Medicare benefit in 2022 was 85 percent of fee-for-service spending. However, Medicare currently pays plans 104 percent of fee-for-service, more than the program would have paid had MA enrollees remained in traditional Medicare. Given Medicare's profound financial problems, the program cannot continue to overpay MA plans, and it should more directly benefit from the efficiencies plans can achieve. I will discuss three problems with the MA program and MPAC's recommendations to fix them. While two of these fixes would reduce payments to plans, this can be done without materially affecting beneficiaries' access to MA plans and the extra benefits they provide.

I will start with coding intensity. MA plans submit their enrollees' clinical diagnostic codes to Medicare. Qualifying diagnoses add to an enrollee's risk score.

More diagnoses lead to a higher risk score, which leads to a higher Medicare payment to the plan. Most diagnoses can boost Medicare payments by thousands of dollars per enrollee. Plans report diagnoses through encounter records, which can include health risk assessments and chart reviews.

These latter may include conditions not under active treatment, thus incurring no cost to the plan, but would still boost Medicare's payments. MPAC estimates that plan coding intensity is now 9.5 percent higher than fee-for-service, resulting in \$12 billion in excess spending in 2020. MPAC recommends changing Medicare's risk adjustment model to reduce differences in coding between fee-for-service and MA, excluding diagnoses collected exclusively from health risk assessments, and recovering all excess payments to MA plans.

Next, I'll discuss the MA quality bonus program or QDP, which is supposed to reward plans for providing high quality care to their enrollees. Plans with a qualifying star rating receive bonus payments, which totalled between 11 and \$12 billion in 2022. Yet, the QDP is fundamentally flawed. It is inadequate for informing beneficiaries about the quality of their local coverage choices, nor can policymakers use the QDP to inform changes to the MA or traditional Medicare based on quality. MPAC recommends that the Congress replace the QDP with a new system that would remedy its flaws and which would be financed through a payment withhold, similar to value based purchasing programs in fee-for-service Medicare.

Lastly, plans are required to submit encounter data to Medicare, records similar to claims under fee-for-service. These records are needed to conduct oversight activities. For example, to determine if any differences in service use between MA and fee-for-service reflect appropriate utilization management techniques or the inappropriate denial of covered care. Yet, after a decade, these data are not complete

enough for these purposes. MPAC has recommended that Medicare evaluate the completeness of encounter data, set goals for plans to submit complete data, and penalize plans that fail to do so.

In sum, Medicare Advantage has the potential to deliver care more efficiently than traditional fee-for-service Medicare. However, the current incentives for MA plans are not adequately aligned with the Medicare program and the beneficiaries and taxpayers who fund it. Substantial reforms to MA are urgently needed, given rapid enrollment in a program that puts greater strain on Medicare's finances than traditional fee-for-service.

That concludes my remarks, and I am happy to answer any questions from the Committee.

[The prepared statement of Dr. Mathews follows:]

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Ms. DeGette. Thank you, Dr. Mathews.

It's now time for Members to ask questions of the panel. And before I begin, I want to once again remind Members to unmute when you ask your questions, and then mute again so that we can avoid background noise.

The Chair will now recognize herself for 5 minutes.

Now, the organizations today, as you've heard, all of you have examined Medicare Advantage over the years and written numerous reports recommending ways the programs can be improved. And so I thought, to kick off the questioning, we might want to hear from each of you what you think the most important recommendations of your organizations have made to CMS that would help improve the quality of care being provided to America's seniors and the cost.

And so, I want to go right down the line starting with OIG, then GAO, then MPAC. So I'm going to start with you, Ms. Bliss.

What would you say are the top one or two recommendations that your office has made to CMS to help it improve its quality and value of Medicare Advantage?

Ms. Bliss. Thank you for the opportunity to highlight these top solutions.

With respect to the denials of care, our top recommendation is that CMS update and clarify its guidance about how Medicare Advantage organizations can use internal clinical criteria that goes beyond Medicare coverage roles. This was one of the driving factors of the denials of care that we found in our evaluation for services that met Medicare coverage roles.

With respect to chart reviews and health risk assessments driving risk adjustment payments, we recommend that CMS reassess whether to even allow unlinked chart reviews and in-home health risk assessments to be sole sources of diagnosis for these payments.

Thank you.

Ms. DeGette. Thank you.

Ms. Gordon, same question.

Ms. Gordon. Yes. As representing the government watchdog and partnering with you in oversight, we highly recommend that action be taken to ensure the completeness and accuracy of the encounter data. Without complete, accurate, valid encounter data, the risk adjusted payments cannot be substantiated, and we cannot know that we're paying appropriately. In addition, the encounter data are necessary for oversight of quality of care and ensuring that beneficiaries are receiving the care that is intended.

Secondly, I would emphasize the need to -- timeliness around the contract level RADV audits, which is CMS' oversight tool to assess plans for improper payments.

Thank you.

Ms. DeGette. Thank you.

Dr. Mathews, same question.

Dr. Mathews. From MPAC's perspective, first and foremost, the most important thing to do would be to address the excess payments that result from coding intensity. These practices on the parts of plans continue and contribute to excess payments at a rate of increase of over 1 percentage point per year. So the problem as it exists now will continue to grow.

The second thing that we believe needs to be done is to completely overhaul the quality bonus program so that Medicare beneficiaries who are trying to make fundamental decisions to remain in fee-for-service or to choose a Medicare Advantage plan or to choose among Medicare Advantage plans in their local area have information on meaningful quality measures and outcomes as the basis for doing so.

Lastly, a recommendation that I did not discuss here today, we would recommend that the Medicare program change its approach to calculating Medicare Advantage benchmarks so that Medicare can benefit from some of the efficiencies that MA plans have demonstrated they can achieve in the forms of their bids, which currently total 85 percent of fee-for-service Medicare.

Ms. DeGette. Thank you.

I have one last question, and I think you can do this with a yes or no, and then supplement your answers later.

Ms. Bliss, do you think that Congress needs to take additional steps to course correct on Medicare Advantage, yes or no?

Ms. Bliss. Yes.

Ms. DeGette. And Ms. Gordon?

Ms. Gordon. Yes.

Ms. DeGette. And Dr. Mathews?

Dr. Mathews. Yes.

Ms. DeGette. So, if you can please supplement just to say specifically what Congress can do, that will be great.

And now the Chair will yield back, and I will recognize the Ranking Member of the full committee, Ms. McMorris Rodgers for 5 minutes.

Mr. Griffith. I believe she's muted.

Ms. DeGette. Ms. McMorris Rodgers, I think you're muted. Kathy? Ms. McMorris Rodgers?

Okay. We can't hear you. We still can't hear you. You're on mute.

Mr. Griffith. Madam Chair, I can go ahead and go if she needs time to figure it out.

Ms. DeGette. Okay. Yes. Thank you, Mr. Griffith, I will recognize you for 5 minutes.

Mr. Griffith. Thank you very much, Madam Chair.

Ms. DeGette just asked each of you if you thought there were things that Congress should do to course correct, and each of you said yes, and I have no problem --

Mr. Rodgers. Madam Chair, can you hear me now?

Ms. DeGette. I can hear you now. Mr. Griffith is asking questions now. Then we'll go to you.

Mr. Griffith. Sorry, Kathy.

And so she asked if there was needed course correction and what can Congress do, and I look forward to seeing those answers as well.

As a part of that, though, are you recommending that we get rid of Medicare Advantage, yes or no?

Ms. Bliss. No.

Ms. Gordon. No.

Dr. Mathews. Absolutely not.

Mr. Griffith. And thank you. I assume that. We can always do things better, and we should, and we appreciate your input on that.

In regard to the sole source for diagnosis being the chart review or the health risk assessment, Ms. Bliss, I would agree with that. I think that's a good suggestion, so I look forward to your input on that.

That being said, I hope we wouldn't get rid of the health risk assessments that are done at home because I do think that that may be helpful for many of our seniors to have people see what their environment is and where they're coming from, but I do agree it shouldn't be the sole source for diagnosis.

Ms. Bliss, what else do you think we can do in that regard to make that better?

And how do you follow up with your recommendations to CMS, Ms. Bliss?

Ms. Bliss. Yes. Thank you.

I completely agree. We're recommending that CMS reconsider allowing in-home health risk assessments be a sole source for added risk adjustment payments. But certainly, in-home health risk assessments can be a very important tool for improving beneficiaries' care, coordination, and health outcomes. And so we had recommended that CMS require Medicare Advantage organizations implement best practices for coordinating the care of beneficiaries who received health risk assessments. Right now, CMS recommends, but does not require best practices. And based on our finding that three and a half million beneficiaries had health risk assessments with no evidence of any follow-up care, we think should tighten up that requirement.

Mr. Griffith. Yes, ma'am. And let me follow up with that, and I'll probably ask a similar question to you, Ms. Gordon, but the question is what are you all doing to see that CMS moves forward? I sense some frustration from Ms. Gordon.

But Ms. Bliss, what is your organization doing to follow up with CMS to make sure that they're implementing the recommendations that you made or even doing better than what you recommended?

Ms. Bliss. Yes. We are following up with CMS. And CMS did agree with our three recommendations from our most recent report. Their final action plans detailing how they're going to implement those are due to us in October. And we follow up with CMS on a regular basis on all of our open recommendations.

With respect to in-home health risk assessments, CMS did not agree with some of those recommendations, including the one I just mentioned about requiring best practices for care coordination. And I'll say even when CMS disagrees with the

recommendation, when we still believe it's needed as we do in this case, we continue to follow up. We continue to press for them to reconsider and to change.

Mr. Griffith. And I appreciate that, and that's part of what we do as an oversight committee too, is we take a look at that. And that's why Ms. DeGette asked you all send us your recommendations as to what we can do, and maybe that's one of them.

Ms. Gordon, you expressed some frustration as well, and I think you had made recommendations, but they still hadn't followed through on things going back as far as 2011.

Is that accurate?

Ms. Gordon. We have a number --

Mr. Griffith. Go ahead.

Ms. Gordon. We have a number of longstanding recommendations from CMS. The encounter data accuracy and validation goes back to the recommendation of 2014. And in terms of actualizing and reporting out on the audits of four improper payments at the contract level, they have not yet reported from 2011 through 2014.

Mr. Griffith. Appreciate that. I will say in closing, that I am a little concerned the most recent study, there were 27 million Medicare Advantage beneficiaries, but the sample size was only 250. So I would hope that we would have probably a bigger study if we've got an area of concern so that we can make better policy.

And with that, I yield back. Thank you, Madam Chair.

Ms. DeGette. I thank the gentleman.

The Chair now recognizes Mr. Pallone for 5 minutes.

The Chairman. Thank you, Chairwoman DeGette.

One of the promises of Medicare Advantage is that the government can save taxpayer dollars by giving private plans the flexibility to find efficiencies and coordinate

care. However, I'm concerned that these efficiencies have not translated into Medicare savings.

So I wanted to start with Mr. Mathews from MPAC. I wanted to better understand why the Federal Government regularly pays more for services provided for Medicare Advantage plans than it would through the fee-for-service program, and why are payments to Medicare Advantage consistently higher than spending on the fee-for-service Medicare program?

Dr. Mathews. Thank you, Mr. Chairman.

Probably the key reason that Medicare is spending more for Medicare enrollees in Medicare Advantage than it does under fee-for-service, is that Medicare payments to plans are in part calculated on the basis for fee-for-service benchmarks. Some of those benchmarks pursuant to provisions of the Affordable Care Act are set at levels in excess of fee-for-service. And there were specific policy rationales for doing that at the time, particularly to induce plans to enter into markets with low fee-for-service spending where they might otherwise have difficulty competing.

Given the benchmarks that are higher than fee-for-service and a mechanism whereby a plan that bids below fee-for-service receives a rebate that is in part used to fund extra benefits, Medicare is not able to fully benefit from the fact that, as I mentioned previously, Medicare Advantage plans in aggregate are bidding far below fee-for-service.

The Chairman. All right. Then what can be done so that, you know -- to better align, I guess, the cost of care to the Medicare program with the quality of care? In other words, if they're getting a lot better care, they're getting a lot more services, you know, then maybe it's justified. But I that may not be the case.

You know, is there some way that we can better align the costs so -- you know, I

want to make sure we're getting the bang for the buck, if you will.

Dr. Mathews. Understood. So there are two components to a response to that question.

First, I mentioned a change to the way Medicare calculates its benchmarks. We would recommend bringing down benchmarks in a way that allows the program to achieve the benefits of plan efficiencies. In high fee-for-service spending areas, MA plans are bidding far, far below fee-for-service, yet Medicare isn't really benefitting from those efficiencies as manifest in their bids.

The second thing goes back to the QDP and encounter data. As I mentioned, we, at MPAC, have concluded that we cannot make definitive determinations about the quality of care provided under the auspices of MA relative to fee-for-service or how that quality varies among MA plans. And one of the reasons we can't do that is the encounter data is insufficiently complete for us to be able to reliably calculate things like patient mortality, avoidable hospital admissions, avoidable ER use. And until we have robust data that would allow us to calculate those things, independent of the plans themselves, we are hamstrung in terms of our ability to tie Medicare payments to outcomes under the Medicare Advantage program.

The Chairman. Well, let me just say, Chairwoman DeGette, I mean obviously, this is complicated, but I know you suggested that we need to follow up from this hearing. And I think that's clear from what Dr. Mathews said, that we really got to dig into this more.

Let me just ask one more question, Ms. Bliss. In September of last year, OIG found that of 162 companies offering MA plans, 20 companies drove a disproportionate share of unjustified payments, and that one plan in particular drove up to 40 percent of unjustified payments across the program, even though it only enrolled 22 percent,

Ms. Bliss, just quickly, because only 30 seconds, what do these findings suggest about the composition of the market for MA plans and how widespread some of the issues we've discussed around plan adequacy and integrity may be, if you will?

Ms. Bliss. Thank you.

Yes. These findings were that a relatively small number of companies were driving a disproportionate share of risk adjustment payments coming solely from chart reviews or health risk assessments. So we've recommended that CMS take a targeted approach to its oversight of those particular companies on these issues.

The Chairman. All right. Thanks so much. Thank you, Chairwoman DeGette. This clearly is a very important hearing.

RPTR ZAMORA

EDTR HUMKE

[11:58 a.m.]

Ms. DeGette. Thank you so much, Mr. Chairman.

Second time is a charm. I'm going to now recognize Mrs. Rodgers for 5 minutes.

Mrs. Rodgers. Thank you, Madam Chair. Sorry about that.

Appreciate everyone joining us today.

The overwhelming majority of Medicare Advantage beneficiaries are satisfied with Medicare Advantage, which is evidenced by the steady growth of the program over the years as well as Medicare Advantage satisfaction surveys. And while the program is incredibly popular, I certainly recognize there is room for process improvements within the Medicare Advantage program; and, in that vein, there are efforts by members of this committee to address some of those areas of improvement.

Ms. Gordon, eHealth conducted a survey of Medicare Advantage, and the results were released in June, earlier. The survey showed that nine out of ten Medicare Advantage enrollees expressed satisfaction with their Medicare Advantage plan. The survey data also indicates beneficiaries prefer Medicare Advantage to their supplemental or Medigap plans. Sixty-seven percent of those who chose Medicare Advantage did so because Medigap was too costly, and 25 percent chose Medicare Advantage since Medigap plans didn't offer drug coverage.

Have you looked into the financial tradeoffs and incentives within Medigap plans, especially as they compare to Medicare Advantage, and, if so, what have you found?

Ms. Gordon. We examined the differences in payments that were made when beneficiaries disenrolled in the last year of life, and in 2017, we also looked at

disenrollment of all Medicare Advantage beneficiaries to join traditional Medicare. So we have not yet examined exactly the differential and the cost associated with supplemental care.

However, we do -- we do recognize and support the fact that Medicare Advantage offers a competitive option for beneficiaries, and they have an opportunity to disenroll for any reason, not just that the -- you know, not for a bad reason but just for preference purposes. So thank you.

Mrs. Rodgers. Okay. Well, I think it's important to distinguish when talking about Medicare Advantage plans the difference between managed care plans and the fee-for-service plans. And there's many benefits to managed care plans, including the additional supplemental benefits, low monthly premiums, and tailored special need plans that are available to beneficiaries. Would you discuss some of the tradeoffs between enrolling in a managed care plan versus a fee-for-service plan? And that's --

Ms. Gordon. There --

Mrs. Rodgers. -- to Ms. Gordon again.

Ms. Gordon. Thank you. There are opportunities for better care coordination in Medicare Advantage plans. There are opportunities for additional benefits. As you said, the plans are able to offer additional services, and, you know, the care coordination is essential. In terms of the special needs plans, they are dedicated to folks with particular special needs who have specialized care needs and need further coordination to address their needs.

Mrs. Rodgers. Thank you. As another followup, the Better Healthcare Alliance issued a data brief in April noting that Medicare Advantage outperforms fee-for-service on cost projections for low-income and diverse populations. Can you talk about why Medicare Advantage provides better cost protections than fee-for-service, and how do

utilization management tools and other features unique to Medicare Advantage factor into reducing costs for seniors?

Ms. Gordon. I'm not prepared to speak to that at this time. I would be happy to respond in writing.

Mrs. Rodgers. Okay. Well, I think these are some important questions that we get answered as we can, you know, think through how to improve Medicare Advantage and really understanding some of the factors between Medicare Advantage, the managed care, the fee-for-service, and just the -- getting a whole picture here. So thank you very much. I yield back.

Ms. DeGette. I thank the gentlelady.

The chair now recognizes Mrs. Schrier for 5 minutes.

Mrs. Schrier. Well, thank you, Chairwoman DeGette.

And thank you to the witnesses today.

The Medicare Advantage program is increasingly popular with seniors because its plans, as we've heard, offer more choices, feel more like traditional health insurance, and the plans can facilitate coordinated care and give these additional benefits that we've already heard about. But we do need to make sure that these plans are working correctly and that seniors are getting the care they deserve in a timely fashion.

So today, I'd like to focus on preauthorization, which is intended to ensure that healthcare dollars are spent appropriately. But in reality, it's become a major frustration for both patients and for providers, and it can delay or sometimes even prevent needed care, as we heard.

The American Medical Association had found that prior authorization is so burdensome that clinics require significant additional staffing just to handle the paperwork and followup, and these resources certainly could be used elsewhere. In

fact, according to the AMA, 34 percent of physicians reported that delays and denials have led to a serious adverse event for a patient in their care.

Ms. Bliss, I wanted to first turn to you. This past April, the Office of the Inspector General found that among the prior authorization requests that Medicare Advantage organizations denied 13 percent met Medicare coverage [inaudible] as you noted. What does this suggest about whether beneficiaries are receiving the care that they need and the timeliness of it?

Ms. Bliss. Thank you for that question. We are concerned about whether --

Mrs. Schrier. I'm having troubles on my end.

Ms. Bliss. -- these beneficiaries are receiving all of the care that they need in a timely fashion in these cases. So in general, Medicare Advantage organizations are supposed to offer the same coverage and access to services that you would get under traditional Medicare, but Medicare Advantage plans are allowed to use internal clinical criteria that go beyond Medicare coverage rules in some circumstances.

And we couldn't tell whether the situations that we found in our sample were ones that CMS in some cases would consider to be appropriate or inappropriate use of that criteria. But what we can say is that there were denials using criteria that are not included in original Medicare's coverage requirement. So coverage looked different in those cases than it would under original Medicare.

Mrs. Schrier. And, of course, these denials that you're referring to can prevent, delay care, and our seniors deserve better.

I wanted to just note that I'm a sponsor and original cosponsor of the bipartisan, bicameral Improving Seniors' Timely Access to Care Act. This would streamline things requiring electronic prior authorizations, implementing some realtime decisions. It would eliminate so much of the delay that can impact the care that seniors receive.

You know, as a doctor, I know providers want to provide the best care for their patients. And when it comes to expensive or invasive treatments, I get the role for oversight and judicious use of those medical resources. But if the vast majority [inaudible].

Dr. Mathews, can you share your perspective on how CMS can balance the need for guarding against unnecessary services and expenditures while ensuring that prior authorization is not preventing the care [inaudible] --

Dr. Mathews. I'm happy to try and answer the question. It was a little bit garbled, but I will do my best. First and foremost, MedPAC has recognized the value of appropriate use of prior authorization as a way to control cost. We are unable, given the current state of Medicare Advantage data, to assess whether it is being used in an appropriate way that does not compromise beneficiary outcomes versus an inappropriate way, along the lines of what my colleagues at the IG have demonstrated, that may indeed negatively affect beneficiary outcomes and quality of care.

Mrs. Schrier. Thank you. I yield back, and I apologize for the timing of the garbled --

Ms. DeGette. Thank you. I thank the gentlelady. I know you are out inspecting the wildfires, and that's an important thing to do too.

The chair now recognizes Mr. Burgess for 5 minutes.

Mr. Burgess. I thank the chair.

I thank our witnesses for being here. Extremely important topic.

I would associate myself with comments of Ranking Member Griffith. I too am a Medicare Advantage patient, and it's always good to know that you've got at least a year left if you're covered by Medicare Advantage.

Look, Dr. -- the doctor just brought up the issue of the patient Timely Access to

Care Act, and our -- the use of the electronic medical records to help facilitate the prior authorization process. I guess this question is for Inspector Bliss. Do you see that as being a helpful adjunct to getting patients the coverage they need when they need it?

Ms. Bliss. Thank you. Yes. We saw in some of the cases in our evaluation that prior authorization requests were denied because the Medicare Advantage plan requested either unnecessary documentation or in some cases documentation that was already contained in the file and didn't need to be requested again. So certainly an electronic system could hold promise to avoid some of those types of errors.

Mr. Burgess. Well, let me ask you this, Inspector General: What about even going one step further? If a physician has -- if all of their submissions have been -- have been consistent with good practice and all reimbursable, does it -- do you ever reach a point where continuing to ask for submission of the paperwork is only redundant and actually delays patient care?

Ms. Bliss. Sure. We did see some examples of redundant requests, and I think the idea of taking a risk-based approach at the healthcare provider level is certainly a very interesting one. It's not one we've studied directly yet, but worth looking into.

Mr. Burgess. Well, some States, in fact, are doing this, I know Texas at a State level, referred to as the gold card here, after State legislation in the last legislative session, again, the idea that we could facilitate care and actually -- actually make it less burdensome on patients and providers if we were to be forward looking with the results of this data.

Inspector Bliss, I guess that -- I would ask you to respond to that.

Ms. Bliss. Sure. Thank you. Yes, certainly streamlining the process, avoiding unnecessary requirements around prior authorization, unnecessary paperwork, unnecessary burden, and getting to a more appropriate response as quickly as possible

are absolutely goals that we share.

Mr. Burgess. But I guess, you know, in the future, if there were a way that -- if you have a physician or a practice that is consistent in their submission of accurate data, could we perhaps forego the prior authorization step for that physician or for that clinic because the history of their submissions has always been one of -- of accurate -- accurate requests, Inspector Bliss?

Ms. Bliss. Sure. Yes, I think certainly an important option for policymakers to consider. As an oversight entity, we take a look at how the program as designed is operating and running effectively, but that certainly seems like a promising option to consider.

Mr. Burgess. Well, sure. And bearing that in mind -- I mean, you cited in your testimony, I think the phrase was numerous -- numerous evidences of inappropriate delays. Do you have an idea as what the cost of this delayed care might be, not just the cost of the medical care itself but the cost as far as what the impact on the patient might be by the delay of that care?

Ms. Bliss. Not from this study, but we're certainly concerned about those costs, both financially and in terms of the patient's health. So we looked at the case files from September 2019 for care that had been denied in June of 2019, so we could see what had happened in that 3-month window, but we can't see beyond that to know ultimately what the costs were financially and otherwise to the patients whose care was delayed or denied.

Mr. Burgess. I appreciate that. It seems like that's an important -- an important concept for us to -- as an Oversight Committee, one that we should know.

Thank you, Madam Chair. I'll yield back.

Ms. DeGette. I thank the gentleman.

The chair now recognizes Miss Rice for 5 minutes.

Miss Rice. Thank you, Madam Chair.

Ms. Bliss, the Department of Health and Human Services OIG report found that in several instances it was not possible to determine whether a prior authorization denial that seemed to meet Medicare coverage rules was appropriate, because CMS -- the CMS guidance on internal clinical criteria was not sufficiently detailed. How widespread was this issue within the 250 prior authorization denials you studied?

Ms. Bliss. So this issue came up in the subset of prior authorization denials that we determined were for care or services that met Medicare coverage requirements, so it was the 13 percent out of that larger total. It was a very prominent issue among those 13 percent. It was the most common issue in the denials for services that did, in fact, meet Medicare's coverage requirement.

Miss Rice. So the OIG report gives the example of a medically necessary computerized tomography scan that was denied because the MAO required the beneficiary to have an x-ray before being approved for a CT scan. The report states that this additional step could be considered appropriate because current CMS guidance allows MAOs to establish additional evidence-based clinical criteria, as long as it does not contradict Medicare's own rules. But it recommends that CMS issue more detailed guidance to provide greater clarity on the appropriate use of these internal clinical criteria. CMS has said they concur with the recommendation and plan to issue guidance.

Dr. Mathews, how detailed should new guidance be to remove existing ambiguity from this process?

Dr. Mathews. I -- on behalf of MedPAC, I have to say that we have not weighed in on a level of detail with respect to regulatory guidance that governs the prior

authorization process, and I would have to defer to my colleagues at the Office of Inspector General.

Miss Rice. But do you have an opinion?

Dr. Mathews. Not on behalf of the commission, no.

Miss Rice. Okay. In issuing new guidance, you know -- I guess this would go back to, I don't know, maybe Ms. Bliss. In issuing new guidance, what factors should CMS weigh to ensure the guidance strikes a balance that allows MAOs to provide appropriate and safe patient care without being unnecessarily restrictive?

Ms. Bliss. Thank you. The -- determining where to draw that line is something that we leave to the program officials, in this case CMS, who are running the program as well as, you know, policymakers in Congress. So what we try to do is take a look at the criteria and see if it's being followed.

In this case, we couldn't tell. And what we pointed out was that the outcome was that in some instances patients in Medicare Advantage were being denied care that would have been covered if that same patient had been in original Medicare. And so, you know, whether or not that's an acceptable outcome is -- we'd really have to defer to policymakers, and so that's why we left it to CMS to set where that line is actually drawn. But we think it does need to be a much clearer line.

Miss Rice. Yeah. I mean, it's clear from this hearing up to this point that there is a lot on the Federal agencies that needs to be done as well for clarification purposes.

Ms. Bliss, very quickly, the OIG report also noted that physician-administered injections, such as those for pain management, are among the most routinely denied services because they are subject to extra scrutiny. Why is that, that injections subject -- why are injections subject to heightened scrutiny by MAOs?

Ms. Bliss. Well, there has been a history of improper payments and, in some

cases, fraud involving injections for pain management treatment, and so it's possible that that would be a rationale that Medicare Advantage plans might want to apply extra scrutiny to those services.

Miss Rice. Thank you.

Dr. Mathews, are there steps CMS should take to ensure patients have access to this care and don't experience delays caused by unnecessary friction in the Medicare Advantage program?

Dr. Mathews. I'll go back to the item that Representative Burgess discussed about gold carding. With respect to prior authorization, the MedPAC last discussed this in detail in a different context, back in 2011, when we looked at prior authorization for high-tech imaging services. And while we didn't discuss gold carding per se, we did say that any such prior authorization requirements should be focused on outlier clinicians. And to the extent that the majority of clinicians were following program rules, that any such additional requirements such as prior auth should be focused on the outliers.

Miss Rice. Thank you, Madam Chair. I yield back.

Ms. DeGette. I thank the gentlelady.

The chair now recognizes Mr. Palmer for 5 minutes.

Mr. Palmer. Let's see if I can avoid everybody else's errors on unmuting.

I want to follow up on the improper payments issue. It's something that I've worked on quite a bit in previous Congresses.

And, Director Gordon, there was an article on Medicare that said the improper payments -- according to the GAO -- were estimated to be \$43 billion in 2020 and accounted for over a quarter of all improper payments made government wide in 2019. What percentage of the Medicare improper payments come from Medicare fee-for-service?

Ms. Gordon. The improper payment rate in the fee-for-service -- Medicare fee-for-service is just around 6 or 7 percent in 2021. The improper payment rate in Medicare Advantage were estimated to be about 10 percent.

Mr. Palmer. How about from Medicare Advantage?

Ms. Gordon. In 2021, the estimated improper payments in Medicare Advantage were about \$23 billion or 10 percent.

Mr. Palmer. Ten percent. When I was working on this, on the Oversight Committee, the standing committee that does oversight and government reform, one of the things that we found was a failure to document eligibility. There was -- one of the areas that I thought was particularly important was the antiquated data systems in the Federal government. Have -- has the GAO looked into that, and is that a problem that's not only persistent with the Federal government but also with the States?

Ms. Gordon. So the -- the -- the ability to collect and have accurate and complete encounter data in the Medicare Advantage plan is something we've been speaking about here today. It is longstanding, and it needs further attention in order to ensure that we have full data for both risk adjusting and for evaluating the quality of care. GAO has work looking at the data systems across the Federal government and is an area of continuing concern for many agencies.

Mr. Palmer. Well, in order to reduce or certainly eliminate the improper payments -- and this is something that I think is very much bipartisan, because the Democrat Congress in 2011 and I believe in 2012 passed two bills dealing with the elimination of improper payments, but we've never really followed up on that.

And the GAO, in December of 2020, put out 89 recommendations to address some of these issues. Obviously, we can't go into all 89 recommendations, but specific to what we're dealing with with Medicare, are there one or two things that you could

recommend that this committee follow up on?

Ms. Gordon. We need to follow up on the timeliness of the RADV audits that both identify and recover improper payments from the Medicare Advantage program. CMS has the ability to conduct annual audits and estimate improper payments and recover improper payments from fee-for-service. They've gotten quite efficient at that.

There's a new benchmark for Medicare Advantage estimation of improper payments, and that is why the rate has gone up to about 10 percent. More attention needs in the Medicare Advantage plan -- program specifically, as we've also seen increased enrollment, you know, and increased spending in the Medicare Advantage plan. So that's the area to focus on for improper payments. I think we also have open recommendations relating to improper payments in part D.

Mr. Palmer. One last question. I think the first bill I introduced as a Member of Congress was to postpone the implementation of ICD-10, which took the number of diagnostic codes from 13,000 to 68,000. Has that increase in diagnostic codes contributed to the improper payments?

Ms. Gordon. We have an open recommendation that CMS evaluate the documentation requirements in Medicare and Medicaid to see that they are both appropriate and necessary for ensuring the quality of care and the services provided are needed.

Mr. Palmer. Okay. With that, Madam Chairman, thank you for holding this hearing, and I yield back.

Ms. DeGette. I thank the gentleman.

The chair now recognizes Ms. Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Madam Chair.

I want to begin by asking unanimous consent to enter into the record a June 5

Washington Post article?

Ms. DeGette. Request for unanimous consent will be handled at the conclusion of the hearing.

Ms. Schakowsky. The headline of that article is, quote, "Beat Cancer? Your Medicare Advantage Plan Might Still Be Billing for It." And then it goes on to say, also a quote -- let's see, oh, firms are -- firms are mining patient records for outdated, irrelevant conditions to increase profits, says the Justice Department.

And so I wanted to refer now to Dr. Mathews. As you mentioned before, one of the tactics that Medicare Advantage plans can use to increase their profits is called coding intensity. And you also mentioned that in March of this year MedPAC released a report that found that coding intensity accounts -- accounted for \$12 billion in additional payments to Medicare Advantage plans. And actually, my understanding is that these are payments that would not have been -- not have occurred had these enrollees been in traditional Medicare.

So here is my question for you, Dr. Mathews: How widespread is this problem of coding intensity?

Dr. Mathews. Thank you. You are correct that we did quantify the excess payments that result from coding intensity relative to fee-for-service at about \$12 billion. And I would like to clarify that this is net of the current 5.9 percent payment adjustment that the Medicare program makes. The \$12 billion is just for the residual that remains.

The second thing I wanted to say is that -- that to the extent that diagnoses are being collected through the form of health risk assessments and chart reviews, I want to be clear that we are not asserting that these diagnoses are improper or erroneous or otherwise falsified. These could be things that very well happened in a beneficiary's past.

But yet, you know, as the Post article indicates, the beneficiary has recovered from a given condition, and those conditions are no longer contributing to the cost of the care that the beneficiary is receiving, and therefore should not be used for purposes of risk adjustment in a way that boosts payments to plans for conditions that are no longer incurring costs. And so we've made a recommendation to CMS that diagnoses collected from health risk assessments should not be used for risk adjustment.

As one of my other colleagues or witnesses on this panel have indicated, to the extent health risk assessments serve a useful purpose to Medicare Advantage plans for purposes of managing the conditions of their enrollees, that is a fine thing, all well and good, but those diagnoses should not be used for purposes of risk adjustment.

Ms. Schakowsky. I thank you for that.

I also wanted to ask you and/or Dr. Bliss to say, so what can we actually do about this? And does CMS need more scrutiny in this area? Dr. Bliss, why don't you start.

Ms. Bliss. Thank you. So CMS does have the authority to make the changes that we've recommended and improvements. I think drawing attention to the importance of the issues and doing oversight like this is important to helping build momentum for those changes.

Ms. Schakowsky. I have a couple more seconds. Dr. Mathews, do you want to add to that?

Dr. Mathews. I would concur with Ms. Bliss. We believe that CMS currently has the statutory authority to make the changes that MedPAC has recommended with respect to coding intensity: Use 2 years worth of data for risk adjustment; eliminate diagnoses obtained exclusively from health risk assessments; and, to the extent it is necessary, CMS should take more than the necessary statutory minimum in recovering overpayments from plans.

Ms. Schakowsky. Thank you so much, and I yield back.

Ms. DeGette. I thank the gentlelady.

The chair does not see any Republicans on screen who have not asked questions, and the only Democrat that I see is Representative O'Halleran. Representative O'Halleran, are you prepared to -- oh, wait. Here's Mr. Ruiz, who is a member of the subcommittee. Are you prepared to ask questions? You need to unmute. Okay.

Mr. Ruiz. Yes.

Ms. DeGette. You're recognized for 5 minutes.

Mr. Ruiz. Thank you. One second. Let me pull up my notes here.

Medicare Advantage is very popular in my district. More than half of the seniors I represent have Medicare Advantage plans as opposed to traditional fee-for-service. That's almost 85,000 seniors. And Medicare Advantage disproportionately serves low-income and minority seniors.

In fact, over half of all Medicare Advantage beneficiaries live on annual incomes of less than \$24,500, and approximately 33 percent of MA enrollees identified as a racial or ethnic minority compared to 16 percent in traditional Medicare. While Black, Asian, and Hispanic Americans sign up for MA programs at higher rates than White enrollees, enrollees from these backgrounds also tend to be in plans with lower quality ratings.

As a member who represents tens of thousands of seniors enrolled in MA plans, and as a doctor who has spent his entire career fighting for health equity, it is of paramount importance to me that the program is serving our seniors in the way that it is intended.

I am disturbed by some of the findings in the HHS Office of Inspector General report released in April that found gaps in data for determining whether MA programs are properly serving Americans from communities of color. Seniors should not have

greater or less access to treatments and services depending on whether they are enrolled in traditional Medicare or Medicare Advantage, and we must get to the bottom of whether disparities exist across MA programs.

So, Ms. Gordon, your office has written extensively about the need for high-quality, verified data detailing enrollees' interactions with their providers. How has the absence of quality data about enrollees encounters with their providers affected CMS's ability to document disparities in the MA program?

Ms. Gordon. Without complete and accurate encounter data, it -- as Dr. Mathews has also testified, it is very difficult to assess exactly what services Medicare Advantage beneficiaries are receiving and whether they are quality care that their beneficiaries are expecting.

Mr. Ruiz. If you can't measure, you can't necessarily fix it. So I think that -- or at least fix it the right way.

So what kind of data should CMS collect to determine whether beneficiaries of color face barriers to care in MA programs, and how would that data better allow CMS to address disparities in the MA program?

Ms. Gordon. CMS needs to be holding the Medicare Advantage organizations accountable for completing all data elements that would be useful for both tracking the services provided as well as their underlying beneficiary characteristics and conditions, so demographics, of course, but also the services provided and the diagnoses.

Mr. Ruiz. Great. I also think that disparities -- a major breakdown in disparities is income and where you live in the spectrum of the United States, so in other words, rural locations too face great disparities.

I was also concerned to learn that OIG found that 13 percent of MA's plans prior-authorization denials that OIG examined met Medicare Advantage coverage rules

and would've been approved under traditional Medicare. While I know that the report didn't include the use of Medicare part B step therapy specifically, likely due to the timing of the change in policy in late 2018, I would be curious to learn if there are similar improper denials as found in prior authorizations.

For a number of years, I have championed the Safe Step Act with my colleague Dr. Wenstrup, which would place guardrails on step therapy protocols in order to ensure that decisions about treatments are made by patients and their doctors, not insurance companies. It is unacceptable for step therapy and prior-authorization protocols be used to deny care to seniors that they are supposed to receive, especially if they have already failed a certain treatment in the step therapy protocols.

So, Ms. Bliss, given the significant access barriers step therapy can cause, I would like to understand how you are thinking about this type of utilization management tool, how the step therapy affects quality, and what oversight processes are in place to ensure MA beneficiaries have the same access as FFC beneficiaries?

Ms. Bliss. Thank you. As you noted, step therapy for part -- for part B coverage was not included in this review, so I can't speak specifically to how well it's actually working. But I think that you're right, that some of the same incentives and concerns about potential delays or denials of access to medically necessary treatments could certainly apply.

So we'd be happy to think about potentially conducting new work that might look specifically into step therapy, and we'd be happy to follow up with your staff to talk more about your specific concerns and think through, you know, how we might address those.

Mr. Ruiz. Thank you. I yield back.

Ms. DeGette. I thank the gentleman.

Mr. Joyce, you're recognized for 5 minutes. Mr. Joyce, do we have you?

Mr. Joyce. Thank you, Chair DeGette, for holding this hearing, and thank you, Ranking Member Griffith, as well.

Last year, over 28 million Medicare beneficiaries were enrolled in a Medicare Advantage plan, which represents nearly 45 percent of all Medicare patients. In my home district, in Pennsylvania's 13th, this percentage is even higher, approximately 50 percent in several of my counties.

The public/private partnership is very popular with patients and offers substantial benefits when compared to traditional fee-for-service Medicare and could lead to better patient outcomes. For example, fewer emergency room visits. MA beneficiaries experienced 33 percent fewer emergency room visits than Medicare fee-for-service beneficiaries; more access to primary care, as nearly 12 percent more office visits per dual eligible beneficiaries in MA compared to dual eligible Medicare fee-for-service beneficiaries; and, most important to me as a physician, better outcomes for beneficiaries with chronic disease. MA beneficiaries with complex diabetes experienced a 52 percent lower rate of any complications and a 73 percent lower rate of serious complications compared to Medicare fee-for-service.

Now, with all that being said, there is room for improvement. And one of the key areas we can work on is cutting the red tape and eliminating unnecessary delays in care through the prior authorization process. I'm proud to cosponsor H.R. 3173, the Improving Seniors' Timely Access to Care Act, and would echo my colleagues' words in support of this legislation.

Another issue that is increasing provider burden is step therapy. Healthcare providers prescribe the medication that they know is best for their patients, but step therapy, also known as fail first, is used by health plans to determine coverage and requires that patients fail on an insured preferred medication before the therapy

prescribed by their healthcare provider can be covered. This can cause unnecessary delay in care that a physician knows will result in a better outcome if the first medicine was available to the patient. Notably, Medicare fee-for-service does not use step therapy protocols and covers products under part B if they are reasonable and necessary.

Ms. Bliss, given the significant access barriers step therapy can cause, I would like to understand what oversight processes are currently in place to ensure MA beneficiaries have the same access as fee-for-service beneficiaries and how you consider patient access in evaluating similar utilization management tools?

Ms. Bliss. Thank you. Step therapy was not part of this particular evaluation. We are looking at prior authorization for other types of services, so I can't speak to it specifically. But certainly, it's very similar in that it's a utilization management technique intended to control costs that potentially could be used appropriate in certain circumstances, but also comes with risks of inappropriately limiting access to care and worsening beneficiary health outcomes. So I can see the --

Mr. Joyce. And that worsening of beneficiary health outcomes to us as a group is severely concerning to each and every one of us.

Now, I would like to, with my remaining time, address prior authorization. We have heard from long care, acute care hospitals of instances in which an MA plan's delay in approving prior authorization requests for medically necessary care have resulted, unfortunately, in patient deaths. Is administration tracking these occurrences, Ms. Bliss?

Ms. Bliss. So I don't have information specific to patient deaths or the health outcomes for the patients in our sample beyond the denial. But I can say that denials for post-acute care were a prominent type of denial in our evaluation.

Mr. Joyce. And would you agree that monitoring for occurrences like patient

death should be important?

Ms. Bliss. Yes, monitoring for patient deaths should be very important.

Mr. Joyce. Thank you. I think that the importance of having this hearing illuminates how these discussions and oversight need to be a part of the solution.

Again, I thank Chair DeGette and Ranking Member Griffith for holding this important hearing, and I yield the remainder of my time.

Ms. DeGette. I thank the gentleman.

The chair is now pleased to recognize the vice chair of this subcommittee, Mr. Peters, for 5 minutes.

Mr. Peters. Thank you very much, Madam Chair.

I'm just struck by one thing, which has been very interesting, is that, again, the government has failed to appreciate the foundational role of good data in decision-making. We -- it's really hard for us in any context -- I said this with respect to COVID -- to make good decisions about what to do when we don't know what's going, and that's data. So I'm interested in any -- anything we can do to bolster the efforts of these agencies to understand this and as well as the public and Congress.

The Medicare Advantage program is intended to cover the same services that beneficiaries receive under traditional Medicare. And while there's been significant movement of beneficiaries to Medicare Advantage, we've heard nearly 50 percent of all beneficiaries choosing MA over traditional Medicare. The rate of disenrollment for Medicare Advantage plans in the past year of life is double that of traditional Medicare, and the churn has come at significant cost to the Medicare program. And for that reason, among others, it's important to get a sense for why that is.

Ms. Gordon, in your testimony, you discussed GAO's findings around beneficiaries disenrolling from Medicare Advantage plans to join traditional fee-for-service Medicare.

Why might some beneficiaries make this decision, and can you elaborate on what these disenrollment numbers suggest about the quality or adequacy of certain plans for older seniors, if we could draw that conclusion?

Ms. Gordon. Some disenrollment is to be expected. There's competition, patients change their mind about what they need, and they disenroll. It's important to monitor for higher levels of disenrollment because it could indicate that beneficiaries are having difficulty accessing providers or specialized care. And we heard from some stakeholders when we were doing this work that folks did, in fact, articulate a disenrollment need because they could not access specialized care.

Mr. Peters. In your testimony you say that disenrollments from MA plans beneficiary's last year of life cost the program \$422 million in 2016, \$419 million [sic] in 2017, more than if they had stayed in Medicare Advantage plans. Why -- what's the basis for making that conclusion? Why is that the case?

Ms. Gordon. We compared what would've been spent had the beneficiary stayed in Medicare -- their Medicare Advantage plan to what they actually received and what was paid under their fee-for-service benefits after they disenrolled for that year. So in 2016, that amount was about \$422 million, and in 2017 it was \$490 million, I believe. And this accounts -- you know, if they had stayed in Medicare Advantage plans, the Medicare Advantage plan would've covered all of those services for the lower amount.

Mr. Peters. Yeah. Yeah. And I do see that in May of 2022, CMS acted in response to GAO's recommendations and began reviewing disenrollment patterns for beneficiaries in the last year of life. If that review corroborates the finding that beneficiaries in the last year of life tend to disenroll at disproportionately high numbers, what changes could CMS put in place -- and maybe you've addressed this already,

but -- to better ensure that MA beneficiaries are receiving the same care -- are receiving the care that they need at all stages of their lives?

Ms. Gordon. So the high proportions of disenrollment are a red flag, and it just requires additional scrutiny in the way that CMS is responsible for overseeing what Medicare Advantage plans provide. They could look -- they have -- they can make changes to the star rating, which would alert beneficiaries when they're making decisions around which plans to choose. CMS can increase its oversight. It can issue warning letters and even findings. They have the ability to look and assess at the benefits package that are being offered and network accuracy, and all those are steps that CMS could take.

Mr. Peters. Okay. Obviously, as our seniors age they're more likely to need more frequent and more sophisticated care, so we want the programs -- make sure that they're well equipped to address the medical needs so that participants aren't looking around for care at a time when they need it the most.

And, Madam Chair, I appreciate very much the chance to hear about this and the hearing, and I yield back.

Ms. DeGette. I thank the gentleman.

Mr. Tonko, you're recognized for 5 minutes.

Mr. Tonko. Madam Chair, can you hear me?

Thank you. Thank you, Madam Chair. I appreciate you holding this hearing today to examine what can be done to strengthen program integrity in the Medicare Advantage program. This is a very important issue in my district, which has a higher-than-average enrollment in Medicare Advantage. Most beneficiaries I speak with in my district are very happy with their locally based MA plans.

However, the witnesses today have described how some other unscrupulous plans

have put profits over patients and overcharged the government. In an effort to be good stewards of taxpayer dollars, we should always be willing to examine how we can make certain our Medicare dollars are being spent wisely and efficiently to help all seniors in need.

We have heard today about how so-called coding intensity can affect the risk scores and thus the amount of money MA plans receive from Medicare. MA plans have several tools available to them to facilitate the collection of the diagnosis codes used for these risk-adjustment purposes, tools that are not available in the traditional Medicare program. I want to particularly discuss one of these tools, health risk assessments, and how MA plans use these assessments to increase payments.

So, Ms. Bliss, OIG used two reports in recent years that focussed on MA plans' use of health risk assessments to drive billions of dollars in additional payments to the plans. Specifically, 80 percent of the \$2.6 billion in payments analyzed by OIG were generated solely using in-home health risk assessments. Can you explain what health risk assessments are and what purpose they are supposed to serve?

Ms. Bliss. Sure. Health risk assessments are when healthcare professionals collect information from beneficiaries about their health status, their health risks, and their daily activities. The intent is to improve care coordination and health outcomes for those patients. Health risk assessments can occur in a medical setting, like in your physician's office as part of a regular visit, but they also can occur in beneficiaries' homes. And sometimes Medicare Advantage organizations contract with vendors to go to beneficiaries' homes and conduct those assessments.

The concern that we have, particularly with the in-home health risk assessment, is when we see those assessments generating diagnoses for often very serious condition that lead to extra payments to the Medicare Advantage plan, but we don't see records of

any other services or followup care being provided to that patient to treat that condition.

Mr. Tonko. So why might the use of in-home health risk assessment be a cause for concern when it comes to the quality of care received by MA enrollees?

Ms. Bliss. Well, when we see that there are serious diagnoses added through one of these assessments but then there's no evidence that any care or services were provided to treat that condition, we're worried about whether that information even made it back to the beneficiary's regular doctors to take into account, or whether that diagnosis really supported or was it not supported, in which case it may have led to an improper overpayment to that plan.

Mr. Tonko. Are there safeguards that can be put in place to address some of the potentially improper uses of in-home health risk assessments?

Ms. Bliss. Absolutely. And we've recommended two really important safeguards: One is to require Medicare Advantage organizations to implement best practices for care coordination for beneficiaries who receive health risk assessment; the other is for CMS to reconsider whether to even allow in-home health risk assessments to be the sole source of diagnoses for risk adjustment payment.

Mr. Tonko. Dr. Mathews, MedPAC has also studied the effects of tools such as health risk assessments on payments to MA plans. Based on your analyses done by MedPAC, would you say that the misuse of high-risk assessments to drive up payments is used broadly or just by a few particular MA organizations?

Dr. Mathews. Like my colleague at the Office of Inspector General, we have estimated that the use of health risk assessments and chart reviews where those are the exclusive sources of diagnoses that are not validated by encounter records reflecting actual service use, we estimate that those two vehicles account for about two-thirds of the overpayments that stem from coding intensity.

Mr. Tonko. Okay. Well, with that, Madam Chair, I have exhausted my time, and I yield back and thank you again.

Ms. DeGette. Thank you so much.

The chair now recognizes Ms. Kaptur for 5 minutes.

Ms. Kuster. Thank you so much, Madam Chair. I appreciate this hearing and your time.

Like so many Americans, people in my home State of New Hampshire rely upon Medicare to access high-quality healthcare when they need it. After paying into the system throughout their professional careers, Medicare is a program they know they can count on to connect them with providers and cover necessary services to stay healthy as they age.

We're seeing dramatic shifts with the way beneficiaries want to receive this care, with enrollment in Medicare Advantage more than doubling over the past 10 years, as we've discussed. Now is the time to ensure that Medicare Advantage programs can continue the tradition of Medicare seeking to provide affordable, accessible care and improve clinical outcomes.

Recognizing that Medicare Advantage plans use prior authorization as a tool for both maintaining clinical standards of practice and containing cost to stay within their benchmark rate, many of the concerns raised here today relate to how prior authorization can become a barrier to care, burdening an already strained workforce with administrative procedures and preventing patients from receiving necessary care.

Ms. Bliss, your testimony addressing how Medicare Advantage organizations delayed or denied beneficiaries access to medical services even in cases where the care was medically necessary. Studies find there's often confusion on who's responsible for handling appeals. How can Medicare Advantage plans better support beneficiaries

seeking to appeal a prior authorization decision in order to receive care?

Ms. Bliss. Thank you. That's an important question. And we have found previously that beneficiaries and providers appeal only about 1 percent of Medicare Advantage denials of prior authorization and payment denials as well. And so that's -- just a tiny fraction of the denials actually get appealed. Typically, a beneficiary would work their provider to go through that process, but we have heard and are concerned about both the delays in care and the administrative burden for all involved in trying to correct inappropriate denials.

Ms. Kuster. Thank you. And reports have found that many prior authorization denials are eventually overturned. And the April OIG report found Medicare Advantage plans approved the vast majority of prior authorization requests. With the goal of facilitating access to care, what are the reasons that a Medicare Advantage organization would reverse an initial denial decision, and what steps can be taken to reduce prior authorization for services that are routinely approved? And that's for you, Ms. Bliss.

Ms. Bliss. Thank you. Yes. There are a number of reasons that a Medicare Advantage organization might initially deny and then later overturn its own denial, which we found happened about 75 percent of the time. It could be that the initial submission for the request did not include all the information that the Medicare Advantage plan would need to approve the request, and so it may have been initially an appropriate denial based on the information that the Medicare Advantage company received.

But it's also possible in some cases that that initial denial was incorrect, should have been approved, and that the Medicare Advantage organization ultimately upon appeal realized its error. But since only 1 percent of denials get appealed, then errors that are made at that initial denial that aren't repealed may go uncorrected.

Ms. Kuster. Well, and may result in delays from lengthy and complex prior

authorization in appeals process and may impact clinical outcomes. That's my biggest concern. This is leading to provider strain. I've been talking in recent weeks with providers who are dealing with burnout. They're just so tired of all this paperwork and red tape.

So I'm wondering if we can consider or require electronic submission that would eliminate burdensome paperwork and simplify the process. In 2022, can't we at least consider electronic prior authorization?

Ms. Bliss. Yes, certainly that's an important consideration, anything that can both reduce the burden for all parties involved in requesting and considering prior authorization and hopefully can improve the accuracy of the determinations that are made. We found some cases where prior authorization was denied because someone had overlooked a document that was in the record.

Ms. Kuster. Well, thank you. I think fax machines are outdated. I would certainly support electronic transfer of records.

And with that, I yield back. Thank you so much, Madam Chair.

Ms. DeGette. Thank you so much.

The chair now recognizes the ever-patient Mr. O'Halleran for 5 minutes.

Mr. O'Halleran. Thank you, Madam Chair and Ranking Member, for this hearing today. And I want to express my extreme disappointment that CMS is not here today. It is important to hear from them as we seek to improve access to care in rural, tribal, and underserved communities and throughout this entire system.

I have sat here in amazement that we're talking about issues that have been unresolved from the GAO from 2011, 2014, 2016, on and on and on. And the only conclusion I can come to is either the Agency is understaffed, it doesn't have the technology to address the issue, it's overwhelmed, Congress has not been paying enough

attention to its ability to make sure that we are saving the taxpayers money by actually reforming the process and seeking the savings from whether it's fraud or other issues to go back into this system so that we can have a system that actually works.

And so I'm very disheartened from what I've seen today. And I think the Medicare Advantage process is a good advantage, but there obviously is room for a lot of improvement, both in the Medicare Advantage system and CMS.

More than 60,000 seniors are enrolled in Medicare Advantage in Arizona's First Congressional District, representing nearly 37 percent of eligible seniors. Across the State of Arizona, more than 47 percent of seniors are on Medicare Advantage. And according to data from the HHS Inspector General, nearly 51 percent of seniors nationwide are going to be on Medicare Advantage by 2030.

This is why it is important to this committee to spend time getting it right. Seniors in rural, tribal, and underserved communities throughout Arizona lack easy access to their doctor in the first place or their healthcare provider. If you travel throughout northern Arizona, you will see how far it is for many to see even their primary care doctor.

And my frustration, as I'm on Medicare Advantage, I'm on Medicare, and just the -- Ms. Kuster just indicated, you know, there's so much paperwork and so much -- many problems. We have to eliminate this process and get it to the point where it actually works for the people that are being provided healthcare and have to go through this terrible system as far as paperwork goes and even getting a hold of somebody to talk to.

CMS quality bonus program was designated to incentivize plans to create higher quality, more accessible care for seniors. However, the program seems to be in need of some improvement, a lot of improvement, I feel, particularly to ensure that seniors in

rural, tribal, and underserved communities can access their providers, the few that there are.

We need to improve transparency to data to ensure what seniors can have as a meaningful way to evaluate which healthcare plan is right for them and their needs and which one is working. Without this transparency and data necessary to make decisions, consumers, particularly those who are historically underserved, will continue to be unable to access care that is necessary for their medical needs.

Having a lack of access to data is not a new issue. In 2014, GAO raised the concern that CMS may not be collecting the data that is needed to best assess the quality of Medicare Advantage plans. Coming from the business environment, I just don't understand how you do things without data, make decisions without data.

It is critical that CMS be appropriately prepared to give consumer notice of quality of their plans so that seniors, particularly those in rural communities, who need specialty care, can make an informed decision.

Ms. Gordon, how would you -- would collecting more robust data allow CMS and the public to better gauge whether seniors in rural and tribal communities are getting the care they need from MA programs and the ability of CMS to respond to an ever-changing environment?

RPTR SCHOETTLE

EDTR HUMKE

[12:58 p.m.]

Ms. Gordon. It's CMS' responsibility to require the Medicare Advantage organizations and their plans to submit fully complete, accurate encounter data. It's also their responsibility to review those data and to ensure that they are meeting -- that they're validated.

The data are needed, as you suggest, in order to be able to monitor the services are appropriately provided, that they are the quality that are expected and meet coverage requirements, and that -- and that they are equitably distributed, and that all beneficiaries are able to access that care. So it is essential that CMS require the Medicare Advantage plans in organizations to submit a complete and accurate encounter data, as well as follow up to ensure that that is happening.

Mr. O'Halleran. Thank you.

And Madam Chair, I yield. And we have a lot of work to do.

Ms. DeGette. I thank the gentleman.

We now have Mr. Bucshon, I understand, in the committee room visiting us as a guest to this subcommittee, and we'd like to welcome you. You're recognized for 5 minutes.

Mr. Bucshon. Thank you, Chairwoman DeGette, and Ranking Member Griffith. I appreciate the subcommittee holding this hearing, and it's timely. And I'm grateful for the opportunity to participate.

Most of us, Members, witnesses, and the Medicare Advantage organizations whose actions we've been discussing share desire to see the Medicare Advantage

program succeed. With so many millions of people enrolling in Medicare Advantage and the number growing exponentially each year, it has never been more important for us to ensure this program works for patients. We know and have heard repeatedly here today that Medicare Advantage means a lot to a lot of seniors.

It offers them options to decide what kind of health insurance they need when they reach age 65. Unlike traditional fee-for-service, Medicare MA plans with zero dollar premiums are often available and 90 percent of plans include additional benefits, like vision, dental, or hearing. We must continue to support the availability of plans like these for seniors who prefer them.

But just because a program is the best option for seniors doesn't mean it's flawless. We've heard quite a bit of evidence today that there is room for improvement. I appreciate that every one of the witnesses came here today has provided concrete ideas for how to improve the program. As you all likely know, I have a few ideas myself about how to improve the MA patient experience when it comes to utilization of services, particularly in the prior authorization process. The improving seniors timely access to care act, the H.R. 3173, has been mentioned a few times today already. It's a bill I've led for several years alongside my colleagues Representatives DelBene, Kelly, and Berra. Our goal with this bill is to facilitate the adoption of an electronic prior authorization process that is far quicker and more efficient than what doctors and patients currently endure.

It also requires -- has HHS to require to establish a process to facilitate realtime decisions for items and services that are routinely approved. It also has MA plans reporting their use of prior authorization and their rate of approvals or denials, and also encourages plans to use evidence-based guidelines in their prior authorization process. The result will be less administrative burden for providers and more information in the

hands of patients.

It will allow more patients to receive care when they need it, reducing the likelihood of additional often more severe complications. In the long-term, I believe it will also result in a cost savings for the healthcare system at large by identifying problems earlier and getting them treated before their patients have more complication.

As was previously mentioned, an AMA survey in 2020 a thousand doctors revealed that about 34 percent of them said that prior authorization has led to serious adverse events for a patient in their care due to delays in the prior authorization process. Most Members of this subcommittee are cosponsors already of the H.R. 3173, and I appreciate that.

Ms. Bliss, the investigation report the OIG released in April discusses 33 denials of prior authorization requests. I know there were requests that were analyzed came from all the largest MAOs.

Was the sample also representative of the Medicare Advantage program in terms of where the providers were geographically located or what the requests were for?

Ms. Bliss. Thank you for that question.

So we sampled from all of the denials issued by 15 of the largest Medicare Advantage organizations by enrollment, which accounted for about 80 percent of all Medicare Advantage enrollees. And so our results are projectable to the totality of denials across all 15 of those large Medicare Advantage organizations.

Mr. Bucshon. Okay. Great so I guess the answer would be, yes, it does take into account geographical locations and what the requests were for.

So Dr. Mathews, your recommendations include a mechanism for direct submission of provider claims to Medicare contractors. Has MPAC considered whether that mechanism could be one that operated electronically in realtime?

Dr. Mathews. Yes, sir, we have. The basis for that recommendation comes from discussions with stakeholders who are currently submitting Medicare Advantage encounter records directly to plans, and sometimes the records are rejected by the plan without explanation, or there is variation among the plans the provider works with with respect to content and format of the encounter records. And some providers that we've talked with said there are other ways of submitting this information directly to CMS the way they currently submit things like Med par records for all of their patients, whether it's fee-for-service or Medicare Advantage. And so we think there are ways that these encounter records on behalf of MA enrollees can be submitted with less administrative burden and more timely than perhaps they are being submitted now.

Mr. Bucshon. Thank you.

In 2022, we should be going to an electronic process for a lot of these things, including prior authorization.

I yield back.

Ms. DeGette. I'm now very pleased to welcome Mr. Bilirakis to the Committee, and recognize you for 5 minutes.

Mr. Bilirakis. Thank you, Madam Chair. I thank you for holding this hearing.

And I think we all share the goals to ensure our Medicare patients have the highest quality of care at the lowest cost to the taxpayer, which is why Medicare Advantage popular, including in my district, we have over 59 percent that's above the average nationwide of seniors that utilize this program. Studies have shown that Medicare Advantage maintains lower per beneficiary government spending and greater value for the taxpayer dollars, including almost \$2,000 per year expenditures.

The researchers explain the Federal Government pays less and gets more for its dollar in Medicare Advantage compared to traditional Medicare Part A and B, this also

means extra benefits, like transportation and dental and vision plans that seniors enjoy. In fact, despite inflation and costs rising for Americans around the country, average premiums for MA actually fell to their lowest levels in 15 years to just \$19 per month. So while I believe it's important to discuss how we can improve the program further, it's important to remember the value these programs provide towards better patient outcomes while saving money in the long run.

So my first question is for Ms. Bliss. In producing this report, did you evaluate a comparison between Medicare fee-for-service versus Medicare Advantage overall patient's outcomes in your analysis?

Ms. Bliss. No, we did not.

Mr. Bilirakis. Okay. One issue of reports, and this discussion is risk adjustment, risk adjustment occurs -- it ensures that there are adequate resources to treat beneficiaries who may need more complex and costly care, and thus, it's important to accurately identify potential illness for at-risk patients early in order to improve health outcomes, you know that, which is what this is all about. I know there are some concerns about the accuracy of risk adjustment reporting, but it's also possible this is due to actual patient needs that not have been found or reported by providers to CMS.

Ms. Gordon, can you explain further how your report discusses the need for CMS to improve its validation methods for risk adjustment purposes? Ms. Gordon, please.

Ms. Gordon. Yes. Complete and accurate encounter data are needed to ensure that Medicare Advantage plans payments are risk adjusted based on the clinical diagnoses and treatments needed by beneficiaries.

Mr. Bilirakis. One more question.

Ms. Gordon, earlier you stated that the improper payment rates for Medicare Advantage are around 10 percent; is that correct?

But is this taking into account underpayments?

Can you clarify what is the net improper payment for fee-for-service, and what's the net rate for Medicare Advantage, please?

Ms. Gordon. So the 10 percent is the net rate, both for overpayments and underpayments. And we can get back to you on the exact amount.

Mr. Bilirakis. Please do. I appreciate it very much.

Thanks for allowing me to wave on, Madam Chair.

Ms. DeGette. Thank you. Good to see you.

I just want to thank all of the witnesses for participating in this hearing today, a lot of good information today. This is really in the grand bipartisan tradition of this subcommittee, and you can be assured that we're going to be following up with the agency.

I'd like to remind Members that pursuant to Committee rules, they all have 10 business days to submit additional questions. [Audio malfunction] for the record to be answered by the witnesses who have appeared here today, and I would ask those witnesses to please respond quickly to any and thoroughly to any of the questions that you might receive. We also have had one unanimous request by Congresswoman Schakowsky from the Washington Post regarding Medicare Advantage billing practices, published June 5, 2022.

And without objection, that is entered into the record.

Thank you, again, to all the witnesses, and this subcommittee is adjourned.

[Whereupon, at 1:11 p.m., the subcommittee was adjourned.]