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ONE HUNDRED SEVENTEENTH CONGRESS

Congress of the United States

House of Representatives

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August 15, 2022

Ms. Erin Bliss
Assistant Inspector General
Office of Evaluation and Inspection
Office of Inspector General
Department of Health and Human Services
300 Independence Avenue SW
Washington, DC 20201

Dear Ms. Bliss:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Tuesday, June 28, 2022, at the hearing entitled "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans." I appreciate the time and effort you gave as a witness before the Committee on Energy and Commerce.

Pursuant to Rule 3 of the Committee on Energy and Commerce, members are permitted to submit additional questions to the witnesses for their responses, which will be included in the hearing record. Attached are questions directed to you from certain members of the Committee. In preparing your answers to these questions, please address your response to the member who has submitted the questions in the space provided.

To facilitate the printing of the hearing record, please submit your responses to these questions no later than the close of business on Monday, August 29, 2022. As previously noted, this transmittal letter and your responses, as well as the responses from the other witnesses appearing at the hearing, will all be included in the hearing record. Your written responses should be transmitted by e-mail in the Word document provided to Caroline Wood, Research Analyst, at caroline.wood@mail.house.gov. To help in maintaining the proper format for hearing records, please use the document provided to complete your responses.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Caroline Wood with the Committee staff at (202) 225-2927.

Sincerely,

Frank Pallone, Jr.
Chairman

Attachment

cc: The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce

The Honorable Diana DeGette
Chair
Subcommittee on Oversight and Investigations

The Honorable H. Morgan Griffith
Ranking Member
Subcommittee on Oversight and Investigations

Attachment—Additional Questions for the Record

Subcommittee on Oversight and Investigations
Hearing on
"Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"
June 28, 2022

Ms. Erin Bliss, Assistant Inspector General, Office of Evaluation and Inspections, Office of Inspector General, Department of Health and Human Services

The Honorable Frank Pallone, Jr. (D-NJ)

1. A 2018 OIG report about CMS's data collection efforts stated that invalid or inaccurate data could "raise concerns about the legitimacy of services" and hampers CMS's ability to determine whether beneficiaries are getting access to the care they need. How do these potential issues with CMS's data collection methodology affect its ability to determine whether MA beneficiaries are receiving needed medical care and whether there are disparities in the quality of care being received?

Response: Our 2018 report *Medicare Advantage Encounter Data Show Promise for Program Oversight, But Improvements Are Needed* (OEI-03-15-00060), which you cite, was our first evaluation to review some aspects of the quality of Medicare Advantage (MA) encounter data. This review did result in the Centers for Medicare & Medicaid Services (CMS) requiring some additional data checks and edits of the MA data to increase the accuracy of data reported by MA organizations (MAOs). This report did not, however, review the comprehensiveness of data reporting by MAOs. Ensuring that all encounters are submitted is an important step in determining whether there are disparities in the quality of care being received.

CMS has implemented several of the report's recommendations that aimed to improve data reporting by MAOs. In addition to implementing new data checks and edits on MA encounter data, CMS selected a subset of critical data elements and shared specific encounter data IDs with MAOs that have invalid or missing values for these critical data fields, to drive improved data integrity. CMS developed these Data Exchange reports that included encounter data element validity analyses for data elements with error rates greater than 1 percent. CMS also included five analyses on encounter data completeness.

OIG is committed to continuing work to ensure that MA beneficiaries are receiving needed care. We will continue to work with CMS to ensure the reporting of accurate and comprehensive data and assess whether policies, including prior authorization, are being used to prevent needed care. The recent COVID-19 pandemic brought to the forefront the need to address ongoing health disparities, especially health disparities by race and

ethnicity. To that end, the Office of Inspector General (OIG) has recent and continuing work addressing the issue of data and health disparities. In June 2022, OIG issued a report *Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities* (OEI-02-21-00100), which found that Medicare's race and ethnicity data were less accurate for certain racial and ethnic groups and that this inaccuracy may limit the ability to assess and address health disparities. In response to our recommendations to address this pressing need, CMS reported that it is exploring opportunities to obtain more accurate and comprehensive data. We will continue to develop work to review both CMS's and MAOs' efforts to ensure quality of care and address disparities in health care access and health outcomes.

The Honorable Diana DeGette (D-CO)

1. In 2018, OIG recommended that CMS address inappropriate payment-denial rates by (a) enhancing oversight of Medicare Advantage Organization contracts, (b) directly addressing persistent issues with inappropriate denials and insufficient denial letters, and (c) providing beneficiaries clear, easily accessible information about any serious violations by Medicare Advantage Organizations.

    a. From your perspective, what progress has CMS made in implementing these recommendations?

    Response: Although CMS concurred with all three recommendations contained in the 2018 report *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (OEI-09-16-00410), to date CMS has implemented only one of these. Specifically, CMS has implemented the recommendation to address persistent problems that CMS had identified through its audits of MAOs related to inappropriate denials and insufficient denial letters in MA. In 2019, CMS released the revised Civil Money Penalty Calculation Methodology to include aggravating factors for inappropriate delay or denial of medical services, drugs, and/or appeal rights, and new aggravating factors for prior offenses—all changes that are designed to better hold MAOs accountable for ensuring appropriate access to care.

    CMS has not implemented OIG's recommendation to enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate. In April 2021 correspondence to OIG, CMS provided a detailed analysis of the 2019 Part C reporting requirements data, including examining the number of appeals and overturns by contract and by parent organization. Although CMS's analysis identified contracts with extreme overturn rates and appeal rates, it did not enhance its oversight of these contracts or take any corrective actions, which OIG continues to believe are needed.

CMS also has not implemented OIG's recommendation to provide beneficiaries with clear, easily accessible information about serious violations by MAOs. In its latest update in 2021, CMS stated that it was continuing to study how plan performance information could and should be shared with consumers.

b. How would providing beneficiaries with better information about serious violations by Medicare Advantage Organizations improve beneficiary outcomes and increase compliance by Medicare Advantage Organizations?

Response: Individuals who are newly enrolling in Medicare, or those considering changing MA plans often rely on information provided by CMS about MA organizations when deciding whether to enroll in MA, and if so, which plan to select. The Medicare Plan Finder website is the central location that CMS offers for individuals to access plan information. Although CMS already includes limited information about MAO sanctions on the Plan Finder website, this information does not include information about other serious MAO violations, including those that result in civil money penalties, which may be valuable information for people choosing between MA plans. Added transparency about serious violations by MAOs may also incentivize plans to reduce noncompliance.

The Honorable Scott Peters (D-CA)

1. As with other health care services, cancer care has been significantly disrupted during the pandemic. Cancer screenings and treatment have been delayed causing cancer care to be more complicated as patients present with more advanced disease. To ensure the goals of the Cancer Moonshot, specifically, increased cancer survivorship, are supported, how can Medicare Advantage plans reduce delays and barriers to Seniors' access to advanced and specialized cancer treatments such as proton therapy?

Response: OIG has found that MAOs' denials of prior authorization requests have sometimes delayed or prevented enrollees from receiving medically necessary care that met Medicare coverage rules. We have made recommendations to CMS to better ensure that MA enrollees receive appropriate care that they need. There are also important actions that MA plans can take to better ensure that their enrollees receive timely access to all medically necessary care covered by Medicare, including advanced and specialized cancer treatments. For example, MA plans can re-examine the services and circumstances where they require prior authorization and consider whether they are overusing that tool. MA plans can also re-examine their prior authorization process and determinations and implement ways to streamline and better ensure the accuracy of their determinations. For example, OIG found that MA plans denied some services based on their requests for unnecessary documentation—in some cases, requesting documents already contained within the case file.

The Honorable Kim Schrier, M.D. (D-WA)

1. Last April, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) found that among the prior authorization requests that Medicare Advantage Organizations (MAOs) denied, 13 percent met Medicare coverage rules. What types of service were improperly denied by MAOs, despite meeting Medicare coverage rules?

Response: Among the denied requests for prior authorizations and payments that met Medicare coverage rules and MAO billing rules that we identified in our sample, there was a wide range of service types. Three prominent service types were advanced imaging services, including magnetic resonance imaging (MRI) and computed tomography (CT) scans; post-acute care in skilled nursing facilities and inpatient rehabilitation facilities (i.e., care after hospital stays); and injections.

2. HHS-OIG's April report states that MAOs may make ambitious use of prior authorizations because they "have an incentive to deny more expensive services" than those that are recommended by providers. Please describe how Medicare Advantage currently incentivizes MAOs to widely use prior authorizations to deny relatively expensive services.

Response: A key feature of capitated payment models, such as the model used in MA, involves incentives for financial savings generated, in part, by providing fewer services. Such incentives are helpful in reducing costs for wasteful, unnecessary services. However, these incentives are concerning in instances when a patient's access to medically necessary health care intended to be covered by Medicare is denied. Higher cost health care services, such as post-acute care in skilled nursing facilities and inpatient rehabilitation facilities, can result in a greater financial incentive because of the higher dollars involved compared to lower cost services. Still, denial of prior authorization requests for any health care services that meet Medicare coverage rules is concerning.

3. HHS OIG has made recommendations to the Centers for Medicare & Medicaid Services (CMS) regarding how to ensure that prior authorizations do not result in improper denials of service.

    a. Please provide a list of the recommendations that HHS OIG has made to CMS to ensure that necessary health care services are not improperly denied.

    b. Can you provide a status update regarding what progress CMS has made to implement HHS OIG's recommendations to prevent improper denials of service?

Response: OIG has made six recommendations to CMS, across two evaluation reports, to help better ensure that MAOs' use of prior authorization does not result in improper denials of services.

From OIG's 2018 report *Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials* (OEI-09-16-00410), we recommended that CMS:

- enhance its oversight of MA organization contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate;
- provide beneficiaries with clear, easily accessible information about serious violations by MA organizations; and
- address persistent issues with inappropriate denials and insufficient denial letters.

Although CMS concurred with all three recommendations contained in the 2018 report, to date CMS has implemented only one of these. Specifically, CMS has implemented the recommendation to address persistent problems that CMS had identified through its audits of MAOs related to inappropriate denials and insufficient denial letters in MA. In 2019, CMS released the revised Civil Money Penalty Calculation Methodology to include aggravating factors for inappropriate delay or denial of medical services, drugs, and/or appeal rights, and new aggravating factors for prior offenses—all changes that are designed to better hold MAOs accountable for ensuring appropriate access to care.

CMS has not implemented OIG's recommendation to enhance its oversight of MAO contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate. In April 2021 correspondence to OIG, CMS provided a detailed analysis of the 2019 Part C reporting requirements data, including examining the number of appeals and overturns by contract and by parent organization. Although CMS's analysis identified contracts with extreme overturn rates and appeal rates, it did not enhance its oversight of these contracts or take any corrective actions, which OIG continues to believe are needed.

CMS also has not implemented OIG's recommendation to provide beneficiaries with clear, easily accessible information about serious violations by MAOs. In its latest update in 2021, CMS stated that it was continuing to study how plan performance information could and should be shared with consumers.

From OIG's 2022 report *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (OEI-09-18-00260), we recommended that CMS:

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

CMS concurred with all three of these recommendations. CMS's specific plans and timelines for implementing these recommendations are due to OIG in October 2022.

The Honorable H. Morgan Griffith (R-VA)

1. Can you please elaborate on the respective differences in the total improper payment rates between MA and FFS?

Response: In fiscal year (FY) 2021, CMS reported an error rate of 10.28 percent for MA and an error rate of 6.26 percent for Medicare fee-for service (FFS); however, there are important differences in what is measured in the two programs.

For MA, CMS measures the extent to which risk-adjustment payments to MA plans, which are based on enrollee diagnoses that MA plans reported, are supported by the enrollees' medical documentation. An overpayment occurs when an MA plan reports an enrollee diagnosis that leads to an increased risk-adjustment payment, but that diagnosis is not supported by the enrollee's medical documentation. An underpayment occurs when an enrollee's medical documentation reveals a diagnosis that was not reported and would have increased the risk-adjustment payment, or when a reported diagnosis was classified at a lower severity than the medical documentation supports. In FY 2021, CMS reported an error rate of 10.28 percent for MA based on calendar year (CY) 2019 payments.

For Medicare fee-for-service (FFS), CMS measures the extent to which it paid claims to providers in accordance with Medicare coverage and payment rules based on the medical documentation supporting the claims. Overpayments may occur, for example, when the medical documentation is missing or is insufficient to support the claim, when the service was not medically necessary for the recipient, or when the claim was incorrectly coded and resulted in an inflated payment. Underpayments may occur when the documentation shows that Medicare paid a lower amount than what was supported by the medical record, for example, due to a coding error resulting in a lower payment. In FY 2021, CMS reported an error rate of 6.26 percent for Medicare FFS.

a. We've been told that the total improper payment rate for MA in 2021 was around 10 percent, is that true? If accurate, does this figure include both overpayments and underpayments to MA organizations? If 10 percent is not accurate, what is the correct number including both overpayments and under to MA organizations?

Response: In FY 2021, CMS reported an error rate of 10.28 percent for MA based on CY 2019 payments, which includes both overpayments and underpayments.

b. How does this compare to the rate in FFS?

Response: In FY 2021, CMS reported an error rate of 10.28 percent for MA based on CY 2019 payments, and CMS reported an error rate of 6.28 percent for

Medicare FFS. Although there are differences in what is being measured and the timeframes (the MA error rate that CMS reported in FY 2021 reflected payments from CY 2019), at a general level, the difference indicates greater discrepancies between the payments made for enrollee diagnoses submitted by MA plans for risk adjustment and the medical documentation supporting those diagnoses, compared to the discrepancies between the Medicare FFS payments to providers for claims and the medical documentation supporting those claims.

c. What sort of policies or behaviors account for the respective rates of net improper payments (i.e., overpayment balance) of MA plans?

Response: OIG is concerned about overpayments to MA plans resulting from unsupported enrollee diagnoses reported by MA plans. Through two series of compliance audits, OIG has questioned costs related to the diagnosis codes that MA plans submit to CMS. One OIG series of audits involves sampling from all diagnosis codes submitted by a plan, and OIG's completed audits of three plans have identified questioned costs of $252 million. The other OIG series is targeting specific diagnosis codes. We have completed nine targeted audits in this series with total questioned costs of $46.6 million. We have additional audits underway for both series.

OIG's identification of billions of dollars in MA risk-adjustment payments that resulted from diagnoses found solely on chart reviews or solely on health risk assessments—with no other records of services being provided for these often-serious conditions—also raises concerns that some MA plans may be misusing these tools to inappropriately inflate their payments.

2. Can you please elaborate as to how you selected the cases found within Exhibit 3 on page 26 in the April 2022 prior authorization report?

a. For example, stratum 4 includes 31 cases out of an eligible 66,608. What statistical test did you utilize to verify that this sample is representative of the broader population of denials?

Response: The statistical estimates presented in the report are representative of two populations of denials—prior authorization denials and payment denials. The statistical method showing the relationship between the sample and the broader population of denials is presented in both the point estimates and the associated confidence intervals for each estimate (shown in Appendix A on page 31). The point estimates and confidence intervals in Appendix A take into account the stratified sampling design and the eligible sample size per stratum. More broadly, OIG uses generally accepted statistical sampling methodologies and this study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* (Blue Book) issued by the Council of the Inspectors General on Integrity and Efficiency.

b. Of the 430 cases selected for review, only 162 were reviewed for administrative and medical necessity. How did you ensure that this was a randomized sample?

Response: All 162 cases in the sample that were denied wholly or partly based on medical necessity received a medical necessity review from an OIG-contracted physician. Examples of such cases included those in which the MAO indicated that the reason for denial of prior authorization or payment request involved medical necessity, and cases in which the level of clinical care was in question and therefore warranted a physician review.

The remaining 268 cases in the sample did not have any medical component that warranted clinical review by a physician. For example, a case did not warrant a medical review if the reason for the denial was because the patient was not enrolled in the MA plan (i.e., the question at issue involved an administrative enrollment issue rather than clinical issues).

Statistical estimates presented in the report represent the eligible cases in the sample, based on the results of the appropriate type of review warranted for each case.

c. The report indicates "reviewers followed a structure protocol that OIG developed in consultant with health care coding experts and physicians." MA plans typically employ clinically trained nurses and physicians with clinical practice experience to review prior authorization requests. Can you elaborate on the structure protocol used in the report and how that standard compares to the protocols used by MA plans in prior authorization cases?

Response: To design the case file review methodology, we consulted with the following: CMS, the Medicare Advantage Independent Review Entity contractor (which reviews denial appeals that are upheld by MA organizations), physicians, and health care coding experts. We also reviewed CMS policy documents such as the Medicare Managed Care Manual.

OIG's review protocol for prior authorization requests used Medicare standards, including applicable Medicare coverage rules outlined in the Medicare Managed Care Manual and Medicare national coverage determinations and local coverage determinations. In applying the Medicare standards, OIG contracted with a panel of experienced clinical physicians to review prior authorization requests to assess medical necessity. OIG also contracted with experienced health care coding and billing professionals who have subject matter expertise with Medicare coverage rules. These reviewers examined MAO coverage documents (i.e., the Evidence of Coverage document for the beneficiary's plan), medical and administrative records, and any other documentation in the case file that supported or disputed whether the request was medically necessary, met Medicare coverage rules, and met MAO billing rules.

In comparison, OIG found that for many of the denials of prior authorization requests in our sample for services that met Medicare coverage rules, MAOs denied the requests by applying MAO clinical criteria that are not required by Medicare. MAOs are permitted to develop and use their own internal clinical criteria or to use commercially available clinical guidelines developed by private health care management companies. OIG is concerned about instances in which an MA organization's use of clinical criteria not required by Medicare results in an MA patient being denied medically necessary health care that meets Medicare coverage rules.

3. In your testimony, you stated there is a lack of data and records to identify if MAOs forwarded their in-home risk assessments to the beneficiaries' primary care providers, if beneficiaries received appropriate follow-up care and treatment, and if the diagnoses reported only on in-home health risk assessments were accurate. What steps has CMS taken, if any, to ensure these in-home risk assessments are not being misused?

Response: In our report *Billions in Estimated Medicare Advantage Payments From Diagnoses Reported Only on HRAs Raise Concerns* (OEI-03-17-00471), OIG made five recommendations to CMS to ensure that in-home health risk assessments are not being misused. Of the five recommendations, CMS agreed with two recommendations to provide targeted oversight of certain MAOs that drove risk-adjustment payments resulting from in-home health risk assessments where no other MA services were provided. In CMS's December 2021 update to OIG on the status of these two recommendations, CMS stated that it is reviewing and assessing the implementation of these recommendations and anticipates providing us an update on actions taken later in 2022.

CMS stated that it did not concur with OIG's other three recommendations because it did not determine that a change in policy was warranted. These include recommendations to require MAOs to implement best practices for care coordination, to flag MAO-initiated health risk assessments in their MA encounter data, and to reassess the risks and benefits of allowing in-home health risk assessments to be used as the source of diagnoses for risk-adjustment payments. OIG continues to recommend that CMS take all these actions. OIG will continue to follow up with CMS on all our open recommendations.

The Honorable Michael C. Burgess, M.D. (R-TX)

1. In your view, what changes does the Center for Medicare and Medicaid Services (CMS) need to make to ensure that Medicare Advantage (MA) beneficiaries receive necessary care?

Response: OIG has recommended that CMS take several actions to better ensure that MA enrollees receive necessary care. These recommendations include that CMS should:

- issue new guidance on the appropriate use of MA organization clinical criteria in medical necessity reviews;
- incorporate the issues identified in our evaluation, including use of additional clinical criteria, into its audits of MA organizations;
- provide beneficiaries with clear, easily accessible information about serious violations by MAOs;
- conduct targeted oversight of MAOs with extremely high overturn rates and/or low appeal rates and those with high or disproportionate risk-adjustment payments deriving solely from health risk assessments or chart reviews, and take corrective action as appropriate; and
- require MAOs to implement best practices for care coordination for beneficiaries who receive health risk assessments.

2. Do you see a role for the Office of Inspector General (OIG) in analyzing other elements of the MA program that could help us improve the efficiency, effectiveness, and value to beneficiaries and taxpayers?

Response: Yes. OIG plays a crucial role in helping to improve the efficiency, effectiveness, and value of the MA program to enrollees and taxpayers through our oversight. In my testimony, I highlighted OIG's oversight work and resulting recommendations to better ensure that MA plans are authorizing and paying for medically necessary care that meets Medicare coverage rules. I also detailed our concerns about billions of dollars in risk-adjustment payments to MA plans that arise solely from diagnoses from chart reviews or health risk assessments with no other records of services for these often-serious diagnoses. These findings raise concerns about whether some of these payments were inappropriate (i.e., the diagnoses driving the payments were not supported by the medical record), whether some of these enrollees have serious health conditions and are not receiving needed care, and whether the MA plans are submitting incomplete or inaccurate service records to CMS.

In addition to those consequential lines of work, OIG is assessing other elements of the MA program. Through two series of compliance audits, OIG has questioned costs related to the diagnosis codes that MA plans submit to CMS. One OIG series of audits involves sampling from all diagnosis codes submitted by a plan, and OIG's completed audits of two plans have identified questioned costs of $252 million. The other OIG series targets specific diagnosis codes. We have completed nine targeted audits in this series with total questioned costs of $46.6 million. We have additional audits underway for both series. OIG also has an evaluation underway assessing the availability of behavioral health care in Medicare Advantage, original Medicare, and Medicaid managed care. OIG will continue to conduct robust oversight of this important program.

3. The OIG report provided numerous concerning case studies of inappropriate delays or denials of medically necessary care for Medicare Advantage beneficiaries.

a. Is the OIG aware of any patient harms/negative clinical outcomes resulting from these prior authorization policies (e.g., worsening health requiring more intensive care, injury/disability, hospitalization, etc.)?

Response: In this evaluation, we reviewed medical records and case files related to the prior authorization denial itself—we do not have followup information on the impacts of these care denials on the enrollee's health outcomes. However, the circumstances of denials in our sample illustrate the potential for patient harm or negative clinical outcomes. For example, an MA plan denied a walker for an enrollee because he had previously received a cane. But our physician reviewers determined that this enrollee could not safely walk with only a cane because of his medical conditions and fall risks. Even when MA plan denials are later reversed, the delays still have the potential to be harmful. For example, an MA plan's denial resulted in a 5-week delay of a CT scan for an enrollee with endometrial cancer, but our physician panel determined that the original request had sufficient documentation to demonstrate that the CT was needed to assess the stage of the cancer and to determine the appropriate course of treatment.

4. If a physician's submissions are consistent with good practice and are reimbursable, is there a point in which continuing to ask for submission of the paperwork is redundant and delays patient care?

Response: Yes. In our sample of MA service denials, we found cases where MA plans denied care based on the plans' requests for unnecessary or duplicative documentation. Requesting unneeded or duplicative documentation can result in enrollees being delayed in receiving needed care or even not receiving the care at all.

5. Does the OIG plan to examine the impact on patient care?
6. Does the OIG plan to examine direct costs associated with delays in care?

Response: OIG is considering what additional work we may undertake related to MA plans' denials of care and will take these ideas into consideration. We make very difficult decisions about what work we can and cannot take on each year, given that OIG is responsible for overseeing more than $2 trillion in HHS funds and programs that impact the lives of all Americans, and yet our spending in FY 2021 was only 0.0197 percent of HHS spending.