U.S. GOVERNMENT ACCOUNTABILITY OFFICE

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August 23, 2022

The Honorable Frank Pallone, Jr.
Chair
Committee on Energy and Commerce
House of Representatives

The Honorable Cathy McMorris Rodgers
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Diana DeGette
Chair
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
House of Representatives

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

Subject: Responses to Questions for the Record; Hearing Entitled *"Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"*

This letter responds to your August 15, 2022 request that I address questions for the record related to the Subcommittee's June 28, 2022 hearing on Medicare Advantage. This letter also responds to and follows up on several questions asked during the hearing; see attachment 2. My responses to the questions, which are in the enclosures, are based on GAO's previous work and knowledge on the subjects raised by the questions.

If you have any questions about the responses to your questions or need additional information, please contact me at (202) 512-4320 or GordonLV@gao.gov.

Leslie V. Gordon
Acting Director, Health Care

Enclosure

Attachment 1—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. Leslie V. Gordon, Acting Director, Health Care, Government Accountability Office

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

1. **In April 2016, GAO studied whether CMS had taken sufficient action to recover the substantial amounts of improper payments made to Medicare Advantage organizations due to unsupported diagnoses. What progress has CMS made in implementing GAO's recommendations on recovering payments from Medicare Advantage organizations that heavily rely on chart reviews for diagnoses?**

   In its April 2016 report, GAO made two recommendations related to improving the timeliness of the Risk Adjustment Data Validation (RADV) audits and appeals process, and one recommendation to improve the Centers for Medicare & Medicaid Services' (CMS) methodology for selecting Medicare Advantage organization (MAO) contracts for RADV audits.[1] CMS has not yet fully implemented the two recommendations to improve the timeliness of RADV audits and appeals, but has implemented the recommendation to improve the agency's selection methodology.

   Timeliness of RADV audits. In 2016, GAO recommended that CMS take several actions to improve the timeliness of RADV audit processes. As of June 2022, the agency has completed some, but not all of these actions. For example, according to CMS officials, the agency has improved audit timeliness by reducing the time gap between notifying MAOs of contract audit selection and notifying them about the beneficiaries and diagnoses that would be audited. In 2016, GAO reported this time gap was 3 months; in March 2022, CMS officials stated they had reduced the gap to 7 weeks. Although CMS has taken some steps to improve audit timeliness, contract-level audits continue to be delayed significantly. For example, as of June 2022, CMS has not yet issued final contract-level audit findings for payments made in 2011 through 2014.[2] In contrast, CMS uses a specific timetable that allows the agency to complete national-level RADV audits on an annual basis to calculate estimated improper payments for Medicare Advantage (MA). Until CMS improves the timeliness of its contract-level RADV audits, the agency may miss out on recovering hundreds of millions of dollars in improper payments annually.

   Timeliness of RADV appeals. In 2016, GAO reported the appeals process for contract-level RADV audits had been ongoing for years and that such delays hindered CMS's ability to recover identified improper payments. GAO recommended that CMS improve the timeliness of the RADV appeals process by, for example, requiring that decisions on MAO appeals of RADV findings be rendered within a specified number of days. CMS agreed with

[1]GAO, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, GAO-16-76 (Washington, D.C.: Apr. 8, 2016).

[2]CMS stated in June 2022 that the agency plans to issue these findings after publishing the final rule on RADV audits, which the agency expects to issue in November 2022.

the recommendation. In March 2022, CMS officials stated they are considering issuing a final rule specifying timelines for MAO appeal decisions, but as of June 2022, had not yet issued a final rule.

Selection of MAOs for RADV audits. CMS has implemented GAO's 2016 recommendation to improve its methodology for selecting a sample of MA contracts for RADV audits. In May 2021, CMS revised the agency's contract selection methodology to better target RADV audits on MA contracts that are more likely to have high rates of improper payments. Under CMS's revised approach, the agency incorporates results from prior contract-level RADV audits to inform contract selection. Moving forward, the revised methodology should allow CMS to more effectively target and recover improper payments.

The Honorable Diana DeGette (D-CO)

1. **GAO's report in January 2013 highlighted the need for CMS to improve the accuracy of risk-adjustment payments.**

    a. **Has CMS implemented the needed reforms in the nearly 10 years since those recommendations were made?**

    b. **If not, which recommendations should CMS prioritize addressing first?**

In January 2012, GAO recommended that the Administrator of CMS take steps to improve the accuracy of the adjustment made for differences in diagnostic coding practices between MA and traditional Medicare; GAO considers this recommendation a high-priority for HHS.[3] GAO subsequently highlighted this recommendation in its January 2013 report.[4] However, as of February 2022, CMS had not fully implemented this recommendation. CMS applied the statutory minimum adjustment to MA payments for calendar year 2021. CMS has also made other changes to its methodology for calculating the diagnostic coding adjustments (i.e., excluding diagnosis codes that were differentially reported in MA and traditional Medicare), which likely have improved the accuracy of the adjustment. However, CMS has not modified its methodology to, for example, incorporate more recent data and account for all relevant years of coding differences, which would better ensure an accurate adjustment in future years. Ensuring the accuracy of the adjustment for differences in diagnostic coding between MA and traditional Medicare could save the Medicare program billions of dollars annually.

The Honorable H. Morgan Griffith (R-VA)

1. **Regarding the June 2021 GAO report detailing Medicare beneficiaries transitioning from Medicare Advantage (MA) to Fee-for-Service (FFS) Medicare in their final year of life, did GAO interview any family members or patient caretakers regarding the patients' end-of-life needs or particular circumstances which may have prompted**

[3]See GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, GAO-12-51 (Washington, D.C.: Jan. 12, 2012), and *Priority Open Recommendations: Department of Health and Human Services,* GAO-22-105646 (Washington, D.C.: May 26, 2022).

[4]GAO, *Medicare Advantage: Substantial Excess Payments Underscore Need for CMS to Improve Accuracy of Risk Score Adjustments*, GAO-13-206 (Washington, D.C.: Jan. 31, 2013).

their decision to transition from MA to Medicare FFS?

a. If so, what sort of feedback did you receive? If not, do you agree that doing so would benefit future studies and our understanding of the unique circumstances and preferences for patients and their families?

b. Did GAO find any specific problems with access to care for patients in MA plans?

GAO's June 2021 report on the disenrollment of MA beneficiaries to Medicare FFS in the last year of life addressed disenrollment rates, CMS's monitoring of such disenrollment, and the cost to Medicare from this disenrollment.[5] As a part of its June 2021 report, GAO interviewed various stakeholders, including several authors of relevant studies on disenrollment, three organizations representing providers and MA plans, and two Medicare beneficiary advocacy organizations, to understand and contextualize the causes of MA disenrollment. The study did not involve analyzing information on the reasons why beneficiaries disenrolled from MA to join Medicare FFS.

However, in a 2017 report, GAO emphasized the importance of information on the reasons for disenrollment from MA plans and recommended that CMS review data on disenrollment by health status and the reasons for disenrollment as part of its MA oversight efforts.[6] GAO noted that, when beneficiaries in an MAO contract who are in poor health are more likely to disenroll than those in better health—referred to as health-biased disenrollment—it may indicate that those beneficiaries could be facing problems with access to care or the quality of services provided.[7] Based on an analysis of CMS survey data, GAO found the reasons for disenrollment from MAO contracts with health-biased disenrollment differed from the reasons for other contracts with relatively high disenrollment rates. For example, in contracts with health-biased disenrollment, 41 percent of surveyed beneficiaries reported leaving their MAO contract because their preferred provider was not in their MAO contract's network, compared to 25 percent of surveyed beneficiaries in contracts without health-biased disenrollment. In addition, 27 percent of surveyed disenrollees from contracts with health-biased disenrollment reported difficulty getting needed care, compared to 16 percent of surveyed disenrollees without health-biased disenrollment.

2. Regarding the June 2021 report referenced in question #1, can you elaborate on the relative costs between Medicare FFS and MA to the taxpayer? While some have claimed that MA coverage is more expensive for the government wouldn't disenrollment from MA into Medicare FFS yield savings to the government?

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[5]See GAO, *Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending*, GAO-21-482 (Washington, D.C.: June 28, 2021).

[6]See GAO, *Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight*, GAO-17-393 (Washington, D.C.: Apr. 28, 2017).

[7]An MAO, such as Aetna, may have one or several contracts with CMS with each contract offering different plan benefit packages, such as a standard plan or an enhanced plan. Each MAO contract is specific to a plan type—such as a health maintenance organization (HMO) or a preferred provider organization (PPO). Therefore, disenrolling from an MAO contract suggests that the beneficiary is choosing a different MAO, a different plan type, or a combination of both.

Compared to Medicare FFS, MA plans may lower cost sharing and offer more generous benefits to beneficiaries. For example, MA plans are required to cap beneficiary out-of-pocket spending, while no such cap exists in Medicare FFS. In addition, MA plans may offer lower cost sharing and additional covered services, such as vision or dental care. The Medicare Payment Advisory Commission (MedPAC) reported in March 2022 that the average MA plan enrollee has access to nearly $2,000 in extra benefits annually that Medicare FFS enrollees cannot access without purchasing additional health insurance coverage.[8] However, although MA plans may lower costs and provide additional benefits for beneficiaries, MedPAC estimated that the Medicare program spent, on average, 4 percent more in 2022 for MA beneficiaries than the program would have spent if these beneficiaries were enrolled in Medicare FFS.[9]

Whether disenrollment of MA beneficiaries to join Medicare FFS would yield savings to the government depends on the FFS costs they incur after disenrollment. For example, GAO found in its June 2021 report that costs to the Medicare program increased by $422 million and $490 million in 2016 and 2017, respectively, when MA beneficiaries in their last year of life disenrolled from MA to join Medicare FFS. However, while MA beneficiaries in the last year of life who disenrolled to join Medicare FFS increased costs to Medicare, there was a relatively minimal difference in the MA payments and FFS payments GAO estimated for all other disenrollees. GAO therefore concluded the additional costs to Medicare stemming from MA to FFS disenrollments may be almost exclusively attributable to the high cost of care for beneficiaries in the last year of life.

a. The report says that those who "disenrolled from MA to join FFS in 2016 and 2017 increased Medicare costs by nearly half of a billion dollars in each year. FFS payments in 2016 for these beneficiaries were $671 million—$422 million higher than our estimated MA payments of $249 million had they remained in MA. In 2017, FFS payments for these beneficiaries were $755 million—$490 million higher than our estimated MA payments of $265 million." Would ubiquitous MA coverage in the final year of life yield savings to the government relative to FFS?

In its June 2021 report, GAO estimated the differences in spending specific to those beneficiaries in their last year of life who disenrolled to join FFS in 2016 and 2017. The difference between what Medicare would have paid for those beneficiaries if they had remained in MA and what was spent on their care in FFS was $490 million in 2017. GAO did not estimate how government

[8]According to MedPAC, these extra benefits are financed by payments to plans through rebates. Medicare payments for MA extra benefits have increased by 53 percent since 2019. In this way, payments to MA plans have increasingly been used to provide an indirect subsidy to offer expanded benefits for MA enrollees. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans (Washington, D.C.: March 2022).

[9]See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy,* Chapter 12: The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans (Washington, D.C.: March 2022).

spending may have changed if all Medicare beneficiaries were enrolled in MA in their final year of life.

b. Is it accurate that greater than 95 percent of MA beneficiaries remain in MA, regardless of their health status, in their final year of life?

It is accurate that in its June 2021 report, GAO found that, for 2016 and 2017, greater than 95 percent of MA beneficiaries remained in MA in their final year of life.

i. If that is the case, is it fair to attribute savings to the government on account of MA plan retention knowing that a sizable portion of patients who incur significant end-of-life costs remain on their MA plans?

GAO did not estimate end-of-life costs for beneficiaries who remained enrolled in an MA plan. It is unclear how end-of-life costs for MA beneficiaries who remained enrolled in an MA plan compared to those who disenrolled to join FFS.

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

Please see responses below.

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?

It is accurate that CMS estimated the gross improper payment rate for MA in fiscal year 2021 to be about 10 percent, which represented about $23.2 billion. The gross improper payment error rate reflects the sum of overpayments and underpayments. CMS estimated the net overpayment error rate for MA in fiscal year 2021 to be about 3 percent, which represented about $7.2 billion.

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

CMS estimated that the fiscal year 2021 gross improper payment error rate for traditional Medicare was about 6.3 percent and represented about $25 billion. CMS did not report net overpayments for traditional Medicare for fiscal year 2021.

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

Improper payments in MA can arise in different circumstances, including from the risk adjustment process. Risk adjustment for MA payments relies on

demographic data, clinical diagnoses, and other factors to adjust prospective payments to plans. Overpayments can occur when diagnoses submitted by MA plans for risk adjustment purposes are not supported by medical documentation. Underpayments can also occur, such as when diagnoses are identified during medical record review that were never submitted for risk adjustment. GAO has not studied MA policies or behaviors that lead to improper payments.

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Attachment 2 — Additional Questions for the Record from Hearing
Subcommittee on Oversight and Investigations
Hearing on
"Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans"
June 28, 2022

Ms. Leslie V. Gordon, Acting Director, Health Care, Government Accountability Office

The Honorable Diana DeGette (D-CO)

CHAIR DEGETTE: I have one last question that can be answered yes/no and you can supplement your answers later. Do you think that Congress needs to take additional steps to course correct on Medicare Advantage?

Congressional oversight is essential to ensure that the Centers for Medicare & Medicaid Services (CMS) takes the necessary actions to implement GAO's recommendations. In particular, ensuring that CMS fully implements GAO's recommendations in the following three areas would improve the Medicare Advantage (MA) program: (1) validating encounter data, (2) improving the timeliness of audits to identify and recover improper payments to MA organizations; and (3) taking steps to ensuring the accuracy of the adjustment made for differences in diagnostic coding.

- **Validating encounter data.** In July 2014, GAO recommended that the Administrator of CMS complete all steps necessary to validate MA data, including performing statistical analyses, reviewing medical records, and providing MA organizations with summary reports on CMS's findings, before using the data to risk adjust payments or for other intended purposes.[10] As of June 2022, CMS had made some progress in examining the completeness and accuracy of MA encounter data. However, CMS still needs to complete all necessary steps to validate MA encounter data, including verifying the data by reviewing medical records. Without fully validating the completeness and accuracy of MA encounter data, CMS cannot confidently use these data for risk adjustment or other program management or policy purposes.

- **Improving timeliness of MA audits to recover improper payments.** In April 2016, GAO recommended that the Administrator of CMS enhance the timeliness of audits to identify and recover improper payments to MA organizations—called contract-level risk adjustment data validation (RADV) audits—by taking various actions.[11] As of June 2022, CMS officials stated that CMS had taken some steps to improve the timeliness of the contract-level RADV audit process, such as reducing the time gap between notifying MA organizations of contract audit selection and notifying them about the beneficiaries and diagnoses that would be audited. However, CMS has yet to provide evidence that it has completed all steps to improve the timeliness of the contract-level RADV audit process, and these audits continue to be delayed significantly. Implementing this recommendation

[10]See GAO, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, GAO-14-571 (Washington, D.C.: July 31, 2014).

[11]See GAO, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, GAO-16-76 (Washington, D.C.: Apr. 8, 2016).

to improve audit timeliness would potentially allow CMS to recover hundreds of millions of dollars in improper payments each year.

- **Ensuring accuracy of adjustment for differences in diagnostic coding.** In January 2012, GAO recommended that the Administrator of CMS take steps to improve the accuracy of the adjustment made for differences in diagnostic coding practices between MA and traditional Medicare.[12] However, as of February 2022, CMS had not fully implemented this recommendation. CMS had applied the statutory minimum adjustment to MA payments for calendar year 2021. CMS has also made other changes to its methodology for calculating the diagnostic coding adjustments (i.e., excluding diagnosis codes that were differentially reported in traditional Medicare and MA), which likely have improved the accuracy of the adjustment. However, CMS has not modified its methodology to, for example, incorporate more recent data and account for all relevant years of coding differences, which would better ensure an accurate adjustment in future years. Ensuring the accuracy of the adjustment for differences in diagnostic coding between MA and traditional Medicare could save the Medicare program billions of dollars annually.

The Honorable Cathy McMorris Rodgers (R-WA)

RANKING MEMBER MCMORRIS ROGERS: The Better Medicare Alliance issued a data brief in April noting that MA outperforms FFS on cost projections for low-income and diverse populations. Can you talk about why MA provides better cost protections than FFS and how do utilization management tools and other features unique to MA factor into reducing costs for seniors?

MA provides certain cost protections for beneficiaries that traditional Medicare does not. In particular, MA plans are required to cap beneficiary annual out-of-pocket spending. Conversely, traditional Medicare does not have such an annual cap, leaving beneficiaries exposed to additional out-of-pocket costs. In part because of this financial exposure, many traditional Medicare beneficiaries obtain supplemental coverage, including private Medigap plans that require additional premiums that can cost beneficiaries thousands of dollars annually.

Additionally, MA plans may implement coverage and beneficiary cost-sharing structures that limit beneficiary out-of-pocket spending. For example, certain MA plans offer supplemental benefits that reduce beneficiary out-of-pocket costs for vision, dental, and other services not covered under traditional Medicare. Further, certain MA plans may also reduce beneficiaries' Part B premium amounts. For example, according to the Kaiser Family Foundation, the majority of MA beneficiaries in 2021 paid $0 in supplemental Part B premiums.[13]

We have also noted that certain aspects of traditional Medicare's reimbursement and cost-sharing structure may contribute to overuse of services, which could unnecessarily increase beneficiary out-of-pocket spending. Practices used by private insurers and MA plans, such as

[12]See GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, GAO-12-51 (Washington, D.C.: Jan. 12, 2012).

[13]Meredith Freed et al., "Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits," accessed July 19, 2022, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/.

prior authorization, help to manage service utilization. Prior authorization also may be used to reduce expenditures, unnecessary utilization, and improper payments. For example, in 2018, we reported that demonstrations of prior authorization for certain services in traditional Medicare likely reduced program improper payments and unnecessary utilization.[14]

The Honorable Gus M. Bilirakis (R-FL)

REP. BILIRAKIS: Earlier you stated that the improper payment rates for MA are around 10 percent, is that correct? Does this 10 percent account for underpayments? Can you clarify what is the net rate of improper payments for FFS and what is the net rate for MA?

The 10 percent improper payment rate accounts for both underpayments and overpayments.

CMS estimated that the fiscal year 2021 gross improper payment error rate for MA, which reflects the sum of overpayments and underpayments, was about 10 percent and represented about $23.2 billion. Net overpayments to MA organizations were about 3 percent and represented about $7.2 billion.

CMS estimated that the fiscal year 2021 gross improper payment error rate for traditional Medicare was about 6.3 percent and represented about $25 billion. CMS did not report net overpayments for traditional Medicare for fiscal year 2021.

[14]See GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, GAO-18-341 (Washington, D.C.: Apr. 20, 2018).