FRANK PALLONE, JR., NEW JERSEY
CHAIRMAN

CATHY McMORRIS RODGERS, WASHINGTON
RANKING MEMBER

ONE HUNDRED SEVENTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

August 15, 2022

Dr. James E. Mathews
Executive Director
Medicare Payment Advisory Commission
425 I Street NW
Suite 701
Washington, DC 20001

Dear Dr. Mathews:

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

Dr. James E. Mathews, Executive Director, Medicare Payment Advisory Commission

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

1. Does Medicare Advantage's Quality Bonus Program adequately incentivize plans to craft high-quality plans, particularly plans in rural areas where there are fewer specialists and limited providers?

It does not. The Commission has concluded that the Quality Bonus Program (QBP) and star rating system do not meaningfully allow beneficiaries (or policymakers) to compare Medicare Advantage (MA) plans to each other, compare the quality of care among plans with fee-for-service (FFS) Medicare, or measure the change in quality of MA plans over time. With regard to rural areas specifically, the QBP currently uses measures reported at the MA contract level, even for contracts encompassing broad and disparate geographic areas, making plan ratings a meaningless indicator of the quality of care provided under the auspices of an MA plan in a beneficiary's local area. Further, the QBP is funded by the Medicare program and its beneficiaries and taxpayers at a cost of roughly $12 billion in 2022.

2. What improvements could be made to the Quality Bonus Plan to allow beneficiaries, particularly those in areas with limited providers, to make better informed decisions when selecting a Medicare Advantage plan?

The Commission has concluded that the current QBP is too flawed to be improved incrementally. The Commission recommended in June of 2020 that the QBP be replaced in its entirety with a new value incentive program that would:

- score a small set of quality measures tied to clinical outcomes as well as patient/enrollee experience measures.
- evaluate quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA plans with incentives to improve the quality of care provided in every geographic area.
- account for differences in enrollees' social risk factors so plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments.

- distribute plan-financed rewards and penalties at a local market level, which would finance the MA quality system in a budget-neutral manner that would not involve additional Medicare program dollars.

3. What adjustments can be made to the Risk Adjustment program to improve accuracy of payments to Medicare Advantage plans?

Medicare can change the MA risk adjustment model in several ways that would improve the accuracy of payments to MA plans:

1) use two years of FFS diagnostic data to calibrate the risk-adjustment model (this would make the FFS diagnostic data more complete and reduce the marginal benefit for MA plans of coding additional diagnoses);[1]
2) exclude diagnoses that are documented only on a health risk assessment;[2],[3] and
3) limit the use of outlier FFS data in calibrating the MA risk adjustment model.[4]

4. What improvements can be made to ensure the accuracy of encounter data including additional data points that should be collected?

The Commission recommended in June of 2019 that the Secretary establish thresholds for the completeness and accuracy of MA encounter data.[5] We recommended that the Secretary rigorously evaluate MA organizations' submitted data and provide feedback to plans, concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds, and institute a mechanism for direct submission of provider claims to Medicare administrative contractors. The Commission specified that the direct submission of provider claims could begin as a voluntary option for all MA organizations that prefer this method, and as a requirement starting in 2024 for MA organizations that fail to meet thresholds or for all MA organizations if program-wide thresholds are not achieved.

The Honorable Diana DeGette (D-CO)

1. In your testimony, you stated that "higher payments for beneficiaries in private plans, combined with growing enrollment in MA, are major factors driving growth in Medicare spending and putting financial pressure on the Medicare program."

[1] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[2] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[3] The Commission has also discussed excluding chart reviews from risk adjustment. Excluding the use of chart reviews would further reduce differences in documentation and coding between beneficiaries enrolled in traditional FFS and those enrolled in MA.
[4] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.
[5] Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

a. What are the most important actions or reforms needed to ensure that the Medicare Advantage program alleviates financial pressure on the Medicare program rather than generates financial pressure?

The most important reforms to address the financial pressure stemming from the current structure of the MA program include addressing the differential in coding practices between beneficiaries in MA and FFS, replacing the current QBP with a revised value incentive program, and changing Medicare's benchmark-based payments to MA plans.

Medicare payments to MA plans are adjusted by each enrollee's risk score, which reflects the accumulation of the enrollees' qualifying diagnoses over time. In general, more qualifying diagnoses yield greater Medicare payments to the MA plan. Unlike in FFS, MA plans have a financial incentive to ensure that all possible diagnoses are submitted to CMS, including those that are not being actively treated by a health care provider. Two practices in particular drive higher coding intensity among MA plans: collecting diagnoses from health risk assessments (which rely on unverified enrollee-reported data) and using medical chart reviews (a practice that does not exist in FFS Medicare). To address these concerns, the Commission recommended that the Congress direct the Secretary to develop a risk-adjustment model that uses two years of diagnostic data (making the FFS diagnostic data more complete and reducing the marginal benefit for MA plans of coding additional diagnoses) and excludes any diagnoses that are documented only on a health risk assessment. After making these changes to the data that inform the risk adjustment model, MedPAC recommended applying a coding adjustment to MA plan payments to eliminate any remaining effect of differential coding between FFS Medicare and MA plans.[6] The Commission has also discussed excluding chart reviews from risk adjustment. Excluding the use of chart reviews would further reduce differences in documentation and coding between beneficiaries enrolled in traditional FFS and those enrolled in MA.[7]

MedPAC identified several flaws in both the QBP and the star rating system: too many measures (most of them being process measures) are used; the ratings cover large geographic areas, making them an unreliable indicator of quality at the local area; social risk of the applicable population is not adequately accounted for; and the program is not budget neutral (i.e., the program is financed with dollars above the cost of providing the Medicare benefit—$12 billion in 2022). Consistent with MedPAC's recommendation, to address these concerns, the Congress should replace the QBP with a new Medicare Advantage value incentive program that would:

- score a small set of quality measures tied to clinical outcomes as well as patient/enrollee experience measures.
- evaluate quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA plans with incentives to improve the quality of care provided in every geographic area.
- account for differences in enrollees' social risk factors so plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments.

[6] Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.
[7] Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy.* Washington, DC: MedPAC.

- distribute plan-financed rewards and penalties at a local market level, which would finance the MA quality system in a budget-neutral manner that would not involve additional Medicare program dollars.

In addition, our June 2021 recommendation that changes payments to MA plans would generate additional savings to the program by explicitly integrating plan efficiency into the benchmark calculation.[8]

b. Does CMS currently have the tools necessary to properly address inflation of payments to MA programs due to diagnostic coding?

The Commission asserts that the Secretary does indeed currently have tools to increase the accuracy of payments to MA plans, which would generate savings for the Medicare program and still maintain supplemental benefits for MA enrollees.

The Deficit Reduction Act (DRA) of 2005 gives the HHS secretary the authority to reduce Medicare payments to MA plans by a *minimum* of 5.9 percent to reflect differential coding between MA and traditional FFS Medicare. To date, the Secretary has reduced MA risk scores *only* by the minimum amount required by law, and the agency will make the same minimum adjustment for 2023. We assert that the evidence documented by MedPAC and others over many years indicates that stronger action to address coding intensity is needed. The current approach of making only the statutory minimum adjustment to MA plan payments is not consistent with current law, since the DRA states that in applying risk adjustment to payments for MA plans "the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences." In our assessment, the Secretary has ample evidence that a larger adjustment is needed, and the Secretary has the statutory authority to make such an adjustment.

In addition, CMS has twice proposed removing diagnoses gathered from health risk assessments from risk adjustment (suggesting the authority to take such action is recognized) but has not implemented such a proposal.

Lastly, the 21st Century Cures Act (the Cures Act) codifies the Secretary's authority to use two years of diagnostic data in MA risk adjustment, stating that, for 2019 and subsequent years, "the Secretary may use at least two years of diagnosis data." However, to date CMS has not issued rulemaking that would implement this Cures Act provision.

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

1. Under certain circumstances, some form of review might be necessary to ensure that providers are not billing for unnecessary expenses. However, oversight of provider billing should not come at the expense of needed care for seniors. How might CMS

[8] Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

balance the need to guard against unnecessary services while ensuring that prior authorization is not preventing medically necessary care?

The Commission has long been concerned with the issue of unnecessary Medicare spending and supported CMS in a 2014 proposal to make prior authorization part of the Medicare program and extend it to additional durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Prior authorization is a technique commonly used by other payers (including by plans participating in the MA program), and the Commission recommended its use for high-cost imaging in the Medicare program. In June 2011, the Commission recommended that: "The Congress should direct the Secretary to establish a prior authorization program for practitioners who order substantially more advanced diagnostic imaging services than their peers." That recommendation limited the program to certain practitioners who order a service that had shown rapid growth and evidence of inappropriate use. Limiting the program to certain practitioners balances the desire to guard against the provision of unnecessary services, while ensuring that prior authorization is not preventing medically necessary care.

The Honorable H. Morgan Griffith (R-VA)

1. Can you elaborate on the benefits for seniors in both MA and traditional FFS? How do they differ?

Traditional FFS Medicare offers beneficiaries an unconstrained choice of health care providers, but it often lacks incentives to coordinate care and provides no limit on beneficiary out-of-pocket costs. In contrast, MA plans offer beneficiaries lower out-of-pocket costs and can give beneficiaries more predictable cost sharing while offering supplemental benefits. However, the choice of providers in MA plan networks is more limited than in FFS Medicare.

   a. Since MA plans typically cover Part A, Part B, supplemental benefits, supplemental coverage, and frequently Part D too, how do we fairly and accurately compare this benefits package to the cost of FFS Medicare?

Comparing spending levels based on the provision of Part A and Part B benefits, which is the basis for the MA plan bids, we have found that over the course of the history of Medicare managed care, the Medicare program has paid more than it would have paid for beneficiaries to have remained in FFS Medicare for the basic Part A and Part B benefits.

Beneficiaries enrolled in MA have a statutory out-of-pocket spending limit that is not available to beneficiaries enrolled FFS without additional coverage provided through a supplemental plan, such as Medigap. Given the difference in the benefits offered by MA and FFS, the costs associated with a Medigap plan should be considered when comparing cost across the two programs; however, the lack of beneficiary-specific Medigap data prohibits any such comparison.

MA plans offer a high level of extra benefits not available to beneficiaries in FFS, so a cost comparison between programs cannot be made. Even within MA, the coverage of extra benefits varies by MA plan both based on the scope of the benefits and the use of such benefit by

beneficiaries. However, CMS does not collect encounter data from MA plans regarding extra benefits, and without such data, policymakers are unable to assess the value of such benefits to include in any comparison across programs.

b. What tools does FFS Medicare have to prevent fraud, waste, and abuse compared to prior authorization in Medicare Advantage?

CMS utilizes several tools in the FFS program to help prevent fraud, waste, and abuse, including medical reviews and education, recovery auditing, and prior authorization and pre-claim review for a limited number of services. CMS's Targeted Probe and Educate program is intended to focus on providers and suppliers who have high claim error rates or unusual billing practices, and items and services that have high national error rates. These reviews do not target providers whose claims are compliant with Medicare policy. Recovery Audit Contractors review claims on a post-payment basis and detect and correct improper payments on a range of approved topics. Pre-claim review initiatives and prior authorization are conducted through several initiatives, including for certain services provided in the hospital outpatient department; certain repetitive, scheduled non-emergent ambulance transports; and certain durable medical equipment, prosthetics, orthotics, and supplies items.

c. Has MedPAC ever analyzed whether FFS Medicare or MA is more effective and efficient at preventing fraud, waste and abuse? If so, please elaborate on the findings.

Because of our advisory (as opposed to oversight) role, we have not analyzed the relative effectiveness of MA and FFS with respect to preventing waste, fraud, and abuse. We defer to (but support) our counterparts in oversight agencies (Centers for Medicare & Medicaid Services, Department of Health and Human Services' Office of Inspector General, and the Department of Justice).

2. Most Medicare beneficiaries who choose FFS Medicare also purchase supplemental coverage (Medigap plans) in addition to Part D coverage. And we've seen recent data and surveys which indicate that in the aggregate MA beneficiaries pay significantly less out-of-pocket than in FFS when considering supplemental coverage plans. What type of analyses has MedPAC done or planning to do that would allow Congress to better understand these differences to both the beneficiary and taxpayer when comparing FFS and MA?

Generally, beneficiaries in MA plans will have lower out-of-pocket costs than they would in FFS because most plans receive rebates that they use to provide extra benefits (such as lower cost sharing for Part A and Part B services and lower premiums for Part D coverage) and because all MA plans are required to have an annual cap on out-of-pocket spending for in-network care. In 2022, rebates for MA plans (excluding employer plans and special needs plans) average $164 per enrollee per month (nearly $2,000 annually per enrollee) and are the highest in the program's history (accounting for 15 percent of plan payment). The average total rebates are 17 percent higher than in 2021, and MA rebates have increased by 53 percent since 2019. MA plans projected that 43 percent of rebate dollars go toward reduction in cost sharing for Medicare

services (an amount that includes MA plans' allocation of administrative costs and profit), while another 17 percent went toward lowering the Part D and Part B premiums in 2022. The majority of MA enrollees in traditional MA plans—an estimated 69 percent in 2022—pay no Part C or Part D premium (beyond the Medicare Part B premium). However, given the continued incompleteness of MA encounter data, we are unable to quantify the full scope of out-of-pocket spending in MA (premiums plus cost sharing).

Similarly, we are unable to precisely quantify the out-of-pocket costs for beneficiaries enrolled in Medigap because Medicare does not collect data linking distinct beneficiaries to certain Medigap plans. Other analyses use the Medicare Current Beneficiary Survey responses or state-level data on premiums for each Medigap plan type. These analyses are unable to calculate the actual Medigap premium paid or the expected out-of-pocket costs for beneficiaries within any particular geographic location. MedPAC's standardized spending comparisons control for differences in beneficiary location, demographics, and health status. Without the capability of linking a distinct beneficiary to a Medigap plan, we are unable to calculate a given FFS beneficiary's actual cost sharing liability.

3. In chapter 12 on page 431 in MedPAC's March 2022 Report to Congress, the report states that aggregate Medicare payments to Medicare Advantage plans have never been lower than FFS Medicare spending. The report indicates in 2022 that "MA bids average 85 percent of FFS spending, but payment benchmarks average 108 percent of FFS—resulting in MA payments that are 100 percent of FFS and an estimated 104 percent of FFS spending after accounting for differences in coding practices between MA and FFS," with a footnote that applies the same coding intensity impact in 2022 as done in 2020 while acknowledging that the report's estimate of MA payments relative to FFS spending does not account for other factors such as how payments would have changed if calculating FFS spending using only beneficiaries with both Part A and Part B and other factors.

    a. Can you please explain in a step-by-step fashion how your "risk standardization" analysis works, including whether and how the respective steps are based off of CMS data and methodology. In doing so, please identify how you account for—irrespective of the aforementioned "risk standardization"—the non-existent Part A or Part B claims from those who only have one or the other of Part A and Part B respectively.

Consistent with the FFS spending estimates used as the basis for MA benchmarks, bids, and payments:

- We use the per beneficiary county-level FFS spending *calculated by CMS*, which includes beneficiaries who do not have both Part A and Part B coverage.
    - CMS separately calculates Part A spending using Part A eligibility and Part B spending using Part B eligibility.
    - CMS risk-standardizes these estimates so that spending reflects a beneficiary with average risk.
- Using beneficiary risk scores and county residence, we account for health status and geographic differences between the FFS and MA populations.

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

1. Do you think it would be effective to implement prior authorization exemptions based off a provider's performance?

We have not taken a position on the policy of allowing exemptions from prior authorization based on a provider's performance ("gold-carding"). Given the Commission's standing policy of not publicly commenting on pending legislation, we are unable to provide any additional response at this time.