Documents for the Record

Energy and Commerce Committee

Subcommittee on Oversight and Investigations

"Examining How Improper Payments Cost Taxpayers Billions and Weaken Medicare and Medicaid"

1. Castor – Letter to DeSantis from Becerra
2. Castor – Orlando Sun Sentinel Editorial
3. Castor – Tampa Bay Times Article
4. Staff – Value of MA - Response to MedPAC
5. Staff – Council for Quality Respiratory Care Statement

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

December 18, 2023

Dear Governor DeSantis:

Maintaining access to uninterrupted health coverage, particularly for children, is critical to the health and well-being of Americans and provides hardworking families the financial security they need to have peace of mind. Medicaid and the Children's Health Insurance Program (CHIP) are two of our nation's standout programs that ensure access to essential healthcare for millions of families, including almost 40 million children – half of all children in this country.

I write to you today because your state is among the nine states with the largest number or highest percentage of children who have lost Medicaid or CHIP coverage since full eligibility renewals for these programs restarted this spring.

Because all children deserve to have access to comprehensive health coverage, I urge you to ensure that no child in your state who still meets eligibility criteria for Medicaid or CHIP loses their health coverage due to "red tape" or other avoidable reasons as all states "unwind" from the Medicaid continuous enrollment provision that was in place during much of the COVID-19 public health emergency. This is especially important for communities of color and underserved communities across the country – we know more than half of all children in Medicaid and CHIP are Hispanic, Black, Asian/Pacific Islander, or American Indian and Alaska Native.[1]

As discussed further below, there are several strategies that I strongly encourage your state to adopt to help eligible children maintain access to the health coverage they need to thrive. My Department stands ready to do all that we can to help your state advance this goal, including by providing Florida with the flexibility to pause procedural disenrollments for children while it adopts other strategies to ensure eligible children remain enrolled.

Children are more likely than their parents to qualify for Medicaid due to higher income eligibility thresholds for children in Medicaid and CHIP. This means that as children go through the renewals process, many children should still be Medicaid or CHIP eligible and should not be getting disenrolled. Many states have already taken steps to ensure eligible children stay enrolled. I am deeply alarmed that, as of September 2023, your data shows that children's Medicaid and CHIP enrollment in your state has declined by 366,633 children or 12 percent compared to March 2023.[2] These coverage losses account for nearly 17% percent of all children who have lost Medicaid or CHIP coverage nationwide during the renewals process so far.

HHS takes its oversight and monitoring role during the renewals process extremely seriously and will not hesitate to take action to ensure states' compliance with federal Medicaid requirements. States can also take critical proactive actions to prevent eligible children from losing Medicaid and CHIP. These actions include:

[1] https://www.medicaid.gov/sites/default/files/2023-08/2020-race-etncity-data-brf.pdf
[2] https://www.medicaid.gov/resources-for-states/downloads/medicaid-unwinding-child-data-snapshot.pdf

- Remove barriers to enrolling in CHIP. While many children who are no longer eligible for Medicaid should be eligible for CHIP, many families are finding it hard to enroll. There are critical steps that Florida can take to dramatically reduce barriers for families to enroll their children in coverage, including eliminating CHIP premiums, and removing the state's 30-day CHIP premium lockout policy.

- Adopt CMS's strategies to make renewals easier for children and families. CMS has put forward dozens of strategies and approved close to 400 "(e)(14)" flexibilities in states to make renewals easier for people.[3] And, today, CMS issued additional important guidance to help states adopt these strategies, including announcing for the first time that (e)(14) flexibilities will be available through 2024, giving states even more opportunity to take these strategies up.[4] We know that states that choose to take up these flexibilities are shown to disenroll fewer children for procedural reasons. To-date, Texas has chosen to adopt 4 such strategies. I strongly encourage you to choose to help keep children enrolled and adopt additional strategies to protect children's coverage, such as renewing individuals with no income on an autorenewal (*ex parte*) basis or delaying procedural terminations to conduct additional outreach. In addition, I urge you to give children who have not yet gone through a renewal up to an additional 12 months to go through the renewals process.

- Improve auto-renewal rates. States have flexibility in how they design their auto-renewal (*ex parte*) systems and can make choices that allow families to renew coverage without needing to provide unnecessary paperwork, which reduces red tape and makes it more likely that people who meet the eligibility criteria stay enrolled. Many states have adopted (e)(14) strategies to achieve higher levels of auto-renewals. For example, states can renew a person's Medicaid eligibility using existing Temporary Assistance for Needy Families (TANF) data. We urge your state to do so as well. HHS stands ready to provide systems support, including with the help of the U.S. Digital Service, which has already been deployed to a number of states to provide impactful support on auto-renewal issues and increase the number of children who can be auto-renewed.

- Take steps to reach more families, including comprehensive, targeted, on-the-ground outreach efforts through schools and community organizations; hiring staff at call centers who speak non-English languages; increasing call center capacity to drive down call center wait times and abandonment rates; and providing data to health plans and pediatric practices to help them provide direct support to families renewing coverage.

- Expand Medicaid. Thousands of youth with Medicaid or CHIP coverage who turned 19 while the Medicaid continuous enrollment condition was in place are at risk of becoming uninsured. That's because they live in one of the 10 states that has yet to expand Medicaid under the Affordable Care Act and are at risk of falling into the coverage gap. As CMS' data indicate, these youth on average account for 27.6% of disenrollments among children in non-expansion states since March 2023. Prior to the pandemic, youth aged 19-25 in non-expansion states had the highest rates of uninsurance of any group in the country. Expanding Medicaid would help ensure that eligible youth maintain coverage, allowing them access to critical services including preventive and behavioral healthcare.

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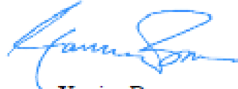
[3] https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html
[4] https://www.medicaid.gov/federal-policy-guidance/downloads/cib12182023.pdf

Access to health coverage is critical to the development of children. The evidence is overwhelming that children with access to healthcare achieve better short-term health and well-being as well as long-term health, educational, and economic gains. Every child eligible for coverage should have it. We also recognize that there may be other factors that can influence child disenrollment rates in your state. If that is the case, please contact HHS.

HHS stands ready to work with you and your team to take the additional, available steps to make sure children have the health coverage they need and deserve. I appreciate your attention.

Sincerely,



Xavier Becerra

Florida's Medicaid downsizing is a moral failure | Editorial

April 13, 2024 by Orlando Sun Sentinel Editorial Board

The headline demanded your attention for the timing, if nothing else: "Some of Florida's sickest kids are losing Medicaid coverage on Easter Sunday."

Advocates around the state worried that the message didn't reach the parents of some of those kids, or the medically fragile adults who also depend on Medicaid coverage.

Despite news stories, warnings from nonprofit groups and messages from state officials, many Florida residents whose coverage and that of their children was being dropped said they had no warning until the ax fell.

While the state claims that 93% of those families whose kids were being dropped had been contacted, that doesn't square with statistics posted during earlier phases of the state's downsizing of its COVID-swollen Medicaid ranks.

It also doesn't explain the large numbers of people who were previously shoved off the Medicaid rolls despite the state's failure to prove them ineligible.

And it casts shade on the state's decision to move as quickly as possible to shed people from the Medicaid system, along with its status as one of only two states that refused to take advantage of assistance offered by the U.S. Department of Health and Human Services.

The great unwinding

The disenrollments stem from a reset of a COVID-era policy that allowed current Medicaid recipients to keep their coverage — even if they no longer qualified — through the end of the pandemic emergency.

Last year, federal officials told states to start moving people into other programs if they were no longer eligible for Medicaid, with guidance to "unwind" participation in the Medicaid program gradually.

Florida moved as quickly as possible. According to data compiled by the Florida Health Justice Project, 3.7 million Floridians had their Medicaid eligibility reviewed by December 2023.

Of those, more than 2 million kept their eligibility, including nearly 900,000 whom the state deemed eligible without contacting the recipient.

That sounds like a lot, but other states did a much better job of keeping people in the Medicaid program using their existing records.

The far more disturbing breakdown is the high percentage of people who had already lost coverage at that point — and may never have known it.

Of the 1.2 million kicked off Medicaid rolls through 2023, about 72% were dropped for “procedural” reasons that said nothing about their current ineligibility.

Most often, it was due to a failure to respond.

That doesn’t speak well for the state’s claim that it is reaching people and letting them know about options before they are dropped.

And that’s why advocates like the Health Justice Project, the Florida Policy Institute, the Kaiser Family Foundation and the Center for Budget and Policy Priorities have been sounding the alarm about Florida’s “unwinding” process since early last year.

They had good reason to be nervous about the last group of state disenrollments, which included the sickest and most frail among Florida’s Medicaid enrollees.

These are people who — if they lose eligibility under Medicaid — should be most qualified to move to another state-backed entitlement program such as Medikids, which offers very low-cost insurance for children ages 1-4, or Children’s Medical Services (CMS) which takes care of special needs kids.

Nowhere to turn

But those programs aren’t seeing as much of a surge in demand as they expected — and our reporting backs up health-access advocates who say the state has little information for families who need to transition to another program.

That puts parents and sick adults in a terrible bind: Many might be eligible to stay on Medicaid. Others can appeal a decision to drop them from Medicaid or move to another program. But they don’t know what to do or how to do it.

Attempts to reach out to state officials often result in long hold times or erroneous responses, the Health Justice Project and other advocates say.

There’s an easy answer to this growing desperation: Florida should expand Medicaid eligibility to cover more hard-working and low-income residents.

The state is one of only 10 that haven’t taken advantage of Medicaid expansion, which reaches people who make too little to participate in “Obamacare” marketplaces but too much to remain on Medicaid.

We have a hard time understanding why Florida didn’t expand Medicaid a long time ago — or why it has failed to take advantage of federal offers of additional time and help for those being cast off Medicaid rolls during the “unwinding” process.

State officials keep insisting they're doing the best they can, but that assertion is proven false every time new statistics are released, or stories appear about parents of very sick children, or disabled adults who have lost the care that could be keeping them alive.

Florida can do better. It should do better. It's a moral failure that it has not.

The Sun Sentinel Editorial Board consists of Opinion Editor Steve Bousquet, Deputy Opinion Editor Dan Sweeney, editorial writer Martin Dyckman and Editor-in-Chief Julie Anderson. Editorials are the opinion of the Board and written by one of its members or a designee.

https://www.sun-sentinel.com/2024/04/13/editorial-florida-had-a-chance-to-do-medicaid-downsizing-right-instead-it-did-this/

Tampa Bay Times: Vulnerable Florida patients scramble after abrupt Medicaid termination

Several disabled and long-term-care patients lost coverage April 1 without notice or explanation, family members said.

By

Published April 12 by Teghan Simonton

Esther JeanBart leaned over her son's wheelchair, caressing his face and trying to make him giggle. Gianni JeanBart was under the weather, but still his eyes rolled toward her and his mouth widened, cracking a smile.

Esther JeanBart said she has missed the sound of Gianni's voice the most. In 2017, the U.S. Marine was in a motorcycle accident on his way to work, about a month shy of his 20th birthday.

Since then, Gianni has undergone more than a dozen surgeries. Now quadriplegic and prone to seizures due to a traumatic brain injury, he requires around-the-clock care from licensed health professionals. For the past seven years, he's lived with Esther in their home in Valrico with his medical care covered by Medicaid.

"He is still here," she said. "He fights every day."

But on April 1, Gianni's Medicaid coverage was abruptly terminated without notice from the Florida Department of Children and Families, the agency that determines eligibility.

Gianni is one of several patients — the full number is unknown — to lose access this month to Medicaid's Home and Community Based Services, which is geared toward patients who are disabled or have extensive long-term-care needs. The program allows beneficiaries to receive services in the home, rather than in an isolated institution or long-term care facility.

Since the beginning of April, Miriam Harmatz, advocacy director and founder of the Florida Health Justice Center, said the organization has received panicked calls from caregivers and patients. Most said they learned their coverage was terminated only after nurses and other providers began canceling services.

In a statement, a spokesperson from the Florida Department of Children and Families said the agency was not aware of any HCBS participant who inappropriately lost Medicaid coverage without receiving proper notification.

"The examples you have provided the Department from so called 'advocates' show that each individual was properly noticed and either did not respond timely or no longer met financial eligibility requirements," said Mallory McManus, the spokesperson. "As we have shared previously, those who were disenrolled because they did not respond to our requests would have

been contacted by us up to 13 times via phone, mail, email, and text before processing their disenrollment."

Harmatz said this is not the reality for a number of home care recipients who contacted her organization. She said her organization reviewed several patients' Medicaid access portals, and saw no notifications from the agency warning them of termination.

These patients are the latest Medicaid recipients to find their coverage threatened amid the state's redetermination process, which began in April 2023. Florida's Medicaid rolls swelled by 1.7 million people during the pandemic, when the federal government gave states additional funding to keep people covered even if they were no longer eligible. Once the funding ended, the Department of Children and Families began conducting its first eligibility checks in years.

The state agency is meant to send notice at least 10 days prior to when a patient loses Medicaid coverage. This notice should include the reason for coverage being terminated.

But most long-term home care patients would have no reason to lose eligibility, Harmatz said.

"Think about who they are, what they're dealing with," she said. "They're so disabled that they could go right into a nursing home or institution, and suddenly, their home health aid didn't show up. How do they get out of their wheelchair? How do they clean themselves? … The level of concern with any interruption is heightened."

Harmatz and her organization are pushing for all home care patients who were removed from the rolls to be immediately reinstated while the state assesses what happened. In an email she sent to general counsels at the Department of Children and Families and the Florida Agency for Health Care Administration, she said it was "the only logical and humane solution."

"We're at the panic point now," Harmatz said. "We should not have to unpack every single reason why a person lost coverage."

JeanBart began worrying about her son's medical coverage in mid-March, when providers already began canceling appointments. They told her their computer systems showed Gianni's coverage ending April 1.

She had been trying to order medical braces to help Gianni stretch the muscles in his arms and hands, but the braces take three to four weeks to create. In emails JeanBart shared with the Tampa Bay Times, employees of the brace company wrote they were concerned Medicaid would not pay. The retrofitted van service that Gianni uses to attend physical therapy and other outings also canceled.

This made little sense to JeanBart, who said her son was previously set for Medicaid renewal in July 2024. She called and emailed his health plan provider, Sunshine Health, as well as state agencies.

JeanBart said representatives at all three groups told her Gianni's coverage was safe. A Sunshine Health case manager told her the April 1 expiration date could be a "ghost term date," and that coverage would automatically renew once it passed.

"If Medicaid is going to give me something in writing, showing me he's qualified, why would I question that?" she said.

But she called Sunshine Health once more on April 1 — just to be sure. This time, the representative told her Gianni's coverage had been terminated.

JeanBart said she never received written notice or an explanation from the state.

Some of Gianni's regular nurses continued to work without pay, but not always for the 24 hours a day he required. The rest of the time, JeanBart was on her own, caring for him through the night.

As his mother, JeanBart said it's an honor to care for Gianni. But she has no medical training, and with three other children between the ages of 11 and 15, as well as her own home health care business to run, she knew she wasn't equipped.

"He's not able to go out; I don't have a car to accommodate him," she said. "He can't go out and see the sun, get his braces, get therapy to move his muscles. … I can't put him on a chair, so he's stuck on a bed. That's deterioration, that's detrimental to his health and his emotional well-being."

It felt like the health care system was erasing her son, JeanBart said.

"As long as I'm breathing, I'm going to fight," she said. "This is not OK."

After 10 days, she received a voicemail from an Agency for Health Care Administration employee, who told her Gianni's coverage would be reinstated by the following morning. But when she called to confirm around 11 a.m. Thursday, he still wasn't in the system.

Even if the issue gets fixed, she said, "It's not over. Tell me what happened, so I can be sure it won't happen again."

Harmatz said it's difficult to determine how many patients like Gianni have been affected or what caused so many ostensibly eligible recipients to lose their coverage. It's part of a larger pattern, she said, in Florida's bumpy redetermination process.

"To DCF's credit, the plan was to put the most vulnerable people last," she said. "But we don't have a dedicated phone line at the relevant agencies … as far as we know, there is no special team or unit set up (to assist). … Florida didn't do that."

https://www.tampabay.com/news/health/2024/04/12/vulnerable-florida-patients-scramble-after-abrupt-medicaid-termination/

Wakely
An HMA Company

January 18, 2024

Lynn Nonnemaker
Vice President
America's Health Insurance Plans
lnonnemaker@ahip.org

via email

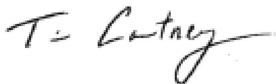
Re: Value of Medicare Advantage Compared with Fee for Service

Dear Lynn:

America's Health Insurance Plans (AHIP) has retained Wakely Consulting Group, an HMA company (Wakely) to provide a targeted analysis on Medicare fee-for-service (FFS) data to assist AHIP in comparing Medicare Advantage (MA) payments compared with FFS costs. Specifically, the analysis considered the impact of the maximum out of pocket provision required under MA that does not exist under FFS and the impact of estimating FFS costs based only on beneficiaries eligible for MA, which are those eligible for and enrolled in both Part A and Part B of Medicare.

This document contains the results, assumptions, and methods used in our analysis, and satisfies the ASOP 41 reporting requirements. Reliance on this report is at AHIP's discretion. Wakely understands that AHIP may post and issue the Report publicly, including but not limited to sharing the Report with its members and may, at AHIP's sole discretion, publish the Report on the ahip.org website. In addition, Wakely understands and anticipates that AHIP may quote portions of the Report in separate AHIP-authored documents. Wakely requests the opportunity to review these citations before publication and such approval shall be provided no later than two business days from Wakely's receipt of such citations.

Sincerely,



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Executive Summary

To assist AHIP in comparing MA payments with FFS spending, Wakely reviewed the following specific aspects of the FFS and MA programs:

- The impact that the mandatory maximum out-of-pocket (MOOP) provision required under MA has when comparing costs under traditional Medicare with those of MA.
- The impact of MA benchmarks based only on beneficiaries eligible for and enrolled in both Part A and Part B of Medicare (i.e., same eligibility criterion for MA enrollment) compared with the current approach where beneficiaries enrolled in Part A only or Part B only are also included in the development of benchmarks.

In summary, our findings for these analyses are as follows:

1. If the traditional FFS program were required to implement a maximum out-of-pocket (MOOP) provision equivalent to the mandatory amount required under Medicare Advantage, the net liability to CMS would increase by 2.8% nationally. The impact of a MOOP provision generally increases as the expenses of a given classification of beneficiaries change, although not in all cases. In particular, we estimate that FFS costs for beneficiaries with ESRD status would increase by 7.6% with a $7,550 MOOP in place.

   Medicare Advantage Organizations (MAOs) are required to cover the additional liability due to the MOOP provision, however, they are paid for it on a rebate percentage basis (i.e. plan's keep less than 100%). This reduced payment for a required benefit should be considered when comparing total MA payments to FFS spend.

2. Costs associated with non-ESRD FFS beneficiaries who are enrolled in both Parts A and B are about 5.9% higher than the total non-ESRD FFS population. This implies that MA benchmarks used to calculate payments to Medicare Advantage Organizations are understated relative to the expected cost of the actual population eligible for enrollment in MA.

   In a March 2021 report to Congress[1], the Medicare Payment Advisory Commission (MedPAC) addressed the impact of basing benchmarks on only those beneficiaries eligible for both Parts A and B instead of also including beneficiaries with either Part A only or Part B only. In that report, MedPAC concludes current benchmarks are understated by about 1%; however, this includes a risk score adjustment. Adjusting for risk scores is not appropriate for this comparison since the nationwide Medicare FFS

[1] https://www.medpac.gov/wp-content/uploads/2021/03/Mar21_MedPAC_Report_To_The_Congressz_v2_SEC.pdf

population is being used as the starting point, and as such the population by definition requires no adjustment or normalization. Furthermore, we are not aware of any risk adjustment model that uses only diagnoses from only Part A or only Part B services to predict both Part A and B expenses. The CMS HCC risk adjustment model is intended only to predict both Part A and B expenses based on diagnoses from all Medicare Part A and B covered services; therefore, it is not appropriate to assign a risk score using this model for beneficiaries with only diagnoses derived from Part A only or Part B only covered services. Without more information on the risk score methodology, we can only assume this comparison is using the current HCC methodology, which, for reasons stated above, would be in error.

Table 1 summarizes the results of the Wakely analyses. These adjustments should be considered when comparing MA payments to FFS costs.

Table 1 - FFS Cost Estimates Under Alternative Conditions

Condition	Change in 2021 Average FFS Cost
MOOP Applies to FFS	2.8%
Non-ESRD beneficiaries with A and B Enrollment	5.9%
All Combined	8.7%

Table 12-5 of the March 2021 MedPAC report to congress displays the ratio of payments made to MA plans relative to FFS spending. For 2021, they estimate this to be 101%, which includes risk adjustment and quality bonuses, but excludes any adjustment for coding intensity differences between MA and FFS that exceed the statutory minimum adjustment. The FFS spending in the denominator of the 101% includes all Part A and B spending. Comparing the payments made to MA plans to FFS spending should be adjusted to only include members that are enrolled in both Part A and Part B. MedPAC includes a footnote for table 12-5, which states their 2017 report estimates that FFS spending for enrollees with both Part A and B was 1 percent higher than spending for all FFS enrollees, therefore, the numbers in table 12-5 should be reduced by about 1 percentage point.

The first row in Table 2 displays the share of FFS spending in 2021 as reported in the March 2021 MedPAC report. By applying the Wakely estimate of the cost difference attributable to including Part A only and Part B only beneficiaries, found in Table 1, the restated ratios show average MA payments below average FFS costs in 2021.

Table 2 – Revised MedPAC MA as Share of FFS Spending Estimates

	MA as Share of FFS Spending in 2021		
	Benchmarks	Bids	Payments
MedPAC March 2021 Report	108.0%	87.0%	101.0%
Beneficiaries Eligible for A and B only	5.9%		5.9%
Revised Share of FFS Spending	**102.1%**	**87.0%**	**95.1%**

Please note, Table 2 only adjusts the starting MedPAC analysis for the Part A/B eligibility issue. We are not providing any validation of various other elements underlying the 108% estimate, which includes adjustments for the MA coding pattern, quality bonus impact, risk adjustment, coding intensity, and other factors.

Analysis and Results

Impact of a Maximum Out-of-Pocket Provision in FFS

Currently, the traditional FFS Medicare benefit does not include a provision to cap beneficiary out-of-pocket expenses. CMS regulations require that all Medicare Advantage Organizations (MAOs) offer a maximum out-of-pocket benefit provision for medical (i.e. Part C) services. Historically, CMS has defined a "mandatory" MOOP amount and a lower, "voluntary" amount. Plans that offered the voluntary MOOP were allowed increased flexibility with respect to cost sharing provisions for certain key services.

While MAOs must offer a MOOP benefit at the mandatory level or less, the increased costs created by this requirement are classified as a Mandatory Supplemental benefit in the bid pricing tool (BPT).

In order to better understand how traditional Medicare FFS costs compare with those under Medicare Advantage, we analyzed how traditional FFS costs would change if the mandatory MOOP provision was applied.

Specifically, we looked at 2021 FFS costs from the 100% claim files and re-priced claims by beneficiary based on an assumption that out-of-pocket expenses could be no greater than $7,550. The use of a $7,5500 MOOP is based on the mandatory MOOP amount in effect for MAOs in contract year 2021.

Based on our analysis, we found that 2021 FFS costs would be 2.8% higher if a MOOP of $7,550 was implemented under traditional FFS.

We further analyzed how costs would increase if a MOOP were in place according to different status markers such as dual, ESRD, institutionalized status and age group.

Table 3 summarizes the results of the different analyses.

Table 3 – Impact of $7,550 MOOP on 2021 FFS Costs by Population Type

Population Group	MOOP Impact
Total FFS	3.0%
Total Dual	4.1%
Total Non-Dual	2.8%
Total non-ESRD	2.8%
Total ESRD	7.6%
65-69	3.1%
70-74	3.1%
75-79	3.0%
80-84	2.9%
85+	2.6%
Institutionalized	6.4%
Non-Institutionalized	2.5%

Generally, the MOOP impact increases as the level of claims by beneficiary increases; although, this was not the case for age groupings, where we saw lower MOOP impact for beneficiaries in older age groups even though claims are higher than average. We believe this dynamic is caused by members in higher age groups having a larger proportion of spend in Part A (vs. Part B) than those in the lower age groups. Part B services average 20% coinsurance for all service categories, whereas the Part A deductible and other cost sharing provisions equate to about 9% to 10% coinsurance.

Notably, the impact of a MOOP benefit is much higher than average for ESRD and Institutionalized beneficiaries. For ESRD beneficiaries, many of whom require regular dialysis treatment at 20% coinsurance, a $7,550 MOOP would increase costs 7.6% for the Medicare program. This finding is particularly important when comparing the programs, because it is easy to ignore ESRD beneficiaries since MA bids are submitted on a non-ESRD basis. Plans are still required to make coverage available to ESRD members and liabilities associated with these members impact MA plans. Any comparison of the MA program and FFS should include consideration for ESRD beneficiaries.

It is also worth noting that there are payment differences for ESRD vs. non-ESRD beneficiaries. Because there is no bid for ESRD beneficiaries, there is no rebate paid for these members, nor is there any quality bonus adjustment for qualifying plans. Instead, MA organizations are paid the

full risk adjusted benchmark and are required to fund the MOOP along with any supplemental benefits offered by the plan.

Similar to the ESRD population, we found that the impact of a MOOP for institutionalized beneficiaries would also be well above the overall average. For these beneficiaries, whose medical needs are associated with high acute care costs, a $7,550 MOOP would result in 6.4% higher FFS costs.

It is important to note that our analysis did not consider potential beneficiary behavioral changes as a result of a MOOP. It is likely that utilization of services would increase for beneficiaries after a MOOP was reached, so our estimate impact of the MOOP in Table 1 should be viewed as a minimum amount.

Benchmark Development – Limiting to Beneficiaries Enrolled in Part A and Part B

Although MA beneficiaries are required to be enrolled in both Part A and Part B, the benchmarks (the primary source of MA revenue) are calculated using FFS costs from the total population, which includes beneficiaries enrolled in Part A only, Part B only or both Part A and Part B. In a March 2017 report titled "Report to the Congress: Medicare Payment Policy", MedPAC made a recommendation for CMS to calculate benchmarks using only the FFS spending of beneficiaries enrolled in both Part A and Part B. In the March 2021 report, they cite the 2017 analysis stating that the risk adjusted FFS spending for beneficiaries with both Part A and Part B was about 1% higher than the risk adjusted spending for all FFS enrollees.

While we agree with the recommendation to develop benchmarks using only the population eligible for MA, we believe the appropriate measure of the impact of changing the benchmark calculation is to only look at the cost difference. The risk score adjustment is not needed since it is a nationwide calculation, and risk scores calculated for beneficiaries with Part A only or Part B only coverage are not comparable to scores for those enrolled in both Part A and B.

For purposes of calculating the benchmark, FFS spending is developed by taking the sum of Part A per capita spending and Part B per capita spending. In the analysis used to support the 1% difference in the March 2017 recommendation, MedPAC takes the following steps:

1. Calculate Part A spending and risk scores for beneficiaries enrolled in Part A and Part B vs. beneficiaries enrolled only in Part A. For beneficiaries enrolled in both, FFS spend was 8% higher and risk scores were 6% higher than those enrolled in Part A only. The risk-adjusted Part A difference in spending between the two programs was 2% higher for those in both Part A and Part B.
2. Calculate Part B spending and risk scores for beneficiaries enrolled in Part A and Part B vs. beneficiaries enrolled only in Part B. MedPAC found no difference in spend or risk scores for the two groups.
3. Blend, the Part A and B FFS risk-adjusted spending for beneficiaries enrolled in both Part A and Part B. The result was that beneficiaries enrolled in both Part A and B experienced

risk-adjusted costs about 1% higher than the total FFS population. Note, we are unclear how MedPAC blended the two impacts to arrive at the 1%.

It is not necessary to adjust for a difference in risk scores because the CMS HCC risk model is developed using only beneficiaries enrolled in both Part A and Part B[2], and thus already reflects the higher average risk of those with both Part A and B. Therefore, it would be inappropriate to use risk scores produced by the model for beneficiaries who are only enrolled in Part A or only Part B since diagnoses will only be based on a subset of claims as compared with beneficiaries enrolled in both A and B. It is also inappropriate to apply a risk adjustment to estimated costs since only the cost difference would flow through to nationwide benchmark rates now based on only those enrolled in both A and B.

Wakely independently calculated the cost difference with the 2021 100% FFS data. We found that Part A spending was 14.2% higher for beneficiaries that were enrolled in Part A and B compared to all beneficiaries. This compares to the 8% in MedPAC's study. We believe one cause of the cost differential increasing is that MA penetration has been increasing over time, leaving fewer beneficiaries in FFS. Since beneficiaries must be eligible for both Part A and B, those with Part A only enrollment comprise a greater percentage of the total remaining in FFS. For example, as of 2021, the Part-A only population is about 15% of the total FFS population, as compared with 14.2% in 2019.

For Part B spend, we also found there was no material difference between the two populations.

Combining the impact based on combined Part A and B costs, the total non-ESRD FFS spend is 5.9% higher for those enrolled in Part A and Part B vs those enrolled in Part A and/or Part B.

Table 4 displays the FFS cost PMPMs for Part A, Part B and combined non-ESRD beneficiaries.

Table 4 – Impact of including Part A and B only Beneficiaries on Benchmark Calculation

Beneficiary Type	Part A	Part B	Total
A and B	$411.43	$496.72	$908.15
A Only	$71.99		$71.99
B Only		$536.76	$536.76
All Beneficiaries	$360.16	$497.11	$857.27
A and B/All	14.24%	-0.08%	5.94%

[2] https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf, page 9.

Data and Methodology

The analyses in this report are based on 2021 FFS costs and membership from the 100% claims and enrollment files. We used logic consistent with CMS's definition of dual, institutional and ESRD members. Age was calculated as of January 2021. Our analysis excludes Hospice members.

Members may switch dual, institutional, or ESRD status throughout the year. For purposes of classifying beneficiaries into appropriate categories, we took the most recent status and assumed it applied for the entire year.

The impact of the MOOP was calculated at a member level. The revised paid amounts equal the original allowed amount minus the minimum of the member's annual cost share and $7,550. Our analysis is limited to members who were enrolled in both Parts A and Part B.

MA membership and risk score information was sourced from the Virtual Research Data Center (VRDC). This data represents nationwide 2021 MA beneficiaries.

The benchmark analysis comparing FFS spending for beneficiaries enrolled in Part A and Part B vs Part A and/or Part B relied on the 2021 100% FFS cost and membership files. We separately calculated the Part A PMPM and the Part B PMPM consistent with how CMS calculates Medicare Advantage benchmarks.

Limitations

The assumptions and resulting estimates included in this report and produced by the model are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely based this analysis primarily on CMS published data, which are subject to revision over time. It is the responsibility of AHIP to review the assumptions carefully and notify Wakely of any potential concerns.

Responsible Actuaries

We, Rachel Stewart, and Tim Courtney are the actuaries responsible for this communication. We are Members of the American Academy of Actuaries. Rachel is an Associate of the Society of Actuaries, and Tim is a Fellow in the Society of Actuaries. We meet the Qualification Standards of the American Academy of Actuaries to issue this report.

Conflict of Interest

Wakely provides actuarial services to a variety of clients throughout the health industry. Our clients include commercial, Medicare, and Medicaid health plans, the federal government and

state governments, medical providers, and other entities that operate in the domestic and international health insurance markets. Wakely has implemented various internal practices to reduce or eliminate conflict of interest risk in serving our various clients. Except as noted here, we, Rachel Stewart and Tim Courtney, are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Subsequent Events

There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report

This document and the supporting exhibits/files constitute the entirety of the actuarial report and supersede any previous communications on the project.

Statement on Improving Medicare Documentation Requirements to Substantially Reduce Improper Payments and Strengthen Medicare

Prepared for the Subcommittee on Oversight And Investigations, Committee on Energy & Commerce, U.S. House of Representatives for April 16, 2024
Hearing on "Examining How Improper Payments Cost Taxpayers Billions And Weaken Medicare And Medicaid."

The Council for Quality for Respiratory Care (CQRC) thanks the Subcommittee for focusing attention on the challenges of improper payments. The current documentation and review process has a particularly negative impact on Medicare beneficiaries who rely upon supplemental oxygen to maintain their quality of life and remain active members of their community. We encourage the Committee to maintain its commitment to strengthening programmatic oversight, curtail improper payments, and ensure efficient use of taxpayer dollars in the Medicare and Medicaid programs. To address the problem of improper payments in the area of supplemental oxygen therapy, we strongly urge the Committee to instruct the Centers for Medicare & Medicaid Services (CMS) to require Medicare contractors to use the CMS created clinical data element templates to establish beneficiary medical necessity. This one step would create a comprehensive set of information for meaningful audit review and would address the problems created by contractors relying solely on physician notes.

The CQRC is a coalition of the nation's leading home oxygen therapy provider and manufacturing companies. Together, we provide in-home patient services and respiratory equipment including liquid oxygen, oxygen concentrators, and sleep therapy devices, to more than two-thirds of all Medicare beneficiaries who rely upon supplemental oxygen therapy to maintain their independence and enhance their quality of life. Our members also employ approximately 35,000 people in the United States to help seniors and others receive the oxygen they need to live healthier lives.

As the Committee recognizes and the U.S. Government Accountability Office has reported, the problem of improper payments has been a critical concern for more than 25 years. In the case of supplemental oxygen, the problem of improper payments is directly linked to the Medicare contractors' sole reliance on physician medical record notes. Since 2016, the CERT has reported that less than one percent of the improper payment rate was due to patients not meeting Medicare's medically necessity requirements.[1] During the same period, the CERT has also reported that 72 to 99 percent of the oxygen improper payment rate was due to problems with the ordering clinicians'

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[1]Centers for Medicare and Medicaid Services. Comprehensive Error Rate Testing (CERT), *2017-2021 Medicare-for-Service Supplemental Improper Payment Data. Tables D2 and J2.* Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports

documentation.[2] These reports indicate that there is no evidence of fraud or abuse in terms of beneficiaries receiving supplemental oxygen who do not medically require the equipment, supplies, and services. Yet, contractors deny millions of claims because physician chart notes meant to be used for physician-patient interactions do not contain the "magic words" Medicare contractors apparently want to see to reimburse supplemental oxygen providers filing physicians' prescriptions. While the initial number of denied claims remains high year-over-year, a survey of national and regional providers found that Administrative Law Judges overturned the vast majority of such denials finding sufficient documentation of medical necessity.

The heart of this problem is that physicians write their medical record notes to support ongoing treatment of their patients and not to meet contractor review criteria, which remain unclear. With the support of physicians, patient advocates, providers, and manufacturers, CMS developed a set of clinical data element that could be incorporated into electronic health records or similar systems to clearly identify the data CMS believes are necessary to support medical necessity of supplemental oxygen claims.[3] These data elements would not only provide clear direction to physicians who prescribe supplemental oxygen, but they also would make the medical review process efficient, accurate, and less costly. For example, if a submission did not include a required data element the system could alert the physician to the missing element, which he/she could then easily provide without undue burden to the patient in need of supplemental oxygen therapy. This approach would eliminate missing information and incomplete records, which in turn would reduce improper payments due to these errors. In addition to ensuring the proper payment for supplemental oxygen claims, this approach would reduce spending on audits and appeals that have historically resulted in the vast majority of such claims being paid.

Despite the clear improvement these data elements would provide, Medicare contractors without explanation have refused to adopt them, and CMS has not required the contractors to do so. As a result, the clinical data elements defined in 2018 have yet to be implemented, resulting in more than five years of additional improper payments for supplemental oxygen due to medical record errors. This situation has led to patients not being able to access medically necessary supplemental oxygen. Some patients have had to pay out of pocket for their life-sustaining supplemental oxygen, while others have been forced to leave their homes, families, and communities to enter nursing homes or long-term care facilities in order to access their Medicare benefit for supplemental oxygen. This situation particularly impacts our nation's seniors, who deserve better.

We encourage the Committee to engage with CMS so that the agency will require the contractors to use the clinical data element template. Contractors should not be permitted to refuse to adopt common-sense approaches that perpetuate incomplete or missing data.

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[2] *Id.;* Centers for Medicare and Medicaid Services. Comprehensive Error Rate Testing (CERT), *Medicare Fee-for-Service 2016 Improper Payment Rate Report.* Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.
[3] CMS. Home Oxygen Therapy Order Template. (2018). CMS also created templates for the face-to-face encounters and lab results.

Taking this approach would then allow the contractors and CMS to target their resources on actual fraud and abuse to protect taxpayer dollars. If CMS will not act, we encourage the Committee and the Congress to pass the Supplemental Oxygen Access Reform (SOAR) Act (S. 3821, H.R. 7829). Among other things, this legislation would require CMS to modernize the contractor documentation review process by adopting the clinical data elements using an electronic submission process. We applaud Senators Cassidy, Warner and Klobuchar and Congressmen Valadao, Bucshon, A. Smith, and Brownley for introducing this important legislation that seeks to reform the Medicare supplemental oxygen benefit and protect patient access to this life-saving and life-sustaining therapy.

We thank you for providing us with the opportunity to submit this statement for the record and would welcome the opportunity to work with you more closely to address this systemic problem.