Congress of the United States
Washington, DC 20515

August 31, 2022

Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Honorable Liz Fowler
Deputy Administrator and Director
Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Comment on Request for Information: Medicare Program (Docket No. CMS-4203-NC)

Dear Administrator Chiquita Brooks LaSure and Deputy Administrator Fowler:

As members of Congress, we are committed to protecting Medicare's promise of comprehensive, affordable, and quality health care for our Nation's seniors and individuals with disabilities. To meet this promise for all beneficiaries, it is essential that the Medicare Advantage program be significantly reformed. We welcome CMS's request for information to improve Medicare Advantage and offer the following comments.

1) **Prevent delays and medically unnecessary restrictions to accessing care.**

Too often, Medicare Advantage plans deny, delay, or prematurely terminate medically necessary health care that would have been covered under Traditional Medicare. A 2018 report by the Office of Inspector General found "'widespread and persistent problems related to denials of care and payment in Medicare Advantage plans" and highlighted that when beneficiaries and providers appealed preauthorization and payment denials, MA plans "overturned 75 percent of their own denials" but at the same time, "beneficiaries and providers appealed only 1 percent of denials to the first level of appeal."[1]

Earlier this year, OIG issued another report which found, among other things, that among the prior authorization requests denied by MA plans, 13 percent met Medicare coverage rules – "in other words, these services likely would have been approved for these beneficiaries under original Medicare."[2]

[1] https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf
[2] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

Recently, the House Ways & Means Committee unanimously approved bipartisan legislation to make some reforms to prior authorization in Medicare Advantage. Building on Congress's work to ensure that MA enrollees have adequate access to medically necessary care, CMS should:

- Implement the OIG's recommendations from the 2018 and 2022 reports to better protect beneficiaries and providers from inappropriate denial, including:
    - Issue new guidance on the appropriate use of clinical criteria in medical necessity reviews
    - Incorporate the issues identified by OIG into CMS audits of MA plans
    - Direct MA plans to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors
    - Enhance oversight of MA contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate, and
    - Provide beneficiaries with clear, easily accessible information about serious violations by MA plans
- Develop standardized guidance for use of prior authorization and other utilization controls across MA plans. Plans should not be permitted to impose restrictions beyond this guidance, though they may offer more generous coverage
- Revise regulations, manual provisions, and other CMS guidance to require plans to provide both providers and enrollees with criteria upon which coverage denials/terminations are made
- Ensure that CMS-created materials – as well as MA plan materials – adequately explain prior authorization, including the scope of its use (how widespread it is) and the limitations on access to services it imposes
- Terminate contracts with MA plans that do not comply with standardized guidance for the use of prior authorization, and plans that have high rates of inappropriate delays and denials.

Step therapy protocols have also contributed to the unnecessary delay and denial of care. In 2018, CMS rescinded its long-standing policy that prohibited MA plans from imposing step therapy for drugs covered under Medicare Part B. Step therapy, also known as "fail first," is a utilization management tactic that frequently delays or disrupts continuity of care. Step therapy also fails to take into consideration that while a drug or therapy may generally be considered appropriate for a condition, individual patient issues such as comorbidities or drug interactions may necessitate the selection of an alternative drug. CMS has previously been presented with examples of patient harm resulting from step therapy.[3] Further, while evidence suggests some cost reductions for specific therapies, there is also evidence suggesting health care costs increase under step therapy.[4] We urge CMS to reinstate the policy prohibiting the use of step therapy in MA plans.

2) Rein in aggressive and misleading marketing tactics.

[3] https://patientsrisingnow.org/wp-content/uploads/2021/11/ST-Follow-up-sign-on-letter_FINAL-1.pdf
[4] https://www.healthaffairs.org/do/10.1377/forefront.20201221.255119

It is difficult to open a newspaper or turn on the television without encountering an advertisement for Medicare Advantage. CMS has reported complaints regarding MA marketing materials more than doubled from 2020 to 2021.[5] Aggressive sales tactics have left vulnerable seniors and people with disabilities susceptible to being misled and unwillingly steered into Medicare Advantage plans. In its finalized Medicare Advantage payment rule for 2023, CMS noted that a review of sales calls showed significant beneficiary confusion, including "that the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations."[6]

Unfortunately, marketing misconduct is not uncommon or new. In 2009, the Government Accountability Office issued a report finding "CMS took compliance and enforcement actions for inappropriate marketing against at least 73 organizations that sponsored MA plans from January 2006 through February 2009." Over a decade later, the National Association of Insurance Commissioners reported "consumers being switched from their original plans after either inquiring in response to ads or receiving cold calls from these marketers. One insurance commissioner described some of these ads as somewhat misleading at the very best and close to fraudulent at the very worst."[7] The commissioners reported an increase in commercials, social media ads, mass mailings, and phone calls—with advertisements emphasizing supplemental benefits often unavailable to the average consumer due to restrictive eligibility criteria.[8] Ultimately, many beneficiaries disenroll from Medicare Advantage, with sicker patients disenrolling at a disproportionately higher rate.[9]

To ensure beneficiaries select coverage based on comprehensive, accurate, and balanced information, CMS should:

- Require third-party marketing organizations to include a referral to the State Health Insurance Assistance Program in all disclosures
- Rescind changes made in 2019 to the Medicare Communications & Marketing Guidelines (MCMG), including blurring the lines between marketing and educational events by those selling MA and Part D products
- Reform agent and broker administrative compensation to reduce the significant financial incentive to sell MA plans over traditional Medicare
- Review rapid disenrollments from Medicare Advantage to identify outlier agents and brokers with high disenrollment figures and immediately recoup administrative compensation, as required under 42 CFR §422.2274(d)(5)(ii)(A)
- Increase transparency surrounding how complaints against agents, brokers, or third-party marketing organizations are received and processed, what enforcement process exists, and what actions are taken by CMS as the result of a complaint

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[5] https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and

[6] *Id.*

[7] https://content.naic.org/sites/default/files/inline-files/E-Vote%20Minutes%2002-25-22_0.pdf

[8] *Id.*

[9] https://www.gao.gov/products/gao-21-482; https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01435; https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725083; https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.01070; https://www.nejm.org/doi/full/10.1056/nejmhpr1804089

- Require agents and brokers to provide a signed attestations that whatever product is sold is appropriate for that beneficiary, as is already required for the sale of a Medigap plan
- Increase promotion and advocate for increased funding and capacity for State Health Insurance Assistance Programs (SHIPs) and Senior Medicare Patrol (SMP) programs

3) Reduce waste of billions of taxpayer dollars in overpayments.

There is consistent and growing evidence that the Medicare Advantage program is paid more than Traditional Medicare would spend on the same beneficiary, and such spending is growing per person, with significant implications for Medicare's long-term solvency. Overpayments are, in part, due to higher diagnosis coding intensity to make enrollees appear sicker than they are and therefore increase reimbursement.

As noted by the nonpartisan Medicare Payment Advisory Commission (MedPAC), in 2020, Medicare spent $1,538 more per beneficiary on Medicare Advantage plans than they would have spent for the same patients if they were in Traditional Medicare—resulting in $12 billion in overpayment. According to MedPAC, "private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed."[10] MedPAC continues: "continu[ing] to overpay MA plans […] will further worsen Medicare's fiscal sustainability."[11] MedPAC also found coding intensity widely varies, with some MA plans receiving significantly higher overpayments. Other independent estimates have found overpayments will cost Medicare up to $600 billion between 2023 and 2031.[12]

Manipulation of the risk-adjusted payment system, incomplete and unverified encounter data, and disproportionate use of chart reviews and health risk assessments all contribute to overpayments. The Office of the Inspector General, MedPAC, GAO, and CMS have all raised concerns about the current risk-adjusted payment system.[13]

To protect taxpayer dollars and prevent the looting of Medicare for private profit, CMS should:

- Implement GAO's recommendations regarding verifying the accuracy of encounter data and improving the timeliness of audits and recovery of improper payments to MA plans[14]

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[10] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf
[11] *Id.*
[12] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3959446
[13] https://oig.hhs.gov/oei/reports/oei-03-17-00470.pdf; https://oig.hhs.gov/oei/reports/OEI-03-17-00471.pdf; https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf; https://www.gao.gov/products/gao-16-76#:~:text=The%20Administrator%20should%20modify%20CMS's,2)%20excluding%20contracts%20with%20low; https://www.cms.gov/files/document/fy-2021-medicare-part-c-error-rate-findings-and-results.pdf
[14] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Gordon_OI_2022.06.28_1.pdf

- Implement OIG's recommendations regarding chart reviews and health risk assessments, including:[15]
    - Conducting targeted audits of plans receiving a disproportionate share of payments from chart reviews and health risk assessments; and 3) requiring plans to implement best practices for care coordination for beneficiaries who receive health risk assessments
    - Reassessing the risks and benefits of allowing unlinked chart reviews and in-home health risk assessments to be used as sources of diagnoses for risk-adjustment payments, and
    - Requiring MA plans to implement best practices for care coordination for beneficiaries who receive health risk assessments.
- Implement MedPAC's recommendations regarding risk-adjusted payments, including:[16]
    - Increasing the coding pattern adjustment above the statutory minimum
    - Eliminating health risk assessments as a source of diagnoses for risk-adjusted payments
    - Establishing thresholds for the completeness and accuracy of MA encounter data
- Establish strong transparency and enforcement requirements on pricing practices of provider-payer organizations to prevent manipulation of medical loss ratio requirements[17]

4) Terminate the ACO REACH program, which unwillingly places beneficiaries in arrangements similar to Medicare Advantage.

In addition to necessary improvements to the Medicare Advantage program, CMS should take further action to protect beneficiaries by terminating the ACO REACH program. This demonstration project, first established by former President Trump, places beneficiaries into arrangements remarkably similar to Medicare Advantage without the enrollee's knowledge or consent. The program's auto-enrollment feature disrespects beneficiaries' informed decision to enroll in Traditional Medicare. Insufficient notice and opt-out procedures do not protect unwitting beneficiaries from being forced into an arrangement that limits their provider choice and creates barriers to access care with burdensome prior authorization and other utilization controls.

Further, we are concerned with the misaligned financial incentives in the ACO REACH program, which may encourage denials of care and medically unnecessary and inappropriate utilization controls in order to increase profit margins from unspent monthly payments for medical care. Many beneficiaries select Traditional Medicare to avoid these access barriers.

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[15] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf

[16] https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf

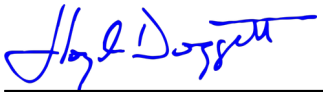
[17] https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2022/07/13/profits-medical-loss-ratios-and-the-ownership-structure-of-medicare-advantage-plans/

The Medicare program as a whole has also been financially strained by the profit incentives in Medicare Advantage, which the ACO REACH model resembles.

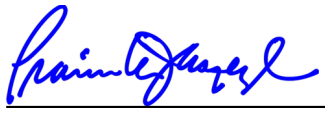
These unresolved problems must be addressed in the MA program before expanding or moving forward with a demonstration with many of the same flaws.

Thank you for the opportunity to provide information and support for strong CMS action to improve the Medicare program for our Nation's older adults and people with disabilities. We encourage CMS to use its statutory authority to the fullest extent possible to deliver comprehensive health care for all beneficiaries while protecting taxpayer dollars from fraud, waste, and abuse. We stand ready to work with you and provide any additional legislative authority necessary to reform Medicare Advantage and assure parity across the Medicare system.

Sincerely,



Lloyd Doggett
Member of Congress



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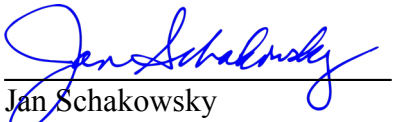

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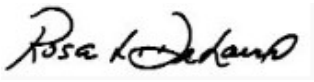

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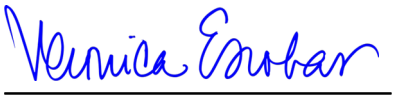

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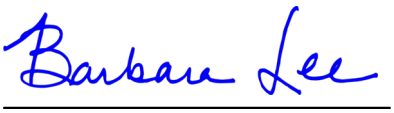

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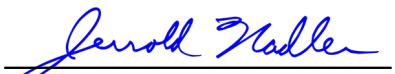

Jerrold Nadler
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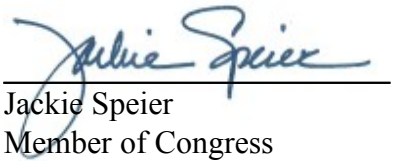

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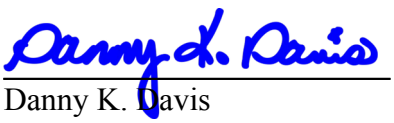

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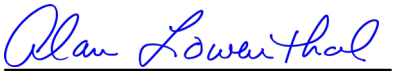

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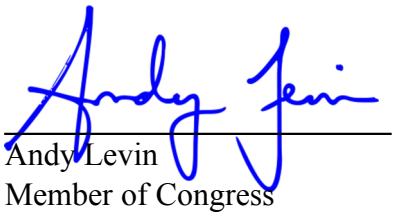

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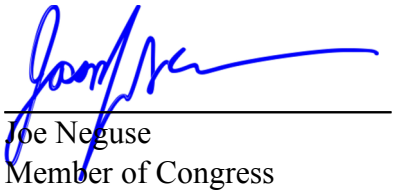

Joe Neguse
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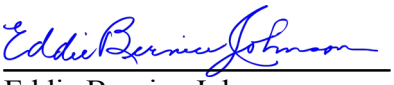

Eddie Bernice Johnson
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