

Congress of the United States

Washington, DC 20515

February 16, 2023

The Honorable Joseph R. Biden, Jr.
President
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

The Honorable Xavier Becerra
Secretary
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear President Biden, Secretary Becerra, and Administrator Brooks-LaSure:

We appreciate the attention you are giving to reforming Medicare Advantage plans and improving care for seniors and people with disabilities. We especially want to applaud the Centers for Medicare and Medicaid Services' (CMS) recent rule that prohibits these plans from imposing additional clinical criteria on patients to approve prior authorization. However, we believe there is still much more that needs to be done to protect seniors and people with disabilities from fraud and abuse. We urge you to build on your current work to improve Medicare by fixing the harms to patient care and rapidly increasing costs within the Medicare Advantage program. This will also save money that can then be used to reinvest in seniors' and people with disabilities' care.

Outside of traditional Medicare, seniors and people with disabilities can choose a Medicare Advantage plan administered by a private health insurance company. Medicare Advantage, also known as Medicare Part C, was intended to improve patient care and decrease growing healthcare costs. Today, close to 50 percent of Medicare beneficiaries are now enrolled in a Medicare Advantage (MA) plan.ⁱ MA plans often offer low or no premiums, out-of-pocket caps on spending, and other benefits that make the plans appear advantageous, especially to low-income beneficiaries and beneficiaries of color who are more likely to enroll in MA than traditional Medicare.ⁱⁱ

Although at its inception the MA program was expected to reduce Medicare spending, MA plans in the aggregate have never produced savings for Medicare due to the MA program's payment policies.ⁱⁱⁱ Instead, as enrollment in MA grows, spending per beneficiary has grown faster in MA than original Medicare,^{iv} and that spending is being funneled into corporate profits under the guise of operating costs instead of into care for patients.^v Additionally, inappropriate care delays and denials within MA are harming seniors and people with disabilities.^{vi} Research and patient experience confirms the harms to MA patients' healthcare. The Government Accountability Office (GAO) found that beneficiaries are more likely to switch from MA to traditional Medicare if they are in bad health compared to good health and that beneficiaries in their last year of life are

more than twice as likely to switch from MA to traditional Medicare.^{vii,viii} Similarly, a statistically significant increased percentage of MA beneficiaries report having trouble paying their medical bills or getting care due to cost than in traditional Medicare.^{ix,x} MA beneficiaries are also more likely to be placed in low quality nursing homes than those in traditional Medicare.^{xi}

In order to ensure that MA plans cover all medically reasonable and necessary services from high quality providers covered under traditional Medicare and protect the fiscal integrity of the Medicare Trust Fund, we urge CMS to make the following improvements:

1. Finalize and strongly enforce the proposed prohibition on MA plans denying prior authorization requests for coverage of a Medicare covered item or service based on criteria not found in traditional Medicare coverage policies, and issue new guidance prohibiting the use of step therapy for Medicare Part B.
2. Require MA plans to cover services from any medical provider that accepts Medicare's approved rate. At a minimum, require MA networks to cover care at the top 50 cancer hospitals in the country.
3. Stop overpayments by developing a more accurate risk scoring model based on patient demographics and prohibiting the use of unscrupulous methods to increase care costs.
4. Reinvest the \$46.5 billion annual savings from MA overpayments into lowering Medicare premiums, eliminating deductibles, expanding benefits to include dental, vision, and hearing, or otherwise improving medical care for all Medicare beneficiaries.

1. Finalize and enforce proposed rule on prior authorization in MA plans:

Thank you for proposing a strong Medicare Part C & D Rule for 2024 that prohibits MA plans from imposing any additional clinical criteria for prior authorization approvals outside of current Medicare coverage policies.^{xii} An April 2022 report from the Department of Health and Human Services Office of Inspector General (HHS OIG) shows that as many as 85,000 medical prior authorizations and 1.5 million payment requests are improperly denied by MA organizations each year.^{xiii} In addition, MA organizations are permitted to use step therapy, a process that requires seniors and people with disabilities to try multiple cheaper medications to prove that they fail to work before the MA insurer will approve the use of the correct medication. During the Obama Administration, step therapy in Medicare Part B was prohibited. Unfortunately, the policy returned during the Trump Administration and is still permitted.

Research shows that prior authorization and step therapy for Part B—two care obstacles used in MA but not original Medicare—are associated with higher health costs, hospitalizations, office visits, and likelihood of hospitalization.^{xiv,xv} The delay in care that prior authorization and step therapy cause irreparably harms seniors and people with disabilities, leading to disease progression, worse health outcomes, and even death.^{xvi,xvii} We are supportive of the proposed rule to address prior authorization issues and urge you to finalize it and vigorously monitor MA plans for compliance. This rule will remove obstacles that currently stand in the way of Medicare beneficiaries receiving the healthcare they need. We also urge you to return to the policy that prohibited step therapy in Medicare Part B, to ensure beneficiaries get the life-saving medications they need.

2. Require MA plans to cover services from any medical provider that accepts Medicare's approved rate:

MA poses a threat to patient care by restricting access to medical providers. Unlike original Medicare, MA imposes a network of providers that beneficiaries must see in order for their care to be covered. If beneficiaries need care outside of the network, if they are in an HMO, they must often pay full price out of pocket. Worse, 40 percent of beneficiaries do not know that they must stay in-network to have their services covered, leading to surprise medical bills. Research has shown that Hispanic and Asian American beneficiaries are more likely to be enrolled in an MA plan with a narrow network. Of particular concern, MA plans restrict access to the top cancer centers in the country. Consequently, there is a significant decrease in the percentage of MA beneficiaries who get care at top-ranked cancer hospitals compared to original Medicare beneficiaries.^{xviii}

3. Stop overpayments by developing a more accurate risk scoring model and prohibiting unscrupulous methods of increasing care costs:

Despite the risk of inferior care, in 2019, payments to MA organizations from the Medicare Trust Fund were \$321 higher per patient compared to original Medicare after adjusting for differences in health status and demographics.^{xix} This resulted in an additional \$7 billion in Medicare spending.

Another driver of increased costs of MA is through risk scoring. CMS currently uses the Hierarchical Condition Category (HCC) method of risk scoring which uses a patient's diagnosis codes and other demographics to calculate a risk score. Although mortality data, prescription drug claims, and demographic data demonstrate that MA beneficiaries are initially healthier than traditional Fee-for-Service (FFS) beneficiaries, MA organizations have taken advantage of this risk scoring system to make their beneficiaries appear sicker to get larger payments from the government, a practice known as upcoding. MA organizations also use unscrupulous methods to increase purported care costs such as conducting unsolicited home health visits to add diagnosis codes to a patient's chart without providing medical care for those diagnoses and use algorithms to search electronic medical chart data and add additional diagnosis codes. Sadly, patients with these codes added to their charts through this practice are too often not treated for the new diagnoses; the codes are simply used to increase payment from the government to the MA plan. Upcoding is so prevalent in the MA sector that the Medicare Payment Advisory Commission, the Congressional Budget Office, the Government Accountability Office, and the Committee for a Responsible Federal Budget all incorporate it into their Medicare cost models.

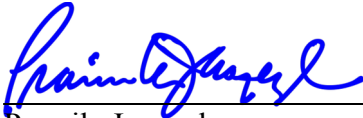
CMS's proposal to use the statutory minimum coding intensity adjustment of 5.9 percent for 2023 is inadequate to keep up with increased upcoding by MA plans. Researchers estimate that the true coding intensity adjustment is over 15 percent.^{xx} An alternative risk scoring method, Demographic Estimate of Coding Intensity (DECI), would address upcoding. The DECI method assumes that after correcting for demographics, MA beneficiaries are no sicker than FFS beneficiaries—an assumption backed up by the data.^{xxi} It also corrects for differences between diagnosis-related risk scores and demographic-related risk scores attributed to upcoding. This calculation can also be applied in a more targeted manner to crack-down on the bad actor plans that participate in intense risk score gaming. Previous corrections to the coding intensity adjustment have not resulted in decreased benefits or increased costs to seniors and people with disabilities.^{xxii} CMS would save over \$465 billion over the next decade by enacting this mathematical change.^{xxiii}

4. Reinvest the \$46.5 billion annual savings from MA profiteering into improvements to traditional Medicare:

Reinvesting savings from Medicare profiteering could include lowering Medicare premiums, eliminating deductibles, expanding benefits to include dental, vision, and hearing, or otherwise improving medical care for all Medicare beneficiaries. For example, reinvesting savings would allow CMS to reduce Medicare Part B premiums by 42 percent to under \$100 per month for all Medicare beneficiaries.^{xxiv} Alternatively, the savings could be used to eliminate the Medicare Part D deductible for everyone enrolled in Medicare. Savings could also fund comprehensive dental, vision, and hearing benefits with \$15 billion left over per year to lower costs of other care.^{xxv} In fact, America's Health Insurance Plans found that it could provide comprehensive dental, vision, and hearing benefits with no increase in government funding and still have money left over.^{xxvi}

Medicare is a foundational piece of the U.S. healthcare system and must be protected. We urge you to eliminate the barriers caused by MA care delays and denials and restricted provider networks, stop overpayments to MA, and reinvest the savings of time and money into care for Medicare beneficiaries. We also respectfully request a response to this letter, detailing actions being taken towards these reforms by March 2, 2023. We thank you for your attention to this vital issue and stand ready to work with you to improve the health and well being of America's seniors and people with disabilities.

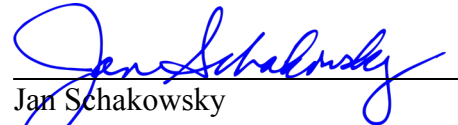
Sincerely,



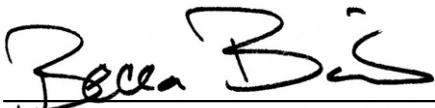
Pramila Jayapal
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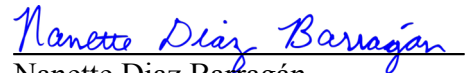
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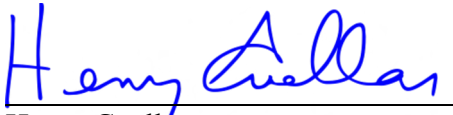
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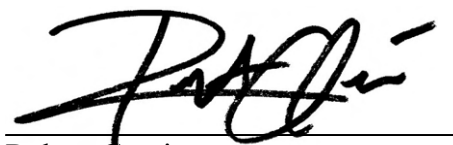

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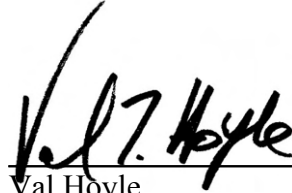
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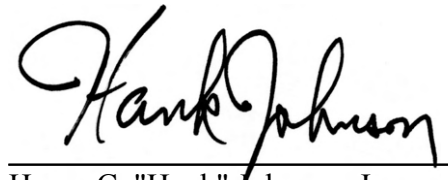
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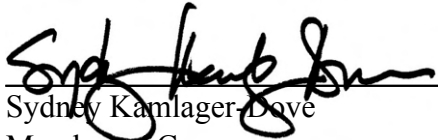
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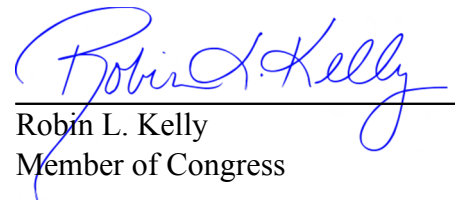
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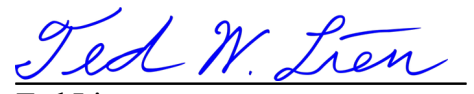
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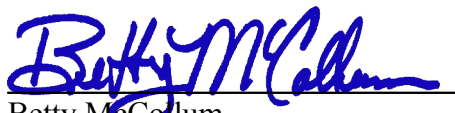
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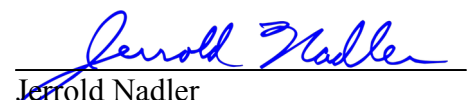
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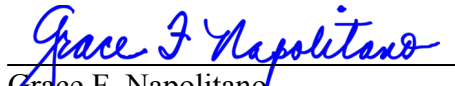
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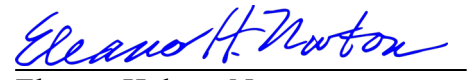


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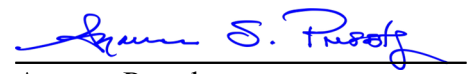

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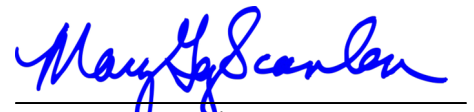

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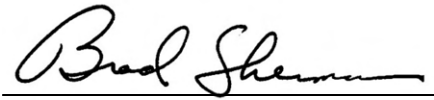

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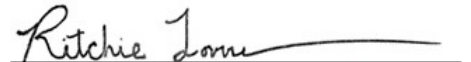
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Jim Tokuda
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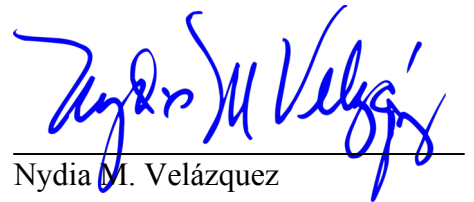
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Bonnie Watson Coleman
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Nikema Williams
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Frederica S. Wilson
Member of Congress

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