

# United States Senate

WASHINGTON, DC 20510

December 7, 2023

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

Dear Administrator Brooks-LaSure,

We write regarding shortfalls in the Centers for Medicare & Medicaid Services' (CMS) data collection and reporting practices for Medicare Advantage (MA) plans. For the first time, over half of all Medicare beneficiaries are choosing to enroll in MA plans.<sup>1</sup> However, in the last few years, federal watchdogs have released numerous reports examining concerning trends in MA. In 2019, the Health and Human Services Office of the Inspector General (HHS OIG) found that among requests MA plans denied, 13 percent of prior authorization denials and 18 percent of payment denials actually met Medicare coverage rules, meaning the MA plan delayed or denied seniors access to services that would have likely been approved under traditional Medicare (TM).<sup>2</sup> The nonpartisan Medicare Payment Advisory Commission (MedPAC) found that seniors in MA who use more services are more likely to disenroll from MA than healthier seniors,<sup>3</sup> while the Government Accountability Office reported that enrollees in MA plans are more than twice as likely as other enrollees to switch to TM during their last year of life.<sup>4</sup>

Additionally, researchers have reported billions in overpayments to MA plans, largely driven by favorable selection and shortcomings in the current risk adjustment model.<sup>5</sup> Between 2010 and 2019, CMS paid MA plans at least \$106 billion in excess payments.<sup>6</sup> For 2023, MedPAC estimates MA plans may receive \$27 billion in additional payment, largely due to diagnostic

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<sup>1</sup> KFF, Half of All Eligible Medicare beneficiaries Are Now Enrolled in Private Medicare Advantage Plans,” Jeannie Fuglesten Biniek, Meredith Freed, Anthony Damico, and Tricia Neuman, May 1, 2023, <https://www.kff.org/policy-watch/half-of-all-eligible-medicare-beneficiaries-are-now-enrolled-in-private-medicare-advantage-plans/#:~:text=in%20Private%20Medicare%E2%80%A6,-Half%20of%20All%20Eligible%20Medicare%20Beneficiaries%20Are,in%20Private%20Medicare%20Advantage%20Plans&text=According%20to%20recently%20released%20data,over%20half%20of%20eligible%20beneficiaries>.

<sup>2</sup> U.S. Department of Health and Human Services Office of Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” April 2022, <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

<sup>3</sup> MedPAC, “The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans, p 432, March 2022, [https://www.medpac.gov/wp-content/uploads/2022/03/Mar22\\_MedPAC\\_ReportToCongress\\_Ch12\\_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf).

<sup>4</sup> GAO, Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending,” June 28, 2021, <https://www.gao.gov/products/gao-21-482>.

<sup>5</sup> Health Affairs, “Lowering Medicare Advantage Overpayments From Favorable Selection By Reforming Risk Adjustment,” <https://www.healthaffairs.org/content/forefront/lowering-medicare-advantage-overpayments-favorable-selection-reforming-risk-adjustment>.

coding intensity and the MA program’s Star Ratings quality bonus program. Further, when assessing the effects of favorable selection into MA, researchers at the USC Schaeffer Center estimate excess payments to MA plans in 2023 could total \$75 billion. These overpayments not only hasten the depletion of the Hospital Insurance Trust Fund,<sup>7</sup> but they also increase costs for seniors and taxpayers.

These findings raise important questions about ensuring the integrity and fiscal sustainability of the Medicare Advantage program. Without publicly available plan-level data on prior authorization requests by type of service, timeliness of determinations and reasons for denials; claims and payment requests denied after a service has been provided; beneficiary out-of-pocket spending; and disenrollment patterns, policymakers and regulators are unable to adequately oversee the program and legislate potential reforms. While CMS already requires MA plans to submit some of these data – such as seniors’ cost-sharing liabilities and enrollment data by demographic – much of this information is collected for internal purposes only or made available with a significant time delay, which further hurts transparency efforts. In both cases, a lack of public data prevents seniors and people with disabilities from making informed decisions about which plan fits their needs.

For Congress and regulators to better understand the effects of MA plan design on cost, coverage, and quality we urge you to collect and publish the following data:

- 1. Prior authorization requests, denials, and appeals by type of service.** Prior authorization is a tool that plans use to manage beneficiary care and control costs. However, prior authorization processes can also burden providers and prevent or delay patient access to necessary care.<sup>8</sup> While CMS reports aggregate data at the contract-level, including the total number of prior authorization requests submitted by MA plans, whether they were approved or denied, and the outcome of any appeal, CMS does not collect these data by type of service, by beneficiary characteristic and health status, or by plan. As a result, researchers, regulators, and lawmakers cannot evaluate whether prior authorization requests, denials, and appeals are more common for certain types of services or patients, or whether MA insurers are complying with CMS requirements to cover all Medicare Part A and Part B services.<sup>9</sup>
- 2. Justification of prior authorization denials.** While CMS collects data on the total number of prior authorization denials, it does not collect information on the reasons for denial decisions. Without explanation, CMS and regulators are limited in their ability to assess whether prior authorization requests were appropriately denied. Additionally, CMS only reports the total number of prior authorization denials at the contract-level,

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<sup>6</sup> Health Affairs, “Medicare Advantage, Direct Contracting, and the Medicare ‘Money Machine,’ Part 1: The Risk-Score Game,” Sept. 29, 2021, <https://www.healthaffairs.org/doi/10.1377/forefront.20210927.6239/full/>.

<sup>7</sup> CBPP, “Ending Medicare Advantage Overpayments Would Strengthen Medicare,” January Angeles, September 14, 2009, <https://www.cbpp.org/research/ending-medicare-advantage-overpayments-would-strengthen-medicare>.

<sup>8</sup> U.S. Department of Health and Human Services Office of Inspector General, “Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care,” April 2022, <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>.

<sup>9</sup> *Id.*

rather than the plan-level, which further obscures plan behavior and prevents beneficiaries from making the most informed choice.

- 3. Timeliness of prior authorization decisions.** We appreciate CMS’s proposed rule to expedite the prior authorization process.<sup>10</sup> However, CMS does not require MA plans to report specifically how long it takes to complete prior authorization requests resolved within the mandated limits. While MA plans can extend the timeframes by up to 14 days in certain circumstances, CMS does not collect data on how often this happens.<sup>11</sup> MA plans are required to complete prior authorization requests as “expeditiously as the enrollee’s health condition requires,” but without these data, CMS cannot properly enforce this requirement.<sup>12</sup> Collecting this data would help researchers track which services take longer than others to receive prior authorization and allow beneficiaries to compare prior authorization response times across plans when selecting coverage.<sup>13</sup>
- 4. Complete encounter data.** CMS already requires MA plans to submit encounter data detailing the health care services provided to an enrollee, the enrollee’s health conditions, and payment information.<sup>14</sup> However, encounter data is often incomplete, which makes it difficult to track plan performance.<sup>15</sup> As HHS OIG highlights, MA plans are not required to specifically identify the services in the encounter data for which payment was denied, information that enables oversight entities to “detect potentially inappropriate billing patterns and investigate suspected fraud and abuse.”<sup>16</sup> Therefore, CMS should require MA plans to submit a denied-claim indicator in encounter data to ensure the agency can investigate appropriateness of denied claims, track denial trends by service type, and assess whether claims from certain demographic groups are denied more frequently than others.<sup>17</sup>
- 5. Utilization of supplemental benefits and associated out-of-pocket costs.** Nearly all MA plans use rebates to offer supplemental benefits, such as hearing, dental, and vision

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<sup>10</sup>KFF, “CMS Prior Authorization Proposal Aims to Streamline the Process and Improve Transparency,” Kaye Pestaina, Justin Lo, Karen Pollitz, and Rayna Wallace, <https://www.kff.org/health-reform/issue-brief/cms-prior-authorization-proposal-aims-to-streamline-the-process-and-improve-transparency/#:~:text=The%20Center%20for%20Medicare%20and,decision%20making%2C%20and%20improve%20transparency.>

<sup>11</sup> *Id.*

<sup>12</sup> KFF, Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries,” Jeannie Biniek, Meredith Freed, Tricia Neuman, April 25, 2023, <https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/>.

<sup>13</sup> *Id.*

<sup>14</sup> Better Medicare Alliance, “Encounter Data in Medicare Advantage,” October 2017, [https://bettermedicarealliance.org/wp-content/uploads/2017/11/BMA\\_OnePager\\_MA\\_EncounterData\\_2017\\_10\\_30-Final.pdf](https://bettermedicarealliance.org/wp-content/uploads/2017/11/BMA_OnePager_MA_EncounterData_2017_10_30-Final.pdf).

<sup>15</sup> U.S. department of Health and Human Services Office of Inspector General, “The Inability to Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight,” March 2, 2023, <https://oig.hhs.gov/oei/reports/OEI-03-21-00380.asp>.

<sup>16</sup> *Id.*

<sup>17</sup> KFF, Gaps in Medicare Advantage Data Limit Transparency in Plan Performance for Policymakers and Beneficiaries,” Jeannie Biniek, Meredith Freed, Tricia Neuman, April 25, 2023, <https://www.kff.org/medicare/issue-brief/gaps-in-medicare-advantage-data-limit-transparency-in-plan-performance-for-policymakers-and-beneficiaries/>.

services, that are not available in TM.<sup>18</sup> The value of these rebates have grown rapidly, from \$1,140 per enrollee in 2018 to \$2,350 per enrollee in 2023.<sup>19</sup> However, there is little information publicly available on enrollees' utilization of these benefits, the specific items or services they receive, or associated out-of-pocket spending. These extra benefits are popular with seniors and utilization data would allow CMS to better assess their quality and value.

In addition to requiring MA plans to submit the data mentioned above, we also urge you to publicly release the following data that CMS is already collecting:

- 6. Out-of-pocket costs and provider payment information.** Beneficiaries like MA products because, unlike TM, MA plans are required to cap out-of-pocket spending. MA plans must also use any rebates to either lower beneficiary cost-sharing or offer supplemental benefits. But publicly available MA encounter data does not include any information on provider payments or out-of-pocket liability for beneficiaries. CMS should validate and publish this information in line with existing regulations, to ensure that researchers, lawmakers, and beneficiaries can better understand cost-sharing structures across MA plan offerings. CMS should also review the Medicare Plan Finder and Medicare Current Beneficiary Survey releases to verify that estimates of out-of-pocket spending are up to date.
- 7. Disaggregated disenrollment data.** At times, beneficiaries enrolled in MA plans may elect to switch to TM. This is particularly true for beneficiaries in their last year of life<sup>20</sup> and those who are dually eligible for Medicare and Medicaid.<sup>21</sup> CMS reports the reasons for disenrollment in aggregate at the contract level, but the characteristics of those enrollees, such as race, ethnicity, age, or care setting, are not specified. Moreover, CMS also does not report disenrollment rates at the plan level, which makes it more difficult for seniors and people with disabilities to choose the plan that would best suit their needs. Publishing these data would allow researchers to evaluate whether certain groups disenroll from MA at higher rates than others, and whether disenrollment rates are associated with out-of-pocket costs or coverage denials.
- 8. Plan comparison information.** CMS is required to publish a comparison between quality and performance indicators in MA and TM, including information on health outcomes. CMS should ensure this information is up to date and easily accessible on the CMS website to assist seniors in comparing the benefits of MA and TM.

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<sup>18</sup> KFF, "Extra Benefits Offered by Medicare Advantage Firms Vary," Jeannie Fuglesten Biniek, Nolan Scroczyński, Meredith Freed, and Tricia Neuman, November 16, 2022, <https://www.kff.org/medicare/issue-brief/extra-benefits-offered-by-medicare-advantage-firms-varies/>.

<sup>19</sup> *Id.*

<sup>20</sup> GAO, Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending," June 28, 2021, <https://www.gao.gov/products/gao-21-482>.

<sup>21</sup> JAMA, "Analysis of Drivers of Disenrollment and Plan Switching Among Medicare Advantage Beneficiaries," David Meyers, Emmanuelle Belanger, Nina Joyce, February 25, 2019, <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2725083>.

CMS can collect and publish these data using its existing authority. To strengthen the transparency of MA plans and improve care for Medicare beneficiaries, we urge CMS to take these actions. We also respectfully request that you provide us with a staff-level briefing on CMS's plan to improve its data collection and reporting practices for MA plans by December 27<sup>th</sup>, 2023.

Thank you for your attention to this important matter.

Sincerely,



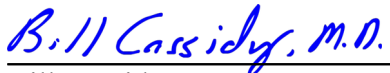
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Elizabeth Warren  
United States Senator




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Catherine Cortez Masto  
United States Senator



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Bill Cassidy, M.D.  
United States Senator



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Marsha Blackburn  
United States Senator