

# United States Senate

WASHINGTON, DC 20510

September 13, 2019

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Administrator Verma:

We write to share our concerns over the recent Department of Health and Human Services (HHS) Payment Accuracy Report for the first quarter of 2019 that reveals Medicare Advantage (MA) plans have been overbilling the government and, as a result, taxpayers have been overpaying these private insurance companies for the past three years.<sup>1</sup> We urge you to take prompt action to ensure MA plan sponsors are held accountable for overcharging the federal government, meeting their contractual obligations, and appropriately managing the needs of older adults and people with disabilities.

The recent HHS Payment Accuracy Report exposes that taxpayers have overpaid Medicare Advantage plans more than \$30 billion dollars over the last three years.<sup>2</sup> This report comes on the heels of a 2016 Government Accountability Office (GAO) report and a 2013 GAO report on MA plan overcharges and the failure of the Centers for Medicare and Medicaid (CMS) to recoup billions of dollars of improper payments from MA plans. In 2017, GAO testimony to the US House of Representatives Oversight Subcommittee of the Ways and Means Committee, revealed that “the soundness of billions of dollars in Medicare expenditures remains unsubstantiated.”

In many cases, CMS has known for years about the tendency for some MA plans to overbill the government yet, despite this, CMS has taken little to no action to course correct. It is critical that CMS act immediately to recoup these overpayments and prevent future overbilling by MA plans. In addition, various reports from the US Office of the Inspector General (OIG), the GAO, MedPAC and CMS itself raise serious concerns about MA plan non-compliance with contractual obligations and failure to meet the needs of older adults and people with disabilities.<sup>3</sup>

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<sup>1</sup> <https://khn.org/news/medicare-advantage-overbills-taxpayers-by-billions-a-year-as-feds-struggle-to-stop-it/>

<sup>2</sup> <https://paymentaccuracy.gov/wp-content/uploads/2019/02/Medicare-Part-C-Getting-Payments-Right-Score-Card-FY-2019-Q1.pdf>

<sup>3</sup> <https://www.gao.gov/products/GAO-16-76>

We request that you provide us with details on CMS's plans to recoup these overpayments and share information about how CMS is conducting oversight of MA plans and enforcing their contractual obligations. More specifically, we would appreciate answers to the following questions:

**Overbilling:** as detailed above, recent reports highlight a common practice across many MA plans – overbilling the government by exaggerating how sick their patients are, despite the fact that many of the sickest individuals choose to disenroll from MA plans and reenroll in traditional Medicare.<sup>4</sup>

1. **Does CMS have a workable plan in place to prevent Medicare Advantage plans from overcharging taxpayers for their services and, if so, what is it?**
2. **Does CMS have a workable plan in place to recoup the tens of billions of dollars in overpayments to MA plans over the last decade and, if so, what is it?**
3. **If CMS cannot recoup more than a small fraction of these MA plan overpayments, does CMS lack the ability to hold Medicare Advantage plans accountable for their overcharges and protect the US Treasury?**
4. **If CMS cannot hold Medicare Advantage plans accountable and recoup these tens of billions of dollars, how can Congress ensure the financial integrity of the Medicare Advantage program?**

**Provider directories:** according to CMS' own reports, MA plans have not provided their members with complete and accurate provider directories as they are required to do by law for several years now.<sup>5</sup> As a result, people with Medicare cannot appropriately distinguish among MA plans based on their provider networks and make an informed decision on which MA plan to choose based on which doctors and hospitals are in network. This lack of accuracy is not just inconvenient for people, it also begs the question as to whether MA networks comply with network adequacy requirements.

5. **What is preventing MA plans from disclosing accurate provider information to their enrollees?**
6. **Why hasn't CMS taken the necessary action to both enforce existing network adequacy requirements and ensure the accuracy of provider networks?**
7. **What additional tools or enforcement mechanisms does CMS need to ensure timely oversight of network adequacy and accurate provider directories?**

**Encounter data:** as MedPAC has reported for several years now, MA plans have not disclosed complete and accurate encounter data, data that reflects actual services provided to MA plan enrollees, as they are required to do by law. This information is critical to ensuring plans are providing appropriate levels of care to their enrollees and billing the government appropriately for their services, among other things. If publicly reported, encounter data could also help people better distinguish among MA plans. We strongly support MedPAC's recommendation that CMS

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<sup>4</sup> <https://www.gao.gov/assets/690/684386.pdf>

<sup>5</sup> [https://www.cms.gov/Medicare/Health-](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf)

[Plans/ManagedCareMarketing/Downloads/Provider\\_Directory\\_Review\\_Industry\\_Report\\_Round\\_3\\_11-28-2018.pdf](https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Round_3_11-28-2018.pdf)

set a higher bar for bonus payments and reduce payments to MA plans that do not disclose complete and accurate encounter data.<sup>6</sup> We urge CMS to consider implementing this recommendation through the regulatory process, and encourage you to consider doing so in advance of plan year 2021.

Additionally, the OIG recommended that “CMS take actions . . . to address potential errors in the MA encounter data, provide targeted oversight of MAOs that submitted a higher percentage of records with potential errors, ensure that billing provider identifiers are active and valid on all records, require MAOs to submit ordering and referring provider identifiers for applicable records; track how MAOs respond to edits that reject data; and establish and monitor performance thresholds related to MAOs’ submission of records with complete and valid data.”<sup>7</sup> CMS should ensure that all MA plans collect all the information that the OIG recommends it submit to CMS. Through this information, CMS can effectively conduct its fraud oversight responsibility and detect fraud.

- 8. How does CMS plan to secure and report MA plan encounter data, as required by law?**
- 9. How does CMS ensure that the reported encounter data is accurate?**

**Persistent performance problems:** we are concerned that CMS has not conducted sufficient, regular oversight over MA plans and reported on the results of this oversight to the extent necessary, as the GAO<sup>8, 9, 10, 11</sup> and OIG<sup>12</sup> have urged. CMS’ own audits have found “widespread and persistent [Medicare Advantage] performance problems related to denials of care and payment”<sup>13</sup> and Medicare Advantage plans that “threaten the health and safety of their members.”<sup>14</sup>

- 10. How does CMS structure its oversight activities related to MA plans?**
- 11. How does CMS address performance problems in MA plans, especially those that pose a direct threat to the health and safety of plan members?**
- 12. What actions can and does CMS take to enforce plan standards?**
- 13. Why did CMS back away from a policy that would have required MA plans to pay for auditors, as a way for CMS to have better oversight of MA plans?**
- 14. Does CMS require additional tools or enforcement mechanisms to ensure higher performance standards across MA plans?**

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<sup>6</sup> <http://www.medpac.gov/docs/default-source/default-document-library/ma-encounter-data-march-2019.pdf>

<sup>7</sup> <https://oig.hhs.gov/oei/reports/oei-03-15-00060.asp>

<sup>8</sup> <https://www.gao.gov/products/GAO-15-710>

<sup>9</sup> <https://www.gao.gov/products/GAO-17-393>

<sup>10</sup> <https://www.gao.gov/assets/680/676441.pdf>

<sup>11</sup> <https://www.gao.gov/products/GAO-17-223>

<sup>12</sup> <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>

<sup>13</sup> Office of the Inspector General: <https://www.oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>

<sup>14</sup> CMS policy memo: [https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Cigna\\_Sanction\\_01\\_21\\_16.pdf](https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/Downloads/Cigna_Sanction_01_21_16.pdf)

Information on MA plan persistent performance problems and plan denial rates by service type and plan type should be made publicly available to help allow people to make a meaningful, informed decision on whether to enroll in one of these plans or to disenroll from these plans if they are already enrolled. We urge CMS to disclose on MedicareCompare and other public outlets the names of health plans with performance problems and the nature of the problems and MA plan denial rates by service type and by plan.

**15. Will CMS take action to make this information publicly available? If not, why not?**

**Star ratings:** MedPAC has observed that people with Medicare “lack important information about the quality of care of [Medicare Advantage] plans in their market. . . it is difficult to reliably compare quality among plans.”<sup>15</sup> We understand that some deficient plans—even those found to threaten people’s health and safety—receive four- and five-star ratings. This is unacceptable. People should be able to distinguish among MA plans based on their star ratings.

**16. How is CMS addressing the issue of misleading MA plan star ratings?**

**Enrollment:** in light of these serious issues, it is critical to ensure older Americans and people with disabilities have access to clear, unbiased information when electing coverage during the Fall Open Enrollment Period as well as any other special enrollment period, so that individuals have the information necessary to make an informed decision. At the very minimum, this should include letting people know that they cannot rely on star ratings or MA plan provider directories (as detailed above), and that their out-of-pocket costs in a MA plan could be as high as \$6,700 for in-network medical and hospital care alone and \$10,000 if they use out-of-network providers. They should also know that in some plans they may face inappropriate delays and denials of care. Finally, they should know that if they choose a MA plan they may be locking themselves in, unable to buy a Medicare supplemental insurance policy if they switch to traditional Medicare in a future plan year. By law, people with Medicare are entitled to an informed health plan choice, and it is critical that CMS take necessary actions to ensure that individuals can make one.

**17. Last year, CMS took several actions to steer people into these privately run plans by “broadcasting information that ‘is incomplete and continues to promote certain options over others.’”<sup>16</sup> Why did CMS engage in this inappropriate “tilting of the scales” through repeated emails to individuals highlighting the benefits of MA over traditional Medicare?**

**18. How much money do MA plans spending on advertising during open enrollment period? How much money did CMS spend to advertise MA over that of traditional Medicare during the 2018 open enrollment period?**

**19. Does CMS require additional tools, resources or authority to carry out its responsibilities and ensure people with Medicare have information necessary to elect the plan option that best fits their needs without being inappropriately steered toward one option or another?**

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<sup>15</sup> [http://www.medpac.gov/docs/default-source/press-releases/mar19\\_newsrelease\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/press-releases/mar19_newsrelease_sec.pdf?sfvrsn=0)

<sup>16</sup> <https://www.axios.com/medicare-advantage-tilting-scales-7db28dd2-25af-4283-b971-21a61fa59371.html>

In sum, we are deeply concerned that CMS has allowed MA plans to overbill taxpayers to the tune of more than \$100 billion dollars over the last decade, while failing to take corrective action in response to MA plan audits that demonstrate some unknown number of these plans put their enrollees at risk year after year. By failing to take sufficient action to ensure MA plan contract compliance and sanction plans appropriately when they violate their contracts, CMS has failed to deter MA plans from violating the terms of their contracts moving forward.

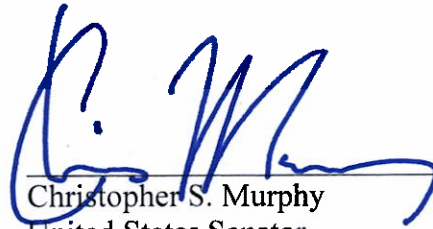
While we recognize that oversight and contract enforcement require resources and that it can be challenging to undertake this work, it is past time for CMS to engage in regular oversight and enforcement of MA plans to ensure overpaid taxpayer dollars are recouped in a timely manner and MA plans are held accountable for their deficiencies. If there are ways Congress can better support CMS as it works to address these challenges, we stand ready to help.

We look forward to receiving answers to the questions above in a timely manner. Thank you in advance for your cooperation.

Sincerely,



Sherrod Brown  
United States Senator



Christopher S. Murphy  
United States Senator



Bernard Sanders  
United States Senator



Richard Blumenthal  
United States Senator



Amy Klobuchar  
United States Senator



Debbie Stabenow  
United States Senator