Congress of the United States
Washington, DC 20515

June 24, 2022

President Joseph R. Biden, Jr.
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

Dear President Biden and Secretary Becerra,

We write to express concerns with the April 2022 report from the Department of Health and Human Services Office of the Inspector General (HHS OIG) entitled "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care." The report demonstrated that as many as 85,000 medical prior authorizations and 1.5 million payment requests are improperly denied by Medicare Advantage Organizations (MAOs) each year.[1] We respectfully request that you take corrective action on these findings. Specifically, we ask that your administration develop new guidance and initiatives to stop inappropriate care denials and activities by MAOs and stop the ACO REACH program which has allowed MAOs to encroach on the traditional Medicare population.

The concept of the Medicare Advantage program and prior authorization in the medical field was intended to decrease the cost of providing care while maintaining or increasing the quality of care that patients receive. Unfortunately, as the HHS OIG report states "capitated payment models, such as Medicare Advantage, can create an incentive for MAOs to deny prior authorization of services for beneficiaries, and payments to providers." Additionally, the report found that in many cases, prior authorizations were denied until beneficiaries had completed additional testing such as x-rays that HHS OIG physician reviewers deemed medically unnecessary. Not only does prior authorization deny care, it leads to superfluous tests being performed thus increasing costs.

Additionally, prior authorization imposes additional barriers and restrictions on medical care compared to traditional Medicare. The Medicare Managed Care Manual states that additional clinical criteria used by MAOs during prior authorizations are only allowed if they are "no more

[1] Grimm, Christi. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care*. U.S. Department of Health and Human Services Office of the Inspector General. April 28, 2022.

restrictive than original Medicare's national and local coverage policies."[2] However, there is perceived ambiguity by MAOs about whether their additional clinical criteria are more restrictive than original Medicare. In practice, any requirements above those in traditional Medicare decrease patient access to treatment and are thus "more restrictive" making any and all additional clinical criteria imposed by MAOs improper according to the care manual.

Despite reports of improper care denials by MAOs in this report, a 2018 HHS OIG report, and many other sources, CMS has only terminated one MA contract for failure to provide Medicare services to beneficiaries in the past four years. Other penalties have included relatively small fines and new enrollment suspension. It is concerning that MAOs are allowed to continue to administer care to seniors after demonstrated delays or refusals to cover medically-necessary care. When medical professionals display the same type of medical negligence and failure to provide the adequate standard of care, their medical licenses are suspended, surrendered, or revoked, therefore, stopping them from continuing to harm patients. [3,4] The organizations administering care must be held to the same standard as medical professionals providing that care. Medical negligence by MAOs is dangerous and deadly and must be stopped.

Bad faith actions from MAOs extend beyond the findings of improper care denials outlined in the report. Along with other members of Congress, we wrote in a public comment on the CMS 2023 Medicare Advantage Rate Notice that it is well documented that MAOs depict their beneficiaries as sicker than they truly are in order to increase the payments they receive from the Federal Government.[5] This upcharging by MAOs is estimated to cost the government and taxpayers over $50 billion per year.[6] Similar to the misconduct discussed above, CMS must quickly fix this problem by altering the risk adjustment model for MAO payments. Additionally, MAOs have increasingly undertaken predatory advertising tactics, with CMS reporting that beneficiary complaints about third-party MAO advertising continue to increase.[7]

This recent report provides solid evidence that MAOs are not acting in the best interest of seniors. However, the ACO-REACH model and its predecessor the Medicare Direct Contracting Model have allowed MAOs to begin to administer the benefits of traditional Medicare beneficiaries as well. Not only is Medicare Advantage not proven to deliver better care to beneficiaries, it is clear that MAOs provide more obstacles to care and decreased medically-necessary care than traditional Medicare. The findings of the HHS OIG further highlight the need to end the ACO-REACH model and stop MAOs and other private entities from administering traditional Medicare benefits.

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[2] CMS, *Medicare Managed Care Manual*, ch. 4, sec. 10.16.

[3] Klein, Kerry. Bakersfield doctor under third investigation for gross negligence surrenders his medical license. NPR for Central California. December 17, 2021.

[4] Nelson, Roxanne. NY Radiation Oncologist Loses License, Poses 'Potential Danger.' Medscape. February 25, 2022.

[5] *Jayapal Leads Members in Urging Secretary Becerra and Administrator Brooks-LaSure to Stop Medicare Advantage Profiteering, Redistribute Funds to Seniors.* March 24, 2022.

[6] Committee for a Responsible Federal Budget. *Reducing Medicare Advantage Overpayments.* February 23, 2021.

[7] Coleman, Kathryn. *Third Party Marketing*. Medicare Drug and Health Plan Contract Administration Group, CMS. October 8, 2021

We are glad to see that the Center for Medicare and Medicaid Services (CMS) plans to issue clarifying guidance regarding medical necessity reviews by MAOs. New guidance and initiatives are needed to stop inappropriate care denials and activities by MAOs. In order to protect the health of our seniors, the actions and guidance by CMS must be expansive enough to address and prevent all malpractice committed by MAOs. This includes:

1. **Issuing new guidance on MA prior authorization medical necessity reviews**. Guidance should clearly state that MAOs cannot impose *any* additional clinical requirements outside of those required by traditional Medicare.

2. **Increasing severity of enforcement actions on MAOs that improperly restrict patient care.** These actions should include contract termination and prohibition of new contracts to ensure bad acting MAOs do not have the opportunity to harm any additional patients.

3. **Undertaking rapid initiatives to address broader issues with MAOs including payment accuracy and predatory advertising.** The current proposed rule to tighten regulations on MAO advertising must be strengthened by drastically limiting the marketing opportunities for MAOs and action must be taken to stop overpayment to MAOs.

4. **Stopping the ACO-REACH program and prevent traditional Medicare beneficiaries from facing the same care denials plaguing MA beneficiaries.** This will prohibit MAOs from further interfering with seniors' medical care through encroachment on traditional Medicare.

Caring for our seniors is a complex but important issue. We are grateful to the HHS OIG for uncovering this concerning pattern within Medicare Advantage and urge the administration and HHS to put a stop to this abuse by MAOs. Medicare for our seniors must be treated as a care vehicle, not a business opportunity. As always, we remain ready to support you in improving Medicare and the health of seniors across the country.

Sincerely,

PRAMILA JAYAPAL
Member of Congress

ROSA L. DELAURO
Member of Congress