United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510–6400
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October 3, 2023

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

Dear Administrator Brooks-LaSure:

I write concerning recent independent watchdog reports that show health insurance companies routinely deny coverage of medically necessary care for people enrolled in Medicaid managed care organizations (MCO). This month, the Office of Inspector General for the Department of Health and Human Services (OIG) released the last in a series of four reports examining improper MCO coverage denials. Conducted in response to my request, the OIG's findings—coupled with the everyday experiences of my constituents in Pennsylvania—demonstrate more must be done so that older adults, people with disabilities, and children, all receive the care they need and deserve. Therefore, I am seeking information to ensure appropriate steps are taken to ensure MCOs are not putting their bottom line ahead of the interests of patients seeking care.

Operated by insurance companies, MCOs administer Medicaid benefits on behalf of states in exchange for fixed fees known as "capitated payments" that are based on the number of members enrolled in a given plan. Independent watchdogs have long expressed concern about the MCO model and the potential financial incentive for insurers to reduce costs by limiting payments and denying coverage.[1] In 2019, I asked OIG to examine whether patients enrolled in MCOs can successfully access the services to which they are entitled, and to review whether the Centers for Medicare & Medicaid Services (CMS) was providing sufficient oversight to ensure enrollees receive the care they deserve.[2] MCOs' footprint has grown tremendously to become what CMS recently described as the "dominant delivery system" for Medicaid, providing full or partial health coverage to more than 67 million Americans, which accounts for 84 percent of Medicaid enrollees.[3]

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[1] E.g., *see* Office of Inspector General for the Department of Health and Human Services (HHSOIG), *New York Did Not Ensure That a Managed Care Organization Complied with Requirements for Denying Prior Authorization Requests*, A-02-21-01016 (September 2023), at 2, *available at* https://oig.hhs.gov/oas/reports/region2/22101016.pdf [hereinafter *New York Audit*]. In 1995, GAO testified that "[b]eneficiary protections are essential because of the financial incentive to underserve inherent in managed care plans that are paid, and are themselves paying providers, on a per capita rather than on a per service basis." GAO noted that private sector employers "have recognized the importance of adequate oversight and are demanding strong quality assurance systems." Government Accounting Office (GAO), *State Flexibility in Implementing Managed Care Programs Requires Appropriate Oversight (Statement of William J. Scanlon before the Senate Finance Committee)*, GAO/T-HEM-95-206 (July 12, 1995), at 5, *available at* https://www.gao.gov/assets/t-hehs-95-206.pdf.

[2] Letter from Senator Bob Casey to The Honorable Daniel R. Levinson, April 5, 2019, *available at* https://www.aging.senate.gov/imo/media/doc/04.05.2019%20RPC%20Letter%20to%20HHS%20OIG%20re.%20Medicaid%20Managed%20Care%20Final%20OCR.pdf.

Following my request, OIG conducted a national evaluation of Medicaid MCOs that it published in July. OIG's review examined 115 plans, each with at least 10,000 enrollees, that were spread across 37 states and operated by seven companies.[4] OIG found that the MCOs it evaluated denied 12.5 percent of requests for prior authorization during the report's 12-month review period in 2019.[5] Denial rates varied from state to state, company to company, and plan to plan. For example, OIG found that one insurer operating plans in 13 states had denial rates ranging from 5 percent to 29 percent, and that denial rates for various MCOs in California ranged from 7 percent to 29 percent.[6] OIG also found that 2.7 million people were enrolled in MCOs that denied 25 percent or more of claims.[7] One Illinois plan denied 41 percent of claims, while two other plans —in Georgia, and Texas—denied one-third of claims, according to the OIG report.[8]

OIG wrote that it was "unclear why some MCOs had rates of prior authorization denials that were so much higher than their peers,"[9] but it is abundantly clear that improper coverage denials can negatively affect patients. The denied care included drug therapy, health screening services for children, and inpatient hospital services, according to OIG's report.[10] In one instance, OIG detailed how an MCO denied in-home skilled nursing care requested for a pediatric patient diagnosed with cystic fibrosis, Down syndrome, and a series of other medical conditions that required gastrostomy tube feeding and enzyme therapy several times a day.[11] In another instance, OIG found that an MCO denied covering the replacement of a broken stairlift for a partially paralyzed 77-year-old enrollee, before overturning its decision more than six weeks later when the denial was appealed.[12] OIG identified several issues contributing to improper denials, including "MCOs allowing inappropriate staff or inadequately trained staff to make decisions about whether to approve prior authorization requests, using incorrect criteria to determine whether to approve requests, and failure to request additional information before issuing decisions."[13] OIG raised further concern that improper denials disproportionately affect communities of color and low-income communities.[14]

While the OIG's data suggest that Pennsylvania's MCOs have comparatively low denial rates compared to other states, Pennsylvanians enrolled in MCOs nonetheless experience difficulties

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[3] Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care Enrollment and Program Characteristics, 2020*, (Spring 2022), https://www.medicaid.gov/sites/default/files/2022-06/2020-medicaid-managed-care-enrollment-report.pdf, see Table 4, at 24. By comparison, MCOs covered 11.6 million, or 32 percent, of Medicaid enrollees in 1995. *See* GAO, *States' Efforts to Educate and Enroll Beneficiaries in Managed Care*, GAO/HEHS-96-184 (September 1996), at 1, *available at* https://www.gao.gov/assets/hehs-96-184.pdf.

[4] HHSOIG, *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*, OEI-09-19-00350 (July 2023), at 4-5, *available at* https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf [hereinafter *MCO Program Evaluation*].

[5] *Id.*, at 7.

[6] *Id.*, at 8 (Ex. 3); *see also* Appendix B.

[7] *Id.*, at 8 (Ex. 3); *see also* Appendix B.

[8] *Id.*, *see* Appendix B.

[9] *Id.*, at 7.

[10] *Id.*, at 9.

[11] HHSOIG, *Keystone First Should Improve Its Procedures For Reviewing Service Requests That Require Prior Authorization*, A-03-20-00201 (December 2022), at 7, *available at* https://oig.hhs.gov/oas/reports/region3/32000201.pdf, [hereinafter *Pennsylvania Audit*].

[12] *Supra*, note 1, New York Audit, at 9-10.

[13] *Supra*, note 4, MCO Program Evaluation, at 10.

[14] *Id.*, at 17.

with improper denials. For example, one Philadelphia resident who relies on in-home care to bathe, use the toilet, and go to medical appointments, reported that the stress of fighting their MCO over cuts to covered care in-home care exacerbates their existing physical illnesses.[15] Providers and patient advocates in Pennsylvania cited multiple examples of patients whose health was put at risk when time-sensitive care was delayed by denials that can take weeks, months, and even years, to appeal.

One attorney who frequently represents Medicaid enrollees on behalf of the Pennsylvania Health Law Project (PHLP), a legal aid organization that represents clients across the Commonwealth, observed that clients with declining health often experience "fear or reluctance … to ask for additional services," due to concern that doing so will limit their existing access to services.[16] In a recent letter to Pennsylvania's Medicaid agency, PHLP shared data showing multiple examples of people receiving at-home medical care whose service hours were cut when they sought additional care coverage. PHLP's data also showed MCOs cut in-home personal assistance services that had been previously approved, absent any demonstrable improvement in patients' health status.[17] PHLP cited 43 patients covered by a single MCO whose personal assistance hours were cut by 25 percent or more over a five-month period, more than half of whom had assistance hours cut by at least 50 percent.[18] One northeastern Pennsylvania resident had their care hours cut from 70 to 35 hours a week despite having had three heart attacks, while still recovering from a car accident.[19] The patient had several other serious health conditions including chronic pain, an unhealed ankle fracture, arthritis in his back, chronic obstructive pulmonary disease (COPD), a hematoma on the brain, nerve damage, dizziness, vision impairment, borderline diabetes, memory loss, and depression.[20]

At Temple University Hospital, where Medicaid is the payer for nearly half of its patients, medical staff raised concern about delays and denials when patients are seeking cancer diagnoses and treatment. Temple reported that MCOs initially deny about 40 percent of imaging tests for cancer patients, even though such measures are the standard of care. Roughly 80 percent of the initial denials by MCOs for imaging are overturned following first-level appeals involving nurses or second-level appeals involving physicians, strongly suggesting the tests should not have been denied in the first place. Temple also reported that more than 10 percent of chemotherapy treatments are initially denied by MCOs. According to the hospital, 85 percent of these denials are overturned following physician-to-physician consultations.

When patients are denied coverage of medically necessary services, they often face tight timelines to file actionable appeals. Assuming such appeals are filed in a timely manner, the process can be complicated and time-consuming, creating barriers that can make it difficult for Medicaid enrollees to seek recourse. In its national evaluation, OIG found that just one in nine MCO denials were appealed, even though 36 percent of those appeals were successful in the first round—indicating that the requested services were medically necessary and should not have

[15] Phone conversation with Aging Committee staff, September 11, 2023. Notes on file with the Committee.
[16] Phone conversation with Pennsylvania Health Law Project, September 9, 2023.
[17] Letter from Amy E. Lowenstein and Kyle Fisher to Jamie Buchenauer and Randy Nolen, February 17, 2023. (On file with the Committee).
[18] *Id.*
[19] *Id.*
[20] *Id.*

been initially denied.[21] Only two percent of the denials that were upheld in the first round of appeals were elevated to a second level of appeal, OIG reported.[22] Moreover, OIG cited multiple examples of MCOs missing required timelines to make coverage decisions, and raised concern about MCOs failing to provide enrollees with proper information about their right to appeal.[23] Such issues have the potential to further impede access to care for those most in need.

OIG warned that capitated payment models "can create an incentive for insurance companies to deny the authorization of services to increase profits,"[24] and its work makes clear that the issues faced by Medicaid enrollees in Pennsylvania and across our Nation must be addressed. I appreciate CMS's commitment to partner with states to strengthen the monitoring and oversight of MCOs. However, it is concerning that CMS did not provide concrete answers to OIG's recommendations aimed at addressing issues identified in its report.[25] As such, I request that you respond to the following questions no later than November 16, 2023:

1. CMS uses robust oversight tools to evaluate Medicare Advantage coverage denials but does not require states to conduct similar oversight of MCOs, which have higher denial rates.[26] Of the 37 states it reviewed, OIG found that 22 did not conduct regular appropriateness reviews of MCO denials, including 13 that did not conduct such reviews at all. An additional 15 states did not analyze MCO denial data.[27] Based on these findings, OIG recommendations called on CMS to (a) require states to regularly review the appropriateness of a sample of MCO prior authorization denials; (b) require states to collect data on MCOs' prior authorization decisions; and (c) require states to implement automatic external medical reviews of upheld MCO prior authorization denials.[28] Please indicate whether CMS concurs with each of the recommendations, and the specific actions CMS plan to take to carry them out.

2. In addition to lower rates of initial denials, OIG found that Medicare Advantage plans were more likely than MCOs to overturn denials at the first stage of the appeals process.[29] OIG suggested that the difference may be due to Medicare Advantage plans having more robust appeals processes in place than MCOs, including the use of external medical reviews.[30] What steps has CMS taken to ensure that MCOs provide more robust appeals processes to Medicaid enrollees, including, but not limited to, external medical reviews?

3. An OIG audit released in December 2022 found that a Pennsylvania MCO sent denial letters that failed to inform recipients of their right to a state "fair hearing."[31] OIG determined the omission was due to the Pennsylvania Medicaid agency removing

[21] *Supra*, note 4, MCO Program Evaluation, at 14.
[22] *Id.*, at 15.
[23] *Id.*, 15-16.
[24] *Id.*, at 17.
[25] *Id.*, at 21-22; *see also*, Appendix E, Letter from Administrator Brooks-LaSure to Juliet T. Hodgkins, at 40-44.
[26] *Id.*, at 9.
[27] *Id.*, at 10-11.
[28] *Id.*, at 17-20.
[29] *Id.*, at 11-12.
[30] *Id.*, at 11-13.
[31] *Supra*, note 11, Pennsylvania Audit, at 9-10.

language that informed enrollees of this right from a notice template that MCOs are required to use.[32] OIG also identified inaccurate appeals information in denial letters sent to enrollees by an MCO operating in Iowa.[33] While the OIG's audits indicated the issues in both states had been resolved in response to its recommendations, such omissions and misstatements mean that enrollees may not have information necessary to understand their rights and options within the appeals process.[34] Has CMS taken steps to ensure that all Medicaid enrollees are receiving accurate and accessible information about their right to appeal denials?

4. States have the authority to take corrective measures and levy fines when MCOs fail to follow requirements set out by the Social Security Act and associated regulations. CMS requires Medicaid programs to report plan-level, state-specific sanctions for MCOs in Managed Care Program Annual Reports (MCPAR), including all administrative penalties, and corrective action plans, it issued.[35] Please provide data from July 1, 2021 onward that each state, territory, and the District of Columbia has reported to CMS in tab D3 of their respective MCPARs.

I appreciate your commitment to ensuring that the Medicaid program, a bedrock for tens of millions of American, remains strong and is subject to appropriate oversight. I look forward to working with you to further strengthen it to ensure patients receive the care they deserve. If you or your staff have questions, please contact Peter Gartrell, chief investigator, at 202-224-5364.

Sincerely,

Robert P. Casey, Jr.
United States Senator
Chairman, Special Committee
on Aging

[32] *Id*.

[33] HHSOIG, *Amerigroup Iowa's Prior Authorization and Appeal Processes Were Effective, But Improvements Can Be Made*, A-07-22-07007 (September 2023), *available at* https://oig.hhs.gov/oas/reports/region7/72207007.pdf, at 8-10.

[34] *Supra*, note 11, Pennsylvania Audit, at 10.

[35] "Medicaid and CHIP Managed Care Reporting," CMS, last visited October 2, 2023, https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html; *see also* 42 CFR 438.66(e)(2)(viii).