United States Senate
WASHINGTON, DC 20510

December 16, 2024

VIA ELECTRONIC TRANSMISSION

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare &Medicaid Services

Administrator Brooks-LaSure:

On July 8, 2024, the Wall Street Journal published an article titled, *Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated*, highlighting how different insurance companies have received more funds from Medicare Advantage (MA) than they should.[1] The insurance companies have accomplished this by adding diagnoses that doctors allegedly didn't actually address with their patients.[2] This behavior is further incentivized because Medicare pays insurers more for sicker patients.[3] For example, patients have reportedly been diagnosed with diabetic cataracts but the patients aren't diabetic and, for some, they've already had cataracts removed.[4] Health care fraud, waste, and abuse harms not only Medicare patients, but also the American taxpayer and must be addressed.

Additionally, on October 24, 2024, the Health and Human Services Office of Inspector General (HHS OIG), released a report entitled, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions*, which reviewed Medicare Advantage Organizations (MAOs) and their alleged unsupported diagnoses that inflated risk-adjusted payments and resulted in improper payments in the MA program.[5] The OIG report highlighted that given the lack of additional follow up on diagnoses for the 1.7 million MA enrollees examined, there are concerns that either the diagnoses are inaccurate and therefore the payments are improper or enrollees did not receive the proper care associated with these diagnoses.[6] As a result of the report, HHS OIG made three recommendations, only one of which the Center for Medicare and Medicaid Services (CMS) concurred with.[7]

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[1] Christopher Weaver, et al., *Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated*, WALL STREET JOURNAL (July 8, 2024), https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d?mod=e2fb&fbclid=IwZXh0bgNhZW0BMAABHSuEbocXln42b5WsdLTgPIFOG3ofrSS1qePfWOnUtV7IPqaG8smXzhqMqg_aem_fTLZhZjekYNUD0b0QqoVOA&utm_campaign=23862284081830105&utm_content=120211493016120106&utm_id=23862284081830105&utm_medium=paid&utm_source=fb&utm_term=120211493016430106.
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] U.S. Dep't of Health and Human Services, Office of Inspector General, *Medicare Advantage: Questionable Use of Health Risk Assessments Continues To Drive Up Payments to Plans by Billions*, OEI-03-23-00380 (Oct. 24, 2024), https://oig.hhs.gov/documents/evaluation/10028/OEI-03-23-00380.pdf.
[6] *Id.* at Report Highlights.
[7] *Id.* ("In addition to implementing prior OIG recommendations, CMS should: (1) impose additional restrictions on the use of diagnoses reported only on in-home HRAs or chart reviews that are linked to in-home HRAs for risk-adjusted payments, (2) conduct audits to validate diagnoses reported only on in-home HRAs and HRA-linked chart reviews, and (3) determine whether select health conditions that drove payments from in-home HRAs and HRA-linked chart reviews may be more susceptible to misuse among MA companies. CMS concurred with our third recommendation but not the other two.")

Risk Adjustment Data Validation (RADV) audits are intended to address instances where MAOs were paid more than what they should have received because medical diagnoses submitted were not supported by the medical record.[8] While these audits do not seek to prove that these diagnoses were added fraudulently, under the Affordable Care Act (ACA), the failure to report and return identified overpayments establishes liability under the False Claims Act (FCA).[9]

On January 30, 2023, the Medicare Advantage Risk Adjustment Data Validation Final Rule (MA RADV rule) was released.[10] However, according the Medicare Program Integrity Manual, CMS is "not adopting any specific sampling or extrapolated audit methodology, but will rely on any statistically valid method for sampling and extrapolation that is determined to be well-suited to a particular audit."[11] I am concerned that using different extrapolation methodology for each specific audit will lead to inconsistent standards. CMS's implementation of this rule must be clear to ensure that MAOs take meaningful steps to reduce improper adjusted payments moving forward.[12]

Over the past ten years, I have supported the RADV audit initiative in order to reduce improper payments associated with inaccurate Medicare Advantage diagnoses.[13] In a 2015 letter from CMS, then-Acting Administrator Slavitt stated that the "report and repay" requirement and RADV audits returned roughly $1.5 billion in overpayments from 2006-2013.[14] In a letter in I sent in 2017, it was estimated that improper payments cost approximately $70 billion between 2008 and 2013.[15] In this letter, I ask five questions regarding what steps CMS is taking in order to reduce and recover improper payments to MAOs.[16] I also seek to find out whether the issues that I have addressed in previous letters have been addressed since the final rule, including whether these audits are effective in recouping MAO overpayments. Medicare Advantage is an important option for America's seniors, but as it adds more patients and spends billions of dollars of taxpayer money, aggressive oversight is needed.

Accordingly, please answer the following questions no later than December 30, 2024:

1. What steps has CMS taken to close each open recommendation from HHS OIG's October 24, 2024, report? Provide all records.

2. How many audits has CMS already conducted under the final rule?
    a. How much taxpayer money was overpaid to plans?

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[8] *Medicare Advantage Risk Adjustment Data Validation Final Rule (CMS-4185-F2) Fact Sheet*, CNTRS. MEDICARE & MEDICAID SRVCS. (Jan. 30, 2023), https://www.cms.gov/newsroom/fact-sheets/medicare-advantage-risk-adjustment-data-validation-final-rule-cms-4185-f2-fact-sheet; Letter from Andrew M. Slavitt, Acting Administrator, Cntrs. for Medicare & Medicaid Srvcs., to Senator Charles E. Grassley, Chairman, Senate Comm. on the Judiciary (July 31, 2015), 2015-07-31 CMS to CEG (Risk Scores) (002)_0.pdf (senate.gov)
[9] Letter from Andrew M. Slavitt, *supra* note 8.
[10] Medicare Advantage Risk Adjustment Data Validation Final Rule, *supra* note 8.
[11] *Id*.
[12] *Id*.
[13] Letter from Senator Charles E. Grassley, Chairman, Senate Comm. on Finance, to Seema Verna, Administrator, Cntrs. for Medicare & Medicaid Srvcs. (Mar. 29, 2019) https://www.finance.senate.gov/imo/media/doc/03292019 Medicare Advantage Letter.pdf; Letter from Andrew M. Slavitt,, *supra* note 8; Letter from Senator Charles E. Grassley, Chairman, Senate Comm. on the Judiciary, to Seema Verna, Administrator, Cntrs. for Medicare & Medicaid Srvcs. (Apr. 17, 2017), https://www.grassley.senate.gov/imo/media/doc/2017-04-17 CEG to CMS (Risk Score Follow Up).pdf; Press Release, *Grassley Presses Federal Agencies On Scrutiny of Payments to Medicare Advantage Plans*, Off. of Senator Charles E. Grassley (May 21, 2015), https://www.grassley.senate.gov/news/news-releases/grassley-presses-federal-agencies-scrutiny-payments-medicare-advantage-plans#:~:text=WASHINGTON%20%E2%80%93%20Sen.%20Chuck%20Grassley%20is%20pressing%20the%20Justice.
[14] Letter from Andrew M. Slavitt, *supra* note 8.
[15] Letter from Senator Charles E. Grassley (Apr. 17, 2017), *supra* note 13.
[16] *Id*.

b. How much taxpayer money, if any, has CMS already recouped?
c. What, if any, issues has CMS had in obtaining audit information from companies?

3. Has CMS created an extrapolation process? If so, what is this process? If not, why has the process not been defined?

4. CMS previously stated to me in 2015 and 2017 that it spent $30 million annually to Medicare Advantage auditing. Your final rule notes the annual cost per year for the contract-level RADV audit program activities is $51 million. How much does CMS allocate annually to combatting Medicare Advantage waste, fraud, and abuse?

5. CMS has previously stated to me that its RADV audit process for each calendar year was at various stages of review and completion. Please provide a status update and expected timeline for Medicare Advantage overpayment audits from 2011 through 2022.

6. Your agency estimates in its final rule that it will collect $4.7 billion in overpayments over a 10 year period.[17] Given the agency's track record on RADV overpayment auditing and the delay of this final rule, what assurances can the agency provide that it will meet the estimates for collections in the next 10 years?

7. What steps has CMS taken to strengthen their whistleblower policies and encourage whistleblowers to come forward?

Thank you for your prompt review and responses. If you have any questions, please contact Tucker Akin on my Committee staff at (202) 224-0642.

Sincerely,

Charles E. Grassley
Ranking Member
Committee on the Budget

[17] 42 CFR Part 422 at 6663 (Feb. 1, 2023), https://www.govinfo.gov/content/pkg/FR-2023-02-01/pdf/FR-2023-02-01.pdf