

August 31, 2022

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Attention: CMS-4203-NC  
P.O. Box 8013  
Baltimore, MD 21244-8013

Submitted electronically via <https://www.regulations.gov/commenton/CMS-2022-0123-0001>

Re: Medicare Program; Request for Information on Medicare (87 F.R. 46918, published August 1, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I am submitting comments regarding CMS-4203-NC, a request for information (RFI) on Medicare Advantage (MA). NASW represents more than 110,000 social workers nationwide. Social workers play an essential role in serving Medicare beneficiaries, including those enrolled in MA. In keeping with NASW's mission to advance sound social policies, we are committed to identifying and mitigating barriers to care for Medicare beneficiaries. These barriers tend to be greater for enrollees in MA plans (also known as MA organizations, or MAOs), particularly for individuals who have serious illnesses or live with chronic conditions. We appreciate the opportunity to offer feedback to ameliorate these problems.

NASW has comments on the following topics:

- Advance Health Equity
- Expand Access: Coverage and Care
- Drive Innovation to Promote Person-Centered Care
- Support Affordability and Sustainability

Multiple entities, including federal bodies, have expressed concerns about MA. In a June 2022 Congressional hearing about MA oversight, the acting director for health care in the General Accounting Office (GAO) stated:

Due to our concerns about the program's susceptibility to mismanagement and improper payments as well as its size and complexity, we have designated Medicare, including Medicare Advantage, as a high-risk program. We—along with Department of Health and Human Services

Office of Inspector General [OIG] and others—have identified significant concerns with CMS’s oversight of the MA program.<sup>1</sup>

Representatives of the Medicare Payment Advisory Commission (MedPAC)<sup>2</sup> and OIG<sup>3</sup> also testified at the hearing, drawing on their agencies’ respective reports highlighting problems with MA practices and payment policies.<sup>4,5,6</sup> Moreover, beneficiary advocacy organizations, such as the Leadership Council of Aging Organizations<sup>7</sup> (of which NASW is a member) and the Center for Medicare Advocacy,<sup>8</sup> have repeatedly drawn attention to the MA program’s shortcomings.

The aforementioned concerns, combined with increasing enrollment in MA plans, necessitate stronger oversight and enforcement of the MA program and MA plan sponsors.

## A. Advance Health Equity

NASW shares CMS’ commitment to health equity within the Medicare program. Trends in MA enrollment indicate significant inequities. Beneficiaries with significant illness or disability tend to

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- <sup>1</sup> Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. 11 (2022) (statement of Leslie V. Gordon, Acting Dir., Health Care, Gov’t Accountability Off.). <https://www.gao.gov/products/gao-22-106026>
- <sup>2</sup> Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. (2022) (statement of James E. Matthew, Exec. Dir., Medicare Payment Advisory Comm’n). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony\\_Mathews\\_OI\\_2022.06.28\\_updated.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf)
- <sup>3</sup> Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. (2022) (statement of Erin Bliss, Ass’t Inspector Gen., Off. of Evaluation and Inspections, Off. of Inspector Gen., Dep’t of Health and Human Services). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony\\_Bliss\\_OI\\_2022.06.28\\_1.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf)
- <sup>4</sup> Medicare Payment Advisory Commission. (2022). *March 2022 report to the Congress: Medicare payment policy*. <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/>
- <sup>5</sup> Office of the Inspector General. (2021). *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments* (OEI-03-17-00474) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/OEI-03-17-00474.asp>
- <sup>6</sup> Office of the Inspector General. (2022). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp>
- <sup>7</sup> Leadership Council of Aging Organizations. (2020). *Statement of Leadership Council of Aging Organizations’ priorities for President-Elect Biden’s 2020 transition*. <https://www.lcao.org/wp-content/uploads/2020/12/lcao-transition-priorities.pdf>
- <sup>8</sup> See, for example:  
 Lipschutz, D. (2022). *(Most) policymakers fail to act on Medicare Advantage oversight and overpayment*. Center for Medicare Advocacy. <https://medicareadvocacy.org/most-policymakers-fail-to-act-on-medicare-advantage-oversight-and-overpayment/>  
 Moon, M. (2022). *Medicare Advantage is not the solution to Medicare equity or solvency problems*. Center for Medicare Advocacy. <https://medicareadvocacy.org/medicare-advantage-is-not-the-solution-to-medicare-equity-or-solvency-problems/>  
 Stein, J., & Lipschutz, D. (2020). *Transition memorandum for Biden Administration Department of Health & Human Services (HHS)*. Center for Medicare Advocacy. <https://medicareadvocacy.org/transition-memo-2020/#MA>

disenroll from MA plans at a disproportionately higher rate than do other MA enrollees.<sup>9,10,11,12</sup> Even higher rates of disenrollment occur within the last year of life, which “may indicate potential issues with beneficiary access to care or with the quality of care provided.”<sup>13</sup> Moreover, racial and ethnic disparities<sup>14,15</sup> persist in Medicare Advantage plans, as do gender disparities.<sup>16</sup>

Consequently, NASW urges CMS to enhance oversight of MA plans to ensure they provide required, medically necessary care. Enforcing current law with respect to individuals with chronic conditions requires two actions: (1) ensuring fair, appropriate, nondiscriminatory coverage of home health in both MA and original Medicare<sup>17</sup> and (2) adequately enforcing the *Jimmo v. Sebelius* settlement<sup>18,19</sup> to ensure that Medicare coverage is determined by a beneficiary’s need for skilled care, not by the individual’s potential for improvement.

To promote equity within the MA program, NASW encourages CMS to enhance oversight in the following ways:

- Increase staff and resource capacity to audit plans annually for compliance with Medicare coverage and appeals rules, including reviewing all plan bids and conducting discriminatory impact reviews.

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<sup>9</sup> Ankuda, C. K., Ornstein, K. A., Covinsky, K. E., Bollens-Lund, E., Meier, D. E., & Kelley, A. S. (2020). Switching between Medicare Advantage and traditional Medicare before and after the onset of functional disability. *Health Affairs*, 39, 809–818. <https://doi.org/10.1377/hlthaff.2019.01070>

<sup>10</sup> Markovitz, A. A., Ayanian, J. Z., Warriar, A., & Ryan, A. M. (2021). Medicare Advantage plan double bonuses drive racial disparity in payments, yield no quality or enrollment improvements. *Health Affairs*, 40, 1411–1419. <https://doi.org/10.1377/hlthaff.2021.00349>

<sup>11</sup> Neuman, P., & Jacobson, G. A. (2018). Medicare Advantage checkup. *New England Journal of Medicine*, 379, 2163–2172. <https://doi.org/10.1056/NEJMhpr1804089>

<sup>12</sup> Meyers, D. J., Belanger, E., Joyce, N., McHugh, J., Rahman, M., & Mor, V. (2019). Analysis of drivers of disenrollment and plan switching among Medicare Advantage beneficiaries. *JAMA Internal Medicine*, 179, 524–532. <https://doi.org/10.1001/jamainternmed.2018.7639>

<sup>13</sup> U.S. Government Accountability Office. (2021). *Medicare Advantage: Beneficiary disenrollments to fee-for-service in last year of life increase Medicare spending* (GAO-21-482). <https://www.gao.gov/products/gao-21-482> [Quote from p. 2]

<sup>14</sup> CMS Office of Minority Health (with RAND Corporation). (2021). *Racial, ethnic, & gender disparities in health care in Medicare Advantage*. <https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf>

<sup>15</sup> Fuglesten Biniek, J., Cubanski, J., & Neuman, T. (2021). Higher and faster growing spending per Medicare Advantage enrollee adds to Medicare’s solvency and affordability challenges. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicare-solvency-and-affordability-challenges/>

<sup>16</sup> CMS Office of Minority Health (with RAND Corporation). (2021). *Racial, ethnic, & gender disparities in health care in Medicare Advantage*. <https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf>

<sup>17</sup> Center for Medicare Advocacy. (2021). *Center For Medicare Advocacy home health survey: Medicare beneficiaries likely misinformed and underserved* [Special report]. <https://medicareadvocacy.org/wp-content/uploads/2021/12/CMA-Survey-Medicare-Home-Health-Underservice.pdf>

<sup>18</sup> Centers for Medicare & Medicaid Services. (2021). *Jimmo settlement*. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center>

<sup>19</sup> Center for Medicare Advocacy. (2022). *Jimmo update: CMS reminds providers and contractors of Medicare coverage to maintain or slow decline*. <https://medicareadvocacy.org/jimmo-update-cms-reminds-providers-and-contractors-of-medicare-coverage-to-maintain-or-slow-decline/>

- Expand analysis of MA disenrollment patterns beyond the last year of life to monitor disproportionate disenrollment by beneficiaries in poorer health; create and implement consequences for plan sponsors, such as carrying greater weight in quality assessments and corresponding bonus payments and public disclosing findings and sanctions for plans that are outliers.
- Collect data from MA plans about all special enrollment periods (SEPs) that are exercised—including those SEPs granted solely at plans’ discretion—and factor those data into audits and quality ratings. These actions would provide important information about beneficiaries who disenroll from MA plans.

## **B. Expand Access: Coverage and Care**

### *Choosing Medicare Options*

As noted in a Commonwealth Fund blog (2022) addressing MA plans and choice, health economists and Medicare experts have observed that “choosing among plans can be difficult, even for the savviest consumers,” agreeing that “most beneficiaries aren’t making informed or active decisions. Instead, many choose plans based on advertising, word-of-mouth, or brand loyalty, then stay with those plans year after year, even if another plan would better serve their interests.”<sup>20</sup>

When deciding how they want to access Medicare coverage, beneficiaries face a myriad of choices among unequal options. These choices are complicated by disparate enrollment rights and opportunities between MA and Medigap plans; for example, although people can enroll in and disenroll from an MA plan on an annual basis, most people have limited opportunities to purchase a Medigap plan. Most people do not compare MA plans;<sup>21</sup> those who do try to compare plans face barriers to informed decision making, such as flawed star ratings (which we discuss subsequently). Another barrier is the increased complexity in MA benefits resulting from recent policy changes that allow plans to target supplemental benefits to some, but not all, enrollees. Additional information

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<sup>20</sup> Hostetter, M., & Klein, S. (2022, March 3). *Taking stock of Medicare Advantage: Choice* [Blog]. Commonwealth Fund. <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice> [Quotes from paras. 2 & 4]

<sup>21</sup> Koma, W., Freed, M., Cubanski, J., & Neuman, T. (2021). *Seven in ten Medicare beneficiaries did not compare plans during past open enrollment period* [Issue brief]. Kaiser Family Foundation. [https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/?utm\\_campaign=KFF-2021-Medicare&utm\\_medium=email&hsmi=2&hsenc=p2ANqtz-82mijV6Zi5irMbwZs3q0kCrSzpqV7SlKq\\_NIRzO1i-6YBZNV637DTnnK-TetdTSIfDkWYm6S1LeNljt1-YnlcrsfQfcA&utm\\_content=2&utm\\_source=hs\\_email](https://www.kff.org/medicare/issue-brief/seven-in-ten-medicare-beneficiaries-did-not-compare-plans-during-past-open-enrollment-period/?utm_campaign=KFF-2021-Medicare&utm_medium=email&hsmi=2&hsenc=p2ANqtz-82mijV6Zi5irMbwZs3q0kCrSzpqV7SlKq_NIRzO1i-6YBZNV637DTnnK-TetdTSIfDkWYm6S1LeNljt1-YnlcrsfQfcA&utm_content=2&utm_source=hs_email)

regarding the limitations on choice in MA can be found in the previously cited Commonwealth Fund blog<sup>22</sup> and several articles by the Center for Medicare Advocacy.<sup>23,24,25</sup>

Given the preceding considerations, NASW recommends that CMS take the following steps to promote informed and unbiased decision making among Medicare beneficiaries:

- Provide balanced and neutral information about both the advantages and disadvantages of MA plans in the *Medicare & You* handbook, which is a primary source of information about coverage options. Although the 2022 edition signified an improvement in this regard, additional clarifications (such as regarding prior authorization requirements and out-of-pocket costs) are needed.<sup>26</sup>
- Promote, in a more active manner, increased funding and capacity for the 1-800-MEDICARE, State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP).
- Urge Congress to expand federal Medigap guarantee issue rights to make Medicare coverage options between MA and original Medicare more equal.
- Overhaul MA star ratings to strengthen public reporting on plan quality and variation, thereby enhancing the value of the tool to consumers.
- Strengthen consumer protections in regard to plan marketing, including enhancing oversight of plan advertising and addressing agent and broker compensation issues.

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<sup>22</sup> Hostetter, M., & Klein, S. (2022, March 3). *Taking stock of Medicare Advantage: Choice* [Blog]. Commonwealth Fund. <https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-choice> [Quotes from paras. 2 & 4]

<sup>23</sup> Center for Medicare Advocacy. (2021). *Medicare and the dilemma of “choice.”* <https://medicareadvocacy.org/medicare-and-the-dilemma-of-choice/>

<sup>24</sup> Lipschutz, D. (2020a). *Medicare’s annual enrollment season enters final weeks: Few people compare options, and the means of comparison are often flawed.* Center for Medicare Advocacy. <https://medicareadvocacy.org/medicares-annual-enrollment-season-enters-final-weeks-few-people-compare-options-and-the-means-of-comparison-are-often-flawed/>

<sup>25</sup> Lipschutz, D. (2020b). *The myth of “choice” in private insurance, including Medicare Advantage.* Center for Medicare Advocacy. <https://medicareadvocacy.org/the-myth-of-choice-in-private-insurance-including-medicare-advantage/>

<sup>26</sup> Center for Medicare Advocacy. (2021). *Medicare & You 2022 – An important first step towards reversing bias in favor of Medicare Advantage* [Special report]. <https://medicareadvocacy.org/wp-content/uploads/2021/09/Medicare-You-2022.pdf?emci=144750ab-161a-ec11-981f-501ac57ba3ed&emdi=ea000000-0000-0000-0000-000000000001&ceid=%7b%7bContactsEmailID%7d%7d>

### *MA Marketing*

A 2021 Commonwealth Fund report found that “much of the information available to beneficiaries shopping for Medicare Advantage, Medicare Supplement (Medigap), or Part D plans comes from agents (brokers) or health insurers.”<sup>27</sup> MA plan payment rates, agent and broker compensation structures, and ubiquitous MA plan advertising have created a marketplace that favors MA enrollment over other Medicare options. For example, a Commonwealth Fund blog analyzing agent commissions for Medicare products stated, “Differing commission rates could force agents to choose between their earning potential and helping beneficiaries choose coverage that meets their needs.”<sup>28</sup>

In the preamble to CMS’ proposed MA and Medicare prescription drug plans rule for contract year 2023, the agency stated that it “has seen an increase in beneficiary complaints associated with and has received feedback from beneficiary advocates and stakeholders concerned about the marketing practices of third-party marketing organizations (TPMOs) who sell multiple MA and Part D products”; moreover, CMS noted that a review of sales calls showed significant beneficiary confusion, to the degree that “the beneficiary may be unaware that they are enrolling into a new plan during these phone conversations.”<sup>29</sup>

NASW urges CMS to address MA marketing problems using multiple strategies:

- Enhance consumer protections regarding plan marketing by strengthening disclosures required by TPMOs, including mandatory references to SHIP.
- Rescind changes made in 2019 to the Medicare Communications & Marketing Guidelines that blurred the lines between marketing and educational events provided by those selling MA and Part D products.
- Tighten oversight of MA plans and their downstream marketing and sales entities, including a clear administrative process for complaints; that process should involve coordination with state regulators and the National Association of Insurance Commissioners.

Furthermore, NASW recommends that CMS increase oversight of agents and brokers in the following ways:

- Overhaul agent/broker compensation to counteract the significant pecuniary advantage in selling MA plans compared to products in original Medicare. For example, CMS set the maximum national commission for initial enrollment in MA plans in 2022 at \$573 per beneficiary in most parts of the country, whereas the maximum national commission for first-

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<sup>27</sup> Ali, R., Cicchiello, A., Hanger, M., Hellow, L., Williams, K., & Jacobson, G. (2021). *How agents influence Medicare beneficiaries’ plan choices* [Report]. Commonwealth Fund.

<https://www.commonwealthfund.org/publications/fund-reports/2021/apr/how-agents-influence-medicare-beneficiaries-plan-choices> [Quote from para. 1]

<sup>28</sup> Ali, R., & Hellow, L. (2021, October 12). *Agent commissions in Medicare and the impact on beneficiary choice* [Blog].

<https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice> [Quote from Toplines]

<sup>29</sup> Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs, 87 F.R. 1842 (proposed Jan. 12, 2022) (to be codified at 42 C.F.R. pts. 422 & 423). [Quotes from pp. 1844–1845 & 1900–1901]

time Part D plan enrollment (for those in original Medicare), is only \$87; similarly, whereas MA commissions are increasing, commissions for Medigap plans are decreasing).<sup>30</sup>

- Impose stronger standards for enforcement and discipline relating to the sale of Medicare products. Such standards should include more transparency surrounding how complaints against agents, brokers, and TPMOs are received and processed, the nature of the enforcement process, and the actions taken by CMS and MA plans in response to each complaint.
- Explore requiring signed attestations that whichever product is sold by an MA or Part D agent and broker is appropriate for that beneficiary; such attestation is currently required for the sale of a Medigap plan.

Finally, more active promotion of increased funding for SHIP, SMP, and 1-800-MEDICARE would enhance program capacity, thereby helping beneficiaries understand MA marketing materials.

### *Network Adequacy*

A 2015 GAO report on MA network adequacy yielded several findings: (1) “the MA criteria do not reflect aspects of provider availability, such as how often a provider practices at a given location”; (2) “CMS does little to assess the accuracy of the network data in applications MAOs submit”; (3) “for established provider networks, CMS does not require MAOs to routinely submit updated network information for review” and “does not measure ongoing MAO networks against its current MA criteria”; and (4) “while CMS requires that MAOs give enrollees advance notice when a provider contract is terminated, the agency has not established information requirements for those notices and does not review sample notices sent to enrollees.”<sup>31</sup> Seven years later, GAO stated that its recommendations to address these issues “had not yet been fully implemented.”<sup>32</sup>

Moreover, in a June 2020 final rule, CMS weakened MA network adequacy requirements in three ways:

- reducing the percentage of beneficiaries who must reside within the maximum time and distance standards in nonurban counties from 90 percent to 85 percent
- allowing MA plans to receive a 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards when they contract with telehealth providers in certain specialty types
- providing to MAOs an additional 10-percentage point credit towards the percentage of beneficiaries residing within published time and distance standards for affected provider and facility types in states that have certificate of need laws or other state imposed anticompetitive restrictions<sup>33</sup>

<sup>30</sup> Ali, R., & Hellow, L. (2021, October 12). *Agent commissions in Medicare and the impact on beneficiary choice* [Blog]. <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>

<sup>31</sup> U.S. Government Accountability Office. (2015). *Medicare Advantage: Actions needed to enhance CMS oversight of provider network adequacy* (GAO-15-710). <https://www.gao.gov/products/gao-15-710> [Quotes from p. 1]

<sup>32</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. 11 (2022)* (statement of Leslie V. Gordon, Acting Dir., Health Care, Gov't Accountability Off). <https://www.gao.gov/products/gao-22-106026> [Quote from p. 7]

<sup>33</sup> Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 85 F.R. 33796 (finalized June 2, 2020) (to be codified at 42 C.F.R. pts. 417, 422, & 423).

NASW recommends robust action by CMS to ensure that MA networks are, indeed, adequate:

- Fully implement GAO’s 2015 recommendations that CMS “augment oversight of MA networks to address provider availability, verify provider information submitted by MAOs, conduct more periodic reviews of MAO network information, and set minimum information requirements for MAO enrollee notification letters.”<sup>34</sup>
- Rescind the June 2020 network adequacy changes and strengthen MA’s network adequacy requirements. If a plan does not have enough providers to serve enrollees in a given geographic area, then CMS should not permit the plan to operate in that area.
- Strengthen protections for beneficiaries in regard to midyear provider network terminations by (a) prohibiting MA plans from terminating providers midyear without cause and (b) strengthening SEP options, which are currently limited to “significant” network terminations.
- Require that Long-Term Care Hospitals be included among mandatory facility specialty types in a plan network; include essential community providers among the types of providers, similar to the requirements for qualified health plans under the Affordable Care Act.<sup>35</sup>
- Adequately enforce requirements concerning plan provider directories, which GAO has stated “have been shown to be inaccurate in a number of government and private studies.”<sup>36</sup> Such inaccuracy presents significant challenges for enrollees; improvements will be even more critical as CMS plans to make provider directories available through the Medicare Plan Finder (MPF) in the coming years.

#### *Prior Authorization*

The Kaiser Family Foundation recently reported that almost all MA enrollees are in plans that require prior authorization for some services, “most often required for relatively expensive services.”<sup>37</sup> Furthermore, a 2018 OIG report found “widespread and persistent problems related to denials of care and payment in Medicare Advantage plans”; the same report highlighted that when beneficiaries and providers appealed preauthorization and payment denials, MA plans overturned three-quarters of their own denials, but “beneficiaries and providers appealed only 1 percent of denials to the first level of appeal.”<sup>38</sup> A subsequent OIG report found that among the prior authorization requests denied by MA plans, 13 percent met Medicare coverage rules—“in other words, these services likely would have been approved for these beneficiaries under original Medicare.”<sup>39</sup>

<sup>34</sup> U.S. Government Accountability Office. (2015). *Medicare Advantage: Actions needed to enhance CMS oversight of provider network adequacy* (GAO-15-710). <https://www.gao.gov/products/gao-15-710> [Quote from p. 1]

<sup>35</sup> See, for example, 45 C.F.R. § 156.230(a)(2).

<sup>36</sup> U.S. Government Accountability Office. (2015). *Medicare Advantage: Actions needed to enhance CMS oversight of provider network adequacy* (GAO-15-710). <https://www.gao.gov/products/gao-15-710> [Quote from p. 1]

<sup>37</sup> Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2021). *Medicare Advantage in 2021: Premiums, cost sharing, out-of-pocket limits and supplemental benefits*. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/>

<sup>38</sup> Office of the Inspector General. (2018). *Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials* (OEI-09-16-00410) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp> [Quotes from pp. 11 & 7, respectively]

<sup>39</sup> Office of the Inspector General. (2022). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp> [Quote from p. 9]

NASW recommends that CMS implement multiple actions to ensure that MA enrollees have access to medically necessary care:

- Enforce current law and enhance oversight of MA plans, as noted in our preceding comments regarding health equity (section A).
- Ensure that CMS-created materials (such as *Medicare & You* and MPF) and all MA plan materials fully explain prior authorization, including its widespread use and the limitations it imposes on access to services.
- Revise regulations, manual provisions, and other CMS guidance to require MA plans to provide both providers and enrollees with the Medicare criteria upon which coverage denials and terminations are made, along with relevant citations, thereby eliminating MAOs' widespread use of the term "proprietary" as a rationale.

To protect beneficiaries and providers from inappropriate denials from MAOs, NASW also urges CMS to implement recommendations from the OIG's 2018<sup>40</sup> and 2022<sup>41</sup> reports and from the OIG's June 2022 Congressional testimony,<sup>42</sup> such as those listed below:

- Enhance its oversight of MA contracts, including those with extremely high overturn rates and/or low appeal rates, and take corrective action as appropriate.
- Provide beneficiaries with clear, easily accessible information about serious violations by MAOs.
- Issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews to ensure the use of appropriate coverage criteria, in accordance with Medicare law.
- Incorporate the issues identified by OIG in their evaluation into CMS' audits of MA plans.
- Direct MA plans to take additional steps to identify and address vulnerabilities that can lead to manual review errors and system errors.
- Direct MA plans to abide by and implement the *Jimmo v. Sebelius* settlement.

### C. Drive Innovation to Promote Person-Centered Care

#### *MA Star Ratings*

A June 2022 briefing memorandum for a Congressional hearing concerning MA oversight provided the following summary of issues relating to the MA star ratings and quality bonus program:

The quality bonus program with its star rating system is intended to be a source of information about the quality of MA plans for beneficiaries. However, MedPAC has found that the program, which cost \$6 billion in 2019 and is projected to cost \$94 billion over 10 years, is flawed.

<sup>40</sup> Office of the Inspector General. (2018). *Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials* (OEI-09-16-00410) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp> [Quotes from pp. 11 & 7, respectively]

<sup>41</sup> Office of the Inspector General. (2022). *Some Medicare Advantage organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care* (OEI-09-18-00260) [Report in brief]. U.S. Department of Health and Human Services. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp> [Quote from p. 9]

<sup>42</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong.* (2022) (statement of Erin Bliss, Ass't Inspector Gen., Off. of Evaluation and Inspections, Off. of Inspector Gen., Dep't of Health and Human Services). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony\\_Bliss\\_OI\\_2022.06.28\\_1.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf)

MedPAC found that the way that measures are examined and reported are not particularly useful as an indicator of quality of care provided in a beneficiary’s local area. Additional studies also suggest that the MA quality bonus program has not improved plan quality.<sup>43</sup>

Nine of 10 MA enrollees are currently in plans with ratings of 4 or 5 stars<sup>44</sup>—that is, plans that qualify for bonus payments from CMS. This homogeneity renders the MA star rating system extremely limited as a consumer comparison tool. Additionally, the removal of audit violations from star ratings has diminished the ability of consumers to measure plan performance.<sup>45</sup> Furthermore, MedPAC has documented the “continuing erosion of the reliability of data on the quality of MA plans,” declaring that “the current state of quality reporting is such that the Commission’s yearly updates can no longer provide an accurate description of the quality of care in MA.”<sup>46</sup>

NASW recommends that CMS overhaul or replace the star ratings system and corresponding bonus payments by implementing the following actions:

- Follow MedPAC’s recommendations for replacing the current program with an MA value incentive program.<sup>47</sup>
- Eliminate double bonuses—which, by some measures, drive racial disparity in payments.<sup>48</sup>
- Account for coverage denials that are overturned on appeal.
- Implement the following OIG suggestion:  
 CMS could also revisit policy options for adjusting Star Ratings in response to audits and enforcement actions, such as adding a new Star Ratings measure that takes enforcement actions into account, or by directly adjusting an MAO’s overall and summary Star Ratings in response to enforcement actions.<sup>49</sup>

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<sup>43</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce*, 117th Cong. (2022) (briefing memo from H. Comm. on Energy and Commerce Staff to Subcomm. on Oversight and Investigations Members and Staff).  
[https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Briefing%20Memo%20Hearing\\_2022.06.28\\_0.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Briefing%20Memo%20Hearing_2022.06.28_0.pdf) [Quote from p. 7]

<sup>44</sup> Herman, B. (2021, October 11). *The Lake Wobegon effect in Medicare Advantage*. Axios.  
<https://www.axios.com/2021/10/11/medicare-advantage-star-ratings-2022>

<sup>45</sup> Office of the Inspector General. (2018). *Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials* (OEI-09-16-00410) [Report in brief]. U.S. Department of Health and Human Services.  
<https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp> [Quotes from pp. 11 & 7, respectively]

<sup>46</sup> Medicare Payment Advisory Commission. (2021). *March 2021 report to the Congress: Medicare payment policy*.  
<https://www.medpac.gov/document/march-2021-report-to-the-congress-medicare-payment-policy/> [Quotes from p. 385]

<sup>47</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce*, 117th Cong. (2022) (statement of James E. Mathews, Exec. Dir., Medicare Payment Advisory Comm’n).  
[https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony\\_Mathews\\_OI\\_2022.06.28\\_updated.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf)

<sup>48</sup> Markovitz, A. A., Ayanian, J. Z., Warrior, A., & Ryan, A. M. (2021). Medicare Advantage plan double bonuses drive racial disparity in payments, yield no quality or enrollment improvements. *Health Affairs*, 40, 1411–1419.  
<https://doi.org/10.1377/hlthaff.2021.00349>

<sup>49</sup> Office of the Inspector General. (2018). *Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials* (OEI-09-16-00410) [Report in brief]. U.S. Department of Health and Human Services.  
<https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp> [Quote from p. 18]

*Employer Group Waiver Plans (EGWPs)*

Employers and unions that offer retirement health benefits are increasingly contracting with private insurance carriers to provide group MA benefits instead of traditional retiree health benefits while providing few or no other options provided to retirees.<sup>50</sup> NASW urges CMS to enhance oversight of such plans, including reviews of how employers and unions handle EGWP enrollment. Oversight of allowable waivers (including more lax network adequacy requirements and plan customization of enrollee materials) for EGWPs are also important. Moreover, NASW encourages CMS both to monitor the practical ability of retirees to choose original Medicare and to ensure that this option is available to all retirees.

**D. Support Affordability and Sustainability**

Consistent, growing evidence demonstrates that the MA program is paid more than original Medicare would spend on the same beneficiary and that such spending is growing per person, with significant implications for Medicare programmatic spending. For example, a 2022 MedPAC report found that Medicare spends 4 percent more on MA than it would spend on traditional Medicare (an estimated \$12 billion in excess payments this year alone) and that “private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.”<sup>51</sup> MedPAC also observes that “continu[ing] to overpay MA plans ... will further worsen Medicare’s fiscal sustainability.”

These overpayments can be attributed, in part, to quality bonus payments based on a flawed MA star ratings system, as noted previously. MAOs’ manipulation of a risk-adjusted payment system also drives overpayment. Although NASW recognizes that CMS doesn’t have full authority over MA payment rates and formulas, we urge CMS to use the tools at its disposal to rein in excessive MA payment. A primary tool is CMS’s discretion to increase the statutory minimum coding intensity adjustment, meant to adjust for differences in patterns of coding between MA and original Medicare. As OIG noted in its recent testimony before Congress, CMS, GAO, MedPAC, and OIG have all raised concerns about the current risk-adjusted payment system.<sup>52</sup> One such concern is the use of health risk assessments (HRAs) and chart reviews to submit more diagnoses to increase payment rather than to improve care for plan enrollees.

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<sup>50</sup> Krupa, E. (2021). *Retiree auto enrollment in Medicare Advantage plans – Choice is under threat* [Issue brief]. Center for Medicare Advocacy. <https://medicareadvocacy.org/wp-content/uploads/2021/10/Issue-Brief-MA-Auto-Enrollment.pdf?emci=4f2a4714-2622-ed11-bd6e-281878b83d8a&emdi=2e3fe7b4-3722-ed11-bd6e-281878b83d8a&ceid=4160012>

<sup>51</sup> Medicare Payment Advisory Commission. (2022). *March 2022 report to the Congress: Medicare payment policy*. <https://www.medpac.gov/document/march-2022-report-to-the-congress-medicare-payment-policy/> [Quotes from pp. 411 & 417]

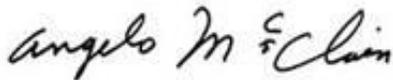
<sup>52</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong.* (2022) (statement of Erin Bliss, Ass’t Inspector Gen., Off. of Evaluation and Inspections, Off. of Inspector Gen., Dep’t of Health and Human Services). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony\\_Bliss\\_OI\\_2022.06.28\\_1.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf)

Consequently, NASW encourages CMS to take the following steps to promote payment parity between MA and original Medicare—that is, to ensure that MA plans are paid no more per enrollee than is spent on average for beneficiaries enrolled in original Medicare:

- Implement GAO’s 2022 recommendations regarding the validity of encounter data, audits, and recovery of improper payments to MA plans.<sup>53</sup>
- Implement OIG’s 2022 recommendations regarding chart reviews and HRAs.<sup>54</sup>
- Implement MedPAC’s 2022 recommendations regarding coding pattern adjustment, HRAs, and encounter data.<sup>55</sup>

Thank you for your consideration of NASW’s comments. We believe the actions we have recommended will not only ensure adequate consumer protections for MA enrollees but will also achieve greater parity between MA and original Medicare. Please contact me at [naswceo@socialworkers.org](mailto:naswceo@socialworkers.org) if you need additional information.

Sincerely,



Angelo McClain, PhD, LICSW  
Chief Executive Officer

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<sup>53</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. 11 (2022)* (statement of Leslie V. Gordon, Acting Dir., Health Care, Gov’t Accountability Off). <https://www.gao.gov/products/gao-22-106026> [Quote from p. 7]

<sup>54</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. (2022)* (statement of Erin Bliss, Ass’t Inspector Gen., Off. of Evaluation and Inspections, Off. of Inspector Gen., Dep’t of Health and Human Services). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony Bliss\\_OI\\_2022.06.28\\_1.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony%20Bliss_OI_2022.06.28_1.pdf)

<sup>55</sup> *Hearing on "Protecting America's Seniors: Oversight of Private Sector Medicare Advantage Plans" Before the H. Comm. on Energy and Commerce, 117th Cong. (2022)* (statement of James E. Matthew, Exec. Dir., Medicare Payment Advisory Comm’n). [https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony Mathews\\_OI\\_2022.06.28\\_updated.pdf](https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Mathews_OI_2022.06.28_updated.pdf)