

February 13, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Submitted electronically via <https://www.regulations.gov/commenton/CMS-2022-0191-0001>

Re: Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications (87 F.R. 79452, published December 27, 2022)

Dear Administrator Brooks-LaSure:

On behalf of the National Association of Social Workers (NASW), I submit comments on the notice of proposed rulemaking (NPRM) addressing Medicare Advantage (MA, or Part C) and Medicare Part D for contract year 2024 (CMS-4201-P).

Founded in 1955, NASW is the largest membership organization of professional social workers in the United States, representing more than 110,000 social workers. The association works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies.

Social workers play an essential role in serving Medicare beneficiaries, including those enrolled in Medicare Part D prescription drug plans and MA. NASW strongly supports the overall intent of the NPRM, particularly CMS's efforts to enhance transparency and accountability for MA organizations (MAOs). It is evident that CMS has carefully considered the perspectives of Medicare beneficiaries and beneficiary advocacy organizations, including NASW. We enthusiastically commend CMS for its work to enhance the information and services MAOs and Part D plans provide to beneficiaries.

Our comments address the following topics:

- implementation of provisions within federal statute that relate to Medicare Part C and Part D
- health equity in MA

- behavioral health in MA
- MA network adequacy and access to services
- enrollee notification requirements for MA provider contract terminations
- utilization management requirements
- rewards and incentives for Part C enrollees
- cost sharing for the COVID–19 vaccine and its administration
- review of medical necessity decisions by an appropriate health care professional
- call center interpreter standards
- call center teletypewriter (TTY) services
- Part C and Part D midyear benefit changes and Part D incorrect collections of premiums and cost sharing
- translation standards for required materials and content
- MA and Part D marketing
- Part D medication therapy management (MTM)
- limitation on prescription drug plan (PDP) contracts held by subsidiaries of the same parent
- Special Needs Plan (SNP) model of care scoring
- special enrollment period (SEP) for disasters or other emergencies
- midyear shortages of formulary drug products
- crosswalk requirements for PDPs
- Programs of All-Inclusive Care for the Elderly (PACE) policy updates
- additional recommended actions

Implementation of Certain Provisions of the Bipartisan Budget Act of 2018 (BBA), the Consolidated Appropriations Act, 2021 (CAA), and the Inflation Reduction Act of 2022 (IRA) (Section II)

NASW supports CMS’s proposals to implement the following provisions:

- applying Dual Eligible Special Needs Plan (D-SNP) look-alike requirements to plan benefit package segments
- Part D SEP change based on CAA Medicare enrollment changes
- alignment of Part C and Part D SEPs with Medicare exceptional condition enrollment
- transitional coverage and retroactive Medicare Part D coverage for certain low-income beneficiaries through the Limited Income Newly Eligible Transition (LI NET) program
- expanding eligibility for the low-income subsidy (LIS) under Part D of the Medicare program

We also refer CMS to an NASW-supported sign-on letter of February 7,¹ which suggests changes to strengthen beneficiary access to LIS.

Health Equity in MA (Section III.A)

NASW commends CMS for its focus on health equity, including within MA. Cultural competence is a cornerstone of social work practice, and all Medicare beneficiaries deserve culturally and linguistically

¹ Niles, A., Bedlin, H., & Hubbard, M. (on behalf of 70 organizations). (2023, February 7). *Comments urging CMS to expand beneficiary access to the Medicare Part D low-income subsidy* [Letter]. <https://bit.ly/LIS-CMS-Feb.2023>

appropriate services. Thus, we strongly support CMS’s proposal to expand the list of populations that may require consideration specific to their needs to include the following groups:

- (i) people with limited English proficiency [LEP] or reading skills; (ii) people of ethnic, cultural, racial, or religious minorities; (iii) people with disabilities; (iv) people who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (v) people who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; (vi) people who live in rural areas and other areas with high levels of deprivation; and (vii) people otherwise adversely affected by persistent poverty or inequality.²

The question of provider directories is less straightforward. Although NASW appreciates CMS’s attempt to enhance such directories, multiple issues remain to be addressed, including development of objective criteria for certain categories, such as language capability within a provider’s office; the process by which directory information will be verified; and the frequency of CMS follow-up with MAOs to monitor directory accuracy.

In regard to telehealth, NASW notes that the phrase “digital health literacy” encompasses three distinct, though interrelated, concepts: digital literacy, health literacy, and health insurance literacy. We underscore the requirement that MAOs develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing any medically necessary covered telehealth benefits. This requirement is particularly important for older adults with low incomes, many of whom struggle with technological barriers such as online portal enrollment. (As noted in the next section, access to in-person services for enrollees who cannot access or prefer not to use telehealth remains essential.) Moreover, we encourage CMS to require regular reporting of data of this type from all MAOs, as proposed. We also encourage CMS to strengthen its language regarding digital health education designs to *require* distribution of educational materials about how to access certain telehealth technologies in multiple languages, including sign language, and in alternative formats.

Behavioral Health in MA (Section III.B)

NASW applauds CMS’s commitment to improving access to behavioral health services and improve outcomes for people with behavioral health care needs. Services for mental health conditions and substance use disorders (SUDs) are integral to the health care provided by MAOs, and such services cannot be without robust provider networks. Therefore, we concur wholeheartedly with CMS’s proposal to add three types of providers to the specialty types that will be evaluated as part of the network adequacy reviews under § 422.116(b)(1):

- licensed clinical social workers (CSWs)
- clinical psychologists
- prescribers of medication for opioid use disorder (OUD)

Similarly, NASW supports CMS’s proposal to add new provisions to § 422.111(e) addressing provider contract terminations that involve behavioral health providers—including psychiatrists, clinical

² Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, 87 Fed. Reg. 79452 (proposed Dec. 27, 2022) (to be codified at 42 C.F.R. pts. 401, 405, 417, 422, 423, 455, 460). [Quote from p. 79480]

psychologists, licensed CSWs, inpatient psychiatric facilities, outpatient behavioral health clinics, and opioid treatment programs—as long as their work with beneficiaries focuses on behavioral health. The requirement that MAOs notify enrollees when the enrollees’ behavioral health providers are dropped midyear from networks will help prevent disruptions in care.

NASW also supports the following CMS proposals:

- amending its general access to services standards (§§ 422.112 and 422.113(b)(1)(i)) to include behavioral health services
- clarifying that some behavioral health services may qualify as emergency services (§ 422.112(b)(3)) and, therefore, must not be subject to prior authorization
- extending current requirements (§ 422.113(b)(3)) for MAOs to establish programs to coordinate covered services with community and social services to behavioral health services programs to close equity gaps in treatment between physical health and behavioral health (social determinants of health are associated with at least 80% of a person’s health outcomes, whereas medical services account for 20% or less of an individual’s health status;³ social workers play a primary role in mitigating social risk factors⁴⁵)

CMS’s other two proposals regarding behavioral health and MA are complex and merit detailed comments.

Proposal to make clinical psychologists, licensed CSWs, and OUD medication prescribers eligible for the 10-percentage point telehealth credit as allowed under § 422.116(d)(5)

As NASW noted in its response to the *Make Your Voice Heard* request for information (RFI) in November 2022, telehealth can be particularly beneficial to Medicare beneficiaries with mobility limitations and those in rural areas,⁶ as well as to people with limited access to transportation and limited time to travel to in-person appointments. On the other hand, telehealth may not be accessible to MA enrollees because they lack the requisite technology, are hard of hearing, have cognitive impairment, or have low digital or health literacy.

³ Hood, C. M., Gennuso, K. P., Swain, G. R., & Catlin, B. B. (2016). County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine*, 50, 129–135. <https://doi.org/10.1016/j.amepre.2015.08.024>

⁴ Dorn, C. (2020). *NASEM report on integrating social care into the delivery of health care* [NASW Practice Perspectives]. <https://bit.ly/nasw-health-social-PP>

⁵ National Academies of Sciences, Engineering, and Medicine. (2020). *Social workers and other social care providers play a key role in promoting better health for all. Findings from Integrating social care into the delivery of health care: Moving upstream to improve the nation’s health.* https://nap.nationalacademies.org/resource/25467/Social_Care_Social%20Workers%20and%20Social%20Care%20Providers%20FINAL_06092020.pdf

⁶ National Association of Social Workers. (2022, November 4). *NASW comments on a request for information (RFI) from the Centers for Medicare & Medicaid Services (CMS). Make your voice heard: Promoting efficiency and equity within CMS programs.* <https://bit.ly/NASW-CMS-equity-RFI-Nov22>

Recognizing the ways in which telehealth has both increased access to health care services and exacerbated existing health disparities,^{7,8,9,10,11,12} NASW emphasizes that telehealth services must not supplant the availability of in-person services for any MA enrollee who prefers or needs to use in-person services. We also underscore the importance of telehealth parity—that is, equal reimbursement, regardless of whether behavioral health services are provided in person or using telehealth—to promote access to underserved communities.

The value of telehealth notwithstanding, NASW has previously expressed concern that the June 2020 final rule allowing MAOs 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 weakened MA network adequacy requirements.¹³ Consequently, we urged CMS to “rescind the June 2020 network adequacy changes and strengthen MA’s network adequacy requirements.”¹⁴ We went on to state: “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.” MA plans abound, and traditional Medicare is available in every geographic area. MAOs, similar to various types of health care facilities, cannot meet the needs of beneficiaries without adequate staffing.

Accordingly, we reiterate our recommendation to CMS to withdraw the 10 percent credit for all MA-contracted providers. Should CMS opt not to do so, it would only be fair, from a parity perspective, to grant that credit to clinical psychologists, licensed CSWs, and OUD medication prescribers.

⁷ Centers for Medicare & Medicaid Services. (2022, December 15). *Medicare telehealth trends report*. <https://data.cms.gov/sites/default/files/2022-12/a7c3a319-5ded-4baf-ad7c-9aa2a897263a/Medicare%20Telehealth%20Trends%20Snapshot%2020221201.pdf>

⁸ St. John, C. (2022, May). *Telehealth and the Medicare population: Building a foundation for the virtual health care revolution*. Center for Medicare Advocacy. https://medicareadvocacy.org/wp-content/uploads/2022/05/Telehealth-Report_CMA_final.pdf

⁹ U.S. Department of Health and Human Services, Office of the Inspector General. (2022). *Certain Medicare beneficiaries, such as urban and Hispanic beneficiaries, were more likely than others to use telehealth during the first year of the COVID-19 pandemic* (OEI-02-20-00522). <https://oig.hhs.gov/oei/reports/OEI-02-20-00522.asp>

¹⁰ Wardlow, L., Roberts, C., Archbald-Pannone, L., Agha, Z., Alkema, G. E., Alwan, M., Age, L., Bates, J., Biese, K., Curtis, K. M., Darling, K. A., DeCherrie, L. V., Edson, B. S., Fletcher, D. A., Gaur, S., Gillespie, S. M., Handler, S. M., Harless, R., Hofmeyer, J., ... Zifferblatt, J. (2022). Perceptions and uses of telehealth in the care of older adults. *Telemedicine and e-Health*. Advance online publication. <https://doi.org/10.1089/tmj.2022.0378>

¹¹ Weigel, G., Ramaswamy, A., Sobel, L., Salganicoff, A., & Cubanski, J. (2020). *Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond*. Kaiser Family Foundation. <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>

¹² Wong Samson, L., Tarazi, W., Turrini, G., & Sheingold, S. (2021, December 3). *Medicare beneficiaries’ use of telehealth in 2020: Trends by beneficiary characteristics and location* (Research Report HP-2021-2). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. <https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf>

¹³ McClain, A. (2022, August 31). *Comments of the National Association of Social Workers in response to CMS’s request for information on Medicare (CMS-4203-NC)* [Letter]. National Association of Social Workers. <https://bit.ly/NASW-Medicare-Advantage-2022>

¹⁴ Please refer to footnote 12; quote from p. 8 of source.

Proposal to codify standards for wait times that apply to both primary care and behavioral health services

NASW appreciates CMS's recognition that long wait times can be problematic for MA enrollees who experience behavioral health concerns, and we affirm the agency's attempt to standardize wait times at § 422.112(a)(6)(i). We support CMS's proposal to apply to behavioral health services the wait times currently used for primary care in MAOs:

- urgently needed services or emergency—immediately
- services that are not emergency or urgently needed, but for which a beneficiary requires medical (behavioral health) attention—within one week (seven calendar days)
- routine and preventive care—within 30 calendar days

Inherent in our support for the preceding standards is the understanding that any MA enrollee could escalate a service request in accordance with their condition. For example, a beneficiary who has a routine appointment scheduled in 22 days may realize they need to meet with a provider sooner. Depending on the beneficiary's condition, the MAO would either offer an appointment within one week or direct the beneficiary to the appropriate urgent care or emergency service provider for immediate service. We urge CMS to specify that the beneficiary must not be required to resort to a cumbersome appeal process to access behavioral health care on a timely basis in such circumstances; rather, the MA plan must respond in a streamlined manner based on the beneficiary's needs.

We believe that use of the behavioral health wait time standards for qualified health plans in federally facilitated exchanges may be too long for some beneficiaries. For instance, if a beneficiary who lives with serious mental illness or is dually diagnosed with a mental health condition and SUD needs service urgently or on an emergency basis, a wait of 10 business days could be disastrous. Such a wait (which can be as long as 14 calendar days, depending on the day of the service request and the provider's business hours) could have dire consequences and decrease engagement even for an enrollee who needs attention on a nonurgent, nonemergency basis. In contrast, the tiered approach of the primary care wait times would better meet the needs of beneficiaries who use behavioral health services.

Likewise, NASW supports CMS's proposal to require new and expanding service area applicants to attest to their ability to provide timely access to care consistent with the proposed primary care wait time standards. Furthermore, we acknowledge that specific appointment wait time limits for emergency or urgently needed services *may* be duplicative of the mandatory coverage and access requirements delineated in § 422.113(b). For example, a beneficiary who seeks mental health or substance use care in the emergency department of an acute medical hospital may be assessed for inpatient care or (in situations of substance withdrawal management) medication and additional observation. On the other hand, some enrollees do not turn first to an emergency department for assistance. In such situations, it is incumbent upon other providers to determine the need for immediate assistance. For this reason, NASW believes that specifying wait time limits for emergency or urgently needed behavioral health services would be valuable. We also encourage CMS to define "immediate assistance" and require MA plans to operationalize their response times accordingly. Otherwise, "immediate" will be left to the subjective judgment of the MA plan.

NASW also offers, for CMS's consideration, one underlying factor influencing wait times for behavioral health services: the discrepancy between how MAOs and beneficiaries define "availability." In the proposed rule, CMS has noted maximum time and distance standards for clinical psychologists,

licensed CSWs, and OUD medication prescribers. Yet, these standards are not realistic for many enrollees. For example, a beneficiary may not be able to meet with a provider in a certain area because of limited mobility, lack of transportation, or insufficient time to reach the provider's office during business hours—factors that do not affect an MAO's definition of availability. When no in-network provider is available *as the plan defines availability*, an MAO must pay an out-of-network provider at an in-network rate. Although this requirement seems satisfactory on the surface, it is rife with problems. Some MAOs help beneficiaries find out-of-network providers; in contrast, others leave this overwhelming responsibility entirely to the beneficiary. Some out-of-network providers may not accept an in-network rate and decline to serve the beneficiary. Moreover, if an in-network provider leaves the plan, the beneficiary may have a limited time (such as 30 to 90 days) to find a new in-network provider.

MA Network Adequacy: Access to Services (Section III.C)

As illustrated in the preceding section, network adequacy and service access are inextricably linked. CMS's proposals focused on behavioral health address network adequacy to some extent.

Nonetheless, NASW reiterates its August 2022 recommendation¹⁵ that CMS rescind two other provisions of the June 2020 final rule¹⁶ that weakened network adequacy requirements:

- reducing the percentage of beneficiaries who must reside within the maximum time and distance standards in nonurban counties from 90 percent to 85 percent
- 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

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. Furthermore, if an in-network provider is unavailable, an MA enrollee should be able to request an out-of-network provider.

Enrollee Notification Requirements for MA Provider Contract Terminations (Section III.D)

NASW supports CMS's proposals to enhance enrollee notification requirements when MA provider contracts are terminated. We encourage CMS to require MAOs to provide to enrollees the option to change plans midyear as a result of provider contract termination. This option could be especially helpful not only for beneficiaries living with a mental illness or substance use disorder, but also for individuals with serious conditions such as cancer or multiple sclerosis.

¹⁵ McClain, A. (2022, August 31). *NASW response to CMS's request for information regarding Medicare (CMS-4203-NC)* [Letter]. National Association of Social Workers. <https://bit.ly/NASW-Medicare-Advantage-2022>

¹⁶ Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, 85 Fed. Reg. 33796 (finalized June 2, 2020) (to be codified at 42 C.F.R. pts. 417, 422, 423).

Utilization Management Requirements: Clarifications of Coverage Criteria for Basic Benefits and Use of Prior Authorization, Additional Continuity of Care Requirements, and Annual Review of Utilization Management Tools (Section III.E)

NASW applauds CMS for its efforts to curb inappropriate use of utilization management by MAOs. As we noted in our August 2022 response¹⁷ to CMS’s request for information (RFI) regarding MA, 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.”¹⁸ Moreover, a 2018 report by the Office of the Inspector General (OIG) 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.”¹⁹ Similarly, a 2022 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.”²⁰

Consequently, NASW asserts that MA plans should not be allowed to use coverage criteria that are more restrictive than those of traditional Medicare. We support CMS’s proposal to require that MA plans comply with national coverage determinations (NCDs), local coverage determinations (LCDs), and general coverage and benefit conditions included in traditional Medicare statutes and regulations as interpreted by CMS. Likewise, we concur with CMS’s proposal to prohibit MA plans from denying coverage of a Medicare-covered item or service based on internal, proprietary, or external clinical criteria not found in traditional Medicare coverage policies.

In contrast, NASW urges CMS to withdraw its proposal to allow MAOs to create internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature when no applicable coverage criteria exist in Medicare statute, regulation, NCDs, or LCDs. Development of such internal coverage criteria should not be needed or permitted, particularly if such criteria are deemed to be “proprietary” and not publicly available. Requiring disclosure (to CMS, enrollees, and providers) of resources MAOs to develop such criteria, rather than the criteria themselves, is inadequate.

Additionally, NASW is concerned that MAOs will not make meaningful changes to their use of prior authorization without increased requirements and enforcement by CMS. Therefore, we respectfully recommend that CMS implement the following additional changes:

¹⁷ McClain, A. (2022, August 31). *NASW response to CMS’s request for information regarding Medicare (CMS–4203–NC)* [Letter]. National Association of Social Workers. <https://bit.ly/NASW-Medicare-Advantage-2022>

¹⁸ 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/>

¹⁹ 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]

²⁰ 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]

- First, we urge CMS to make clear that the parity in coverage criteria between traditional Medicare and MA plans precludes MAOs' use of "rules of thumb" policies, such as predeterminations that a plan will cover certain services (type and quantity) for certain conditions. Rather, CMS should make clear that all service determinations must be based on individualized assessments.
- We also encourage CMS to enhance the requirements related to Notices of Medicare Non-Coverage (NOMNCs) and Detailed Explanations of Non-Coverage (DENCs) for services rendered by comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), skilled nursing facilities (SNFs), and hospice programs in both traditional Medicare and MA. Under current Medicare rules for both traditional Medicare and MA, these four provider types must give a DENC to a beneficiary only if a beneficiary requests an expedited determination after receiving an NOMNC when previously approved services are being terminated. In traditional Medicare, Medicare administrative contractors (MACs) provide external oversight of provider decision making through processing of claims. However, in MA, no such routine oversight exists unless beneficiaries choose to appeal decisions of non-coverage—a challenging process in which, as noted previously, relatively few beneficiaries engage. Accordingly, the 2018 OIG report found, in addition to inappropriate clinical decisions by MAOs, "(1) insufficient denial letters issued to beneficiaries and providers, (2) insufficient outreach before issuing denials." To remedy these problems, NASW encourages CMS to require MA plans to make available the scope of information required in the DENC not only when NOMNCs are issued, but also when prior authorization results in initial denials of service (regardless of whether a beneficiary chooses to appeal an initial denial or termination of service). The onus of responsibility for justifying why the service does not meet Medicare criteria must be on the plan, rather than putting the burden on beneficiaries to appeal lack of coverage.
- Furthermore, NASW encourages CMS to require plans to submit all utilization management tools and criteria to CMS for review. If CMS finds such criteria to be discriminatory either in text or in practice, it should impose financial penalties on MAOs. Such action would make more explicit and effectual the statement included in CMS's preamble to the proposed rule:

Plan benefit designs may not discriminate against beneficiaries, promote discrimination, discourage enrollment or encourage disenrollment, steer subsets of Medicare beneficiaries to particular MA plans, or inhibit access to services. We consider prior authorization policies to be part of the plan benefit design, and therefore cannot be used to discriminate or direct enrollees away from certain types of services. (p. 79504)
- We support CMS's proposal to require all MA plans to establish a Utilization Management Committee to review all utilization management (including prior authorization) policies annually and ensure they are consistent with current NCDs and LCDs and associated guidelines used in traditional Medicare national and local coverage decisions and guidelines. We encourage CMS to strengthen this requirement by requiring plan Utilization Management Committees to engage in internal oversight of plan operations, including randomized audits, assessment of rates of and reasons for denial, and duration of time between denials issued. Such committees should include both clinicians and individuals who are familiar with Medicare coverage rules.

Duration of prior authorization approvals is a complex issue. NASW appreciates CMS's intent in requiring that all approved prior authorizations must be valid for the duration of the entire approved prescribed or ordered course of treatment or service. We believe the latter change would help beneficiaries in certain circumstances. Yet, we are concerned that such a requirement will not help beneficiaries in situations in which plans authorize, on the front end, fewer services than enrollees actually need. For example, a plan may authorize only one week of physical therapy in a SNF when a beneficiary needs four weeks, or three weeks of HHA coverage when six weeks are needed. We are also concerned that the introduction of the new requirement could inadvertently exacerbate such patterns among MAOs, incentivizing them to approve fewer services on the front end in anticipation of being unable to terminate coverage.

Recognizing the potential unintended consequences of this duration of prior authorization approval proposal, we encourage CMS to consider options to address situations in which a beneficiary still needs medically necessary care, in the clinical opinion of the treating provider, after the preapproved course of treatment has ended. Possibilities include adding a qualifier such as a requirement for reassessment, with the participation of the treating provider, based on a beneficiary's changing condition or need for continued coverage. Another option could be to incorporate in this regulation some type of presumption in favor of the beneficiary in need of ongoing coverage.

More straightforward is CMS's proposal to require plans to provide a minimum 90-day transition period when an enrollee who is currently undergoing treatment switches to a new MA plan. NASW supports this proposal. In response to CMS's question regarding reinstatement of coverage based on a decision by a Quality Improvement Organization (QIO) (p. 79507), NASW affirms that the enrollee *should* have more than the two-day period from the date of a new termination of services notice before coverage can be terminated again by the MAO, taking into account any medical necessity determinations made by the QIO.

Additionally, NASW encourages CMS to consider requiring some type of deference to the treating clinician rather than allowing the judgment of MA plan staff or contractors to supersede both the clinical expertise of treating providers and Medicare coverage guidelines. We believe that CMS may have intended such deference in the following statement of the NPRM: "These prior authorization policies must reflect that all approved prior authorizations must be valid for the duration of the entire approved prescribed or ordered course of treatment or service" (p. 79504), but more explicit language is needed.

We also urge CMS to implement the following recommendations from the OIG's 2018 and 2022 reports and from the OIG's June 2022 Congressional testimony:²¹

- 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.
- Incorporate the issues identified by OIG in their evaluation into CMS' audits of MA plans.

²¹ 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, Assistant 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

- 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, which invalidated the “improvement standard” frequently applied to skilled nursing and skilled therapy services: The Jimmo Settlement Agreement (January 2013) ... clarified that the Medicare program covers skilled nursing care and skilled therapy services under Medicare’s skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration (provided all other coverage criteria are met).^{22,23}

To promote informed decision making by Medicare beneficiaries, we encourage CMS to ensure that its own materials (such as the *Medicare & You* handbook and the Medicare Plan Finder) and all MA plan materials fully explain prior authorization, including its widespread use and the limitations it imposes on access to services.

We also urge CMS to reconsider its proposal to allow MAOs to continue using step therapy for drugs covered under Part B. This “fail first” policy, instituted in calendar year 2019,²⁴ requires beneficiaries to try a less expensive or otherwise preferred medication before the drug prescribed by the treating health care practitioner. Only if that drug is ineffective or causes the beneficiary harm would the MAO cover the prescribed medication. Part B drugs include, among others, medications used in durable medical equipment (such as an infusion pump), certain medications for end-stage renal disease, antirejection drugs for organ transplants, blood clotting factors for hemophilia, home-based intravenous immune globulin for primary immune deficiency disease, and some chemotherapy agents, as well as drugs that are both supplied by and administered by a provider.²⁵ Given the severity of the condition many Part B–covered drugs treat, limiting beneficiary access to these medications presents serious health and economic consequences for beneficiaries.

Request for Comment on the Rewards and Incentive Program Regulations for Part C Enrollees (Section III.F)

NASW urges CMS to forbid the provision of any type of sign-up reward or incentive to beneficiaries who enroll in Part C. Such rewards and incentives exacerbate the uneven playing field between MA and traditional Medicare and distract beneficiaries from the significant financial and health consequences of their coverage choices. Moreover, some rewards and incentives can lead to “cherry picking” (such as when an MAO provides a gift card to a sporting goods store, which would appeal to physically active

²² Centers for Medicare & Medicaid Services. (2023). *Jimmo settlement*. <https://www.cms.gov/Center/Special-Topic/Jimmo-Center> [Quote from para. 1]

²³ Please refer, also, to CMS’s 2021 *MLN Connects*® newsletter, https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2021-12-02-mlnc#_Toc89267937, and the Center for Medicare Advocacy’s Jimmo settlement microsite, <https://medicareadvocacy.org/jimmo-update-cms-reminds-providers-and-contractors-of-medicare-coverage-to-maintain-or-slow-decline/>

²⁴ Verma, S. (2018, August 7). *Memo from CMS Administrator Seema Verma to Medicare Advantage organizations regarding prior authorization and step therapy for Part B drugs in Medicare Advantage*. U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/MA_Step_Therapy_HPMS_Memo_8_7_2018.pdf

²⁵ Centers for Medicare & Medicaid Services. (n.d.). *Prescription drugs (outpatient)*. <https://www.medicare.gov/coverage/prescription-drugs-outpatient>

beneficiaries). It is also worth noting that some rewards and incentives, such as grocery cards provided by some D-SNPs, could affect a beneficiary's eligibility for Medicaid.

Section 1876 Cost Contract Plans and Cost Sharing for the COVID–19 Vaccine and Its Administration (Section III.G)

NASW affirms CMS's proposal to require that section 1876 cost plans cover, without beneficiary cost sharing, the COVID–19 vaccine and its administration described in as described in Section 1861(s)(10)(A) of the Social Security Act. We believe this change is essential to promote equitable access to care.

Review of Medical Necessity Decisions by a Physician or Other Health Care Professional with Expertise in the Field of Medicine Appropriate to the Requested Service and Technical Correction to Effectuation Requirements for Standard Payment Reconsiderations (Section III.H)

NASW supports CMS's proposal to require that the health care professional who conducts review of the initial medical necessity determination have expertise in the health field that is appropriate for the item or service being requested before the MAO or applicable integrated plan issues an adverse organization determination decision. We believe that the physician or other appropriate health care professional reviewing the request *should* be of the same specialty or subspecialty as the treating physician or other health care provider. Furthermore, as noted in our comments on utilization management, we encourage CMS to consider requiring some type of deference to the treating clinician rather than allowing the judgment of MA plan staff or contractors to supersede both the clinical expertise of treating providers and Medicare coverage guidelines. Such a requirement is needed to mitigate the pattern of MAO staff and contractors substituting their own clinical judgement for the opinions of treating providers and Medicare coverage guidelines.

Call Center Interpreter Standards (Section III.K)

NASW supports CMS's proposal to codify requirements for minimum qualifications for interpreters available to individuals who have limited English proficiency (LEP) or don't speak English at MA and Part D call centers. Because multiple levels of language proficiency (including low functional ability) exist,^{26,27} we urge CMS to strengthen the requirement that call center interpreters demonstrate "proficiency" in speaking and understanding at least spoken English and the spoken language in need of interpretation.

Call Center TTY Services (Section III.L)

NASW supports CMS's proposal to require MAOs and Part D sponsors to connect at least 80 percent of incoming calls requiring TTY services to a TTY operator within seven minutes.

²⁶ American Council on the Teaching of Foreign Languages. (2012). *ACTFL proficiency guidelines 2012*.

<https://www.actfl.org/sites/default/files/guidelines/ACTFLProficiencyGuidelines2012.pdf>

²⁷ Interagency Language Roundtable. (n.d.). *History of the ILR scale*.

<https://www.govtilr.org/Skills/IRL%20Scale%20History.htm>

Part C and Part D Midyear Benefit Changes and Part D Incorrect Collections of Premiums and Cost Sharing (Section III.M)

NASW supports the following CMS proposals addressing midyear benefit changes for Part C and Part D plans:

- prohibiting changes to nondrug benefits, premiums, and cost sharing by an MA organization starting after plans are permitted to begin marketing prospective contract year offerings on October 1 of each year for the following contract year and until the end of the applicable contract year
- prohibiting Part D sponsors from making midyear changes to the benefit design or waiving or reducing premiums, bid-level cost sharing (for example, the cost sharing for an entire formulary tier of Part D drugs), or cost sharing for some or all of a Part D plan's enrollees starting after plans are permitted to begin marketing prospective contract year offerings on October 1 of each year for the following contract year and until the end of the applicable contract year

These changes will reduce economic insecurity and disruptions in care for beneficiaries.

NASW also supports the proposed requirements for Part D sponsors and the enactment of similar requirements for MAOs:

- refunding incorrect collections of premiums and cost sharing
- recovering underpayments of premiums and cost sharing
- establishing both a look-back period and time limit to complete overpayments and underpayment notices, as well as a de minimis threshold for such refunds and recoveries

Updating Translation Standards for Required Materials and Content (Section III.O)

NASW supports CMS's proposal to require MAOs, cost plans, and Part D sponsors to provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or in an accessible format (using auxiliary aids and services) upon receiving a request for the materials or otherwise learning of the enrollee's preferred language and/or need for an accessible format using auxiliary aids and services. We encourage CMS to apply the rule for a standing order for translated materials to the agency itself—that is, to allow enrollees with LEP to make a standing order with CMS for a translated version of *Medicare & You* and other CMS publications. Likewise, we encourage CMS to establish a standing order for an interpreter if a beneficiary has requested an interpreter in the past, thereby eliminating the need for repeated requests when enrollees with LEP call 1-800-Medicare. The need for an interpreter and the language to be interpreted should be entered permanently in the beneficiary's record, and an interpreter should be used for both outgoing calls to the beneficiary and incoming calls from the beneficiary. Moreover, NASW supports extending these requirements to individualized plans of care for SNPs.

Additionally, NASW supports CMS's proposal to require that fully integrated dual eligible special needs plans (FIDE SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and applicable integrated plans (AIPs) translate required materials into any languages required by the Medicare translation standard at § 422.2267(a), plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts. We encourage CMS to

apply these translation requirements to *all* D-SNPs and related plans and programs. Although most D-SNPs are neither FIDE-SNPs nor HIDE-SNPs,²⁸ all D-SNPs have a responsibility to coordinate care for enrollees, including those with LEP.

MA and Part D Marketing (Section III.P)

NASW strongly supports each of the proposals in this section of the NPRM. Social workers increasingly report that beneficiaries don't understand whether radio, TV, digital, and print ads for MA plans and Part D plans have been issued by CMS. This unclear (and, sometimes, misleading) marketing is confusing for beneficiaries and detrimental to informed decision making. We offer a few considerations to strengthen CMS's excellent proposals.

We believe the proposed requirement that insurance agents explain the effect of an enrollee's enrollment choice on their current coverage as part of the pre-enrollment checklist needs to be strengthened. We urge CMS not only to consider developing model language that would serve as the required foundation for all such communications, but also to specify how the requirement will be enforced.

The proposed requirement that plans notify individuals of the ability to opt out of phone calls regarding MA and Part D plan business could also be strengthened. NASW believes individuals should have to opt in to be contacted by plan sponsors. CMS would defer to plans regarding the format and timing of opt-out information. Such information must be explicit in messaging and prominent. Furthermore, we urge CMS to issue a general prohibition on contact about the availability of other plan options or types within the same parent organization. This ban would prevent Part D enrollees from being pressured to enroll in the same company's MA plans.

NASW supports CMS's proposal to continue requiring third-party marketing organizations (TPMOs) to record calls (including virtual connections such as Zoom and FaceTime) between TPMOs and beneficiaries when those calls address sales, marketing, and enrollment. We encourage CMS to specify the types of calls TPMOs are *not* required to record, thereby preventing misunderstanding and unintentional loopholes.

We also urge CMS to take additional steps to increase oversight and enforcement of MA marketing, as noted in our August 2022 comments on the MA RFI:

- 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.
- 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

²⁸ Burke, G. (2022). *Dual eligible special needs plans (D-SNPs): What advocates need to know* [Issue brief]. Justice in Aging. <https://justiceinaging.org/wp-content/uploads/2021/12/Dual-Eligible-Special-Needs-Plans-Issue-Brief.pdf>

beneficiary in most parts of the country, whereas the maximum national commission for first-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.²⁹

- Consider requiring signed attestations that whichever product is sold by an MA or Part D agent or broker is appropriate for that beneficiary; such attestation is currently required for the sale of a Medigap plan.
- Strengthen penalties for plans that engage in marketing misconduct.

Part D MTM Program (Section III.R)

NASW supports CMS's proposal to require Part D sponsors to include all core chronic diseases when identifying enrollees who have multiple chronic diseases, as provided under § 423.153(d)(2)(i)(A); to codify the nine core chronic diseases currently identified in guidance (Alzheimer's disease, bone disease arthritis, chronic congestive heart failure, diabetes, dyslipidemia, end-stage renal disease, hypertension, respiratory disease, and chronic or disabling mental health conditions); and to add HIV/AIDS to the list of core chronic diseases. We agree with CMS that these changes to the MTM targeting criteria will promote consistent, equitable, and expanded access to MTM services.

Additionally, we agree that the following CMS proposals will reduce eligibility gaps for MTM:

- decreasing the maximum number of covered Part D drugs a sponsor may require from eight to five drugs
- requiring Part D sponsors to include all Part D maintenance drugs in their targeting criteria
- revising the methodology for calculating the cost threshold (\$4,935 in 2023) to be commensurate with the average annual cost of five generic drugs (\$1,004 in 2020).

NASW also supports CMS's proposal to clarify that the comprehensive medication review must include an interactive consultation that is conducted in real time, regardless of whether it is done in person or using synchronous telehealth.

Limitation on PDP Contracts Held by Subsidiaries of the Same Parent (Section III.V)

NASW supports CMS's proposal to limit the number of PDP contracts under which a Part D sponsor or its parent organization (as defined in § 423.4), directly or through subsidiaries, can offer individual market plan benefit packages in a PDP region to one contract per region. Choosing a Part D plan is daunting for beneficiaries in the best of circumstances. A proliferation of plans without substantial differences renders this decision even more difficult.

Codification of SNP Model of Care Scoring and Approval Policy (Section IV.F)

Each D-SNP is required to establish a model of care to direct its operations. NASW recommends that CMS require each D-SNP to make public its model of care. This change would help beneficiaries and other stakeholder determine whether a given D-SNP is actually fulfilling its own model of care.

²⁹ Ali, R., & Hellow, L. (2021, October 12). *Agent commissions in Medicare and the impact on beneficiary choice* [Blog]. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2021/agent-commissions-medicare-and-impact-beneficiary-choice>

Possible End Dates for the SEP for Government Entity–Declared Disaster or Other Emergency (Section IV.O)

SEPs are critical for beneficiaries faced with challenging circumstances such as disasters or other public emergencies. NASW appreciates CMS’s effort to establish an automatic incident end date that would apply if no end date for the period of disaster or emergency is otherwise identified within one year of the start of the SEP. We encourage CMS to extend the SEP six months (rather than the proposed two) after the incident end date, thereby providing additional time for beneficiaries as they cope with the ongoing effects or aftereffects of a disaster or emergency.

Shortages of Formulary Drug Products During a Plan Year (Section IV.U)

NASW appreciates CMS’s attention to the impact of drug shortages on beneficiaries. We affirm the proposal to enable beneficiaries to obtain a therapeutic equivalent or nonformulary alternative without having to go through the nonformulary exceptions process. However, we urge CMS to prohibit PDP sponsors from charging enrollees the difference in price between the formulary drug product and the therapeutic equivalent or nonformulary alternative. Beneficiaries should not be held financially responsible for systemic problems that are beyond their control.

Crosswalk Requirements for PDPs (Section IV.AD)

NASW appreciates CMS’s efforts to standardize the process and conditions under which PDP sponsors can transfer enrollees into another PDP’s plan benefits package from year to year when such enrollees have made no other election. For beneficiaries, the impact of such crosswalks extends far beyond the cost of the monthly premium. Thus, when a PDP sponsor chooses to crosswalk in a consolidated renewal scenario, the sponsor should be required to consider overall out-of-pocket costs and the formulary. We also encourage CMS to grant an SEP right to beneficiaries in such scenarios, similar to those in nonrenewing or terminating PDPs.

PACE Contracted Services (Section VI.F)

NASW supports CMS’s proposal to add back into the regulation the requirement that PACE organizations execute and maintain a contract with the following health care specialties: anesthesiology, audiology, cardiology, dentistry, dermatology, gastroenterology, gynecology, internal medicine, nephrology, neurosurgery, oncology, ophthalmology, oral surgery, orthopedic surgery, otorhinolaryngology, plastic surgery, pharmacy consulting services, podiatry, psychiatry, pulmonary disease, radiology, rheumatology, general surgery, thoracic and vascular surgery, and urology.

NASW appreciates CMS’s request for comment regarding whether other behavioral health providers, such as psychologists and licensed CSWs, should be added to the list of required health care specialists with which PACE organizations contract. We urge CMS to add such behavioral health providers, including licensed CSWs—who constitute the largest group of mental and behavioral health providers

in the United States^{30,31}—to that list. Behavioral health care includes not only the medication prescribing and management services offered by psychiatrists, but also ongoing psychosocial assessment, psychotherapy, and crisis intervention. Accordingly, various behavioral health providers play complementary roles, each essential to the behavioral health of PACE participants.

Moreover, NASW encourages CMS to add the following additional specialty services in the list of minimum required services: endocrinology, hematology, immunology, neurology, colorectal surgery, palliative medicine, infectious disease, and physical medicine and rehabilitation. We agree with CMS that these additional specialty services are often necessary for PACE participants. Similarly, we support CMS's proposals to require not only that a PACE organization to execute these contracts with specialists before enrolling participants, but also that the PACE organization maintain such contracts on an ongoing basis to ensure participants receive appropriate and timely access to all necessary care and services. Additionally, NASW concurs that the proposed list of required specialists is not exhaustive and that PACE organizations must provide access to other medical specialists, as needed, in a timely manner.

Additional Recommendations for Consideration

NASW firmly believes that this NPRM exemplifies CMS's renewed commitment to enhance consumer protections for beneficiaries enrolled in MA and Part D plans and to provide oversight of MAOs and PDP sponsors. Ultimately, however, the effectiveness of the proposed rule will be in direct proportion to its enforcement. Nearly half of Medicare beneficiaries were enrolled in MA plans in 2022;³² many are individuals receiving retiree health benefits who have no other option.³³ Given this landscape, NASW offers the following recommendations to foster informed and unbiased decision making among Medicare beneficiaries:

- Promote, in a more active manner, increased funding and capacity for 1-800-MEDICARE, the State Health Insurance Assistance Program, and Senior Medicare Patrol.
- Rebalance beneficiary-focused information about MA and traditional Medicare, especially on Medicare.gov and during the annual open enrollment period. For example, replacing the ubiquitous term “plan” (“Which plan is right for you?”) with “coverage” (“Which kind of coverage is right for you?”) in CMS's messaging would decrease bias toward MA.

³⁰ Heisler, E. J. (2018). *The mental health workforce: A primer* (R43255). Congressional Research Service. <https://crsreports.congress.gov/product/pdf/R/R43255>

³¹ National Center for Health Workforce Analysis. (n.d.). *Behavioral Health Workforce Projections, 2017–2030* [Fact sheet]. U.S. Department of Health and Human Services, Health Resources and Services Administration. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf>

³² Freed, M., Fuglesten Biniek, J., Damico, A., & Neuman, T. (2022). *Medicare Advantage in 2022: Enrollment update and key trends*. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/>

³³ Freed, M., Neuman, T., Rae, M., & Fuglesten Biniek, J. (2022). *Medicare Advantage coverage is rising for the declining share of Medicare beneficiaries with retiree health benefits*. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medicare-advantage-coverage-is-rising-for-the-declining-share-of-medicare-beneficiaries-with-retiree-health-benefits/>

- Reinstate requirements regarding meaningful differences among plans and limitations on the number of plan offerings, parallel to those proposed for plans available through the federal Marketplace.³⁴
- Urge Congress to expand federal Medigap guarantee issue rights to make Medicare coverage options between MA and original Medicare more equal.
- Overhaul MA and Part D star ratings, as recommended by the Medicare Payment Advisory Commission (MedPAC)³⁵ and the OIG,³⁶ to strengthen public reporting on plan quality and variation, thereby enhancing the value of the tool to consumers.
- Enhance oversight of Employer Group Waiver Plans (EGWPs), including reviews of how employers and unions handle EGWP enrollment and oversight of allowable waivers (such as lax network adequacy requirements and plan customization of enrollee materials); monitor the practical ability of retirees to choose original Medicare and ensure this option is available to all retirees.

We are also concerned that the NPRM does not address long-standing overpayments to MAOs. Thus, we encourage 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 the Government Accountability Office’s 2022 recommendations regarding the validity of encounter data, audits, and recovery of improper payments to MA plans.³⁷
- Implement OIG’s 2022 recommendations regarding chart reviews and health risk assessments (HRAs).³⁸
- Implement MedPAC’s 2022 recommendations regarding coding pattern adjustment, HRAs, and encounter data.³⁹

³⁴ Centers for Medicare & Medicaid Services. (2022). *HHS notice of benefit and payment parameters for 2024 proposed rule* [Fact sheet]. <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-proposed-rule>

³⁵ 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://www.congress.gov/117/meeting/house/114959/witnesses/HHRG-117-IF02-Wstate-MathewsJ-20220628.pdf>

³⁶ 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>

³⁷ 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>

³⁸ 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://oig.hhs.gov/documents/testimony/1039/E_Bliss_Medicare_Advantage_Testimony.pdf

³⁹ 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://www.congress.gov/117/meeting/house/114959/witnesses/HHRG-117-IF02-Wstate-MathewsJ-20220628.pdf>

This NPRM has tremendous potential to improve the information and services provided to beneficiaries by MAOs and PDPs. Thank you for your consideration of NASW's comments. Please contact me at BBedney.nasw@socialworkers.org if you have any questions.

Sincerely,

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