February XX, 2023

Chiquita Brooks-LaSure

Administrator

Centers for Medicare and Medicaid Services

7500 Security Blvd.

Baltimore, Maryland 21244

**RE: CMS-4201-P**; 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

***Submitted electronically via regulations.gov.***

Dear Administrator Brooks-LaSure,

[YOUR ORGANIZATION] is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for calendar year (CY) 2024 policy and technical changes to the Medicare Advantage program. We appreciate CMS’ continued commitment to the needs of the more than 60 million Americans that reside in rural areas.

[Brief paragraph explaining your organization/hospital and your overall experience working with Medicare Advantage plans.]

[YOUR ORGANIZATION] thanks CMS for the opportunity to comment on this proposed rule.

**III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Programs**

B. Behavioral Health in Medicare Advantage (MA) (§§ 422.112, 422.113, and 422.116)

[YOUR ORGANIZATION] is broadly supportive of proposals that strengthen rural beneficiaries’ access to behavioral health services. [Insert a couple of sentences that explain your experience with MA beneficiaries trying to access behavioral health services, especially if it is usually difficult].

*2. Behavioral Health Specialties in Medicare Advantage (MA) Networks (§§ 422.112 and 422.116)*

[YOUR ORGANIZATION] applauds CMS’ addition of clinical psychologists, clinical social workers, and providers that can prescribe medications for opioid use disorder to the provider specialty types. Requiring that Medicare Advantage organizations (MAOs) contract with at least one of each of these providers in each network will expand MA beneficiaries’ access to behavioral health services.

[Include any concerns that you have about network adequacy and behavioral health services and how this proposal is helpful or falls short.]

*4. Medicare Advantage (MA) Access to Services: Appointment Wait Time Standards (§ 422.112)*

[YOUR ORGANIZATION] support CMS’ proposal to assign the same appointment wait time standards for primary care and behavioral health at 42 C.F.R. § 422.112(a)(6). This creates parity between the two and works against the stigma associated with behavioral health in rural communities. However, we urge CMS to consider a shorter timeframe of 15 days for routine and preventive care.

C. Medicare Advantage (MA) Network Adequacy: Access to Services (§ 422.112)

[YOUR ORGANIZATION] supports proposed § 411.112(a)(1)(iii) with a slight modification. This proposed subsection requires MAOs to arrange for out-of-network services at in-network cost sharing prices if medically necessary covered benefits are not available within the plan network. We ask that CMS include language in this subsection that ensures MAOs will consider beneficiary preferences so that beneficiaries are able to access out-of-network care that best meets their needs. For example, the time and distance from the beneficiary’s home and/or their family or caregiver should be considered when arranging for care.

E. 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 (§§ 422.101, 422.112, 422.137, and 422.138)

[YOUR ORGANIZATION] has serious concerns about current prior authorization practices by MAOs. We broadly support CMS’ proposals that strengthen prior authorization protections for beneficiaries.

[Insert paragraph about your experience with prior authorization and the associated challenges.]

*2. Coverage Criteria for Basic Benefits*

We applaud CMS for including new clarifying language in § 422.101(b)(2) stating that MAOs must comply with general coverage and benefit conditions under Traditional Medicare. This policy has been in place in the Medicare Managed Care Manual and we support its inclusion in the regulatory text.

[Provide examples of MAOs denying medically necessary care using standards other than traditional Medicare coverage guidelines. If you are or work with an inpatient facility or skilled nursing facility, describe how prior authorization is challenging for these provider types in particular.]

*3. Appropriate Use of Prior Authorization*

[YOUR ORGANIZATION] appreciates the new proposed § 422.138(a) which outlines that prior authorization may only be used to confirm the presence of a diagnosis, to ensure that basic benefits are medically necessary, or to ensure that supplemental benefits are clinically appropriate. [YOUR ORGANIZATION] also supports the new language § 422.138(c) stating that MAOs cannot retroactively deny coverage or payment for a previously approved request.

[Provide examples of times that you experienced MAOs retroactively denying coverage or payment for a previously approved request. How did this negatively affect you or patients you serve?]

*4. Continuity of Care*

Proposed § 422.112(8) would require that MAOs approve a prior authorization request for the course of treatment. This, in conjunction with proposed § 422.138, discussed above, should in theory protect beneficiaries from losing access to needed care as well as reduce administrative burden for understaffed rural providers. When MAOs do not authorize a covered service for the entire course of treatment, and require providers to submit several repetitive requests, this creates extra work for already burdened rural providers. The same is true when prior authorization approvals are retroactively denied, and providers must work to appeal the decision. This also creates uncertainty and disruptions in needed care for beneficiaries that may lead to poor health outcomes in some situations.

[Discuss the burden associated with prior authorization requests on your organization. Provide specific examples or anecdotes if possible.]

We support the inclusion of continuity of care provisions insofar as they protect beneficiaries from inappropriate denials and simplify administrative burdens for providers.

*6. Additional Areas for Consideration and Comment*

a. Termination of Services in Post-Acute Care

[This section is seeking information on early termination of services post-acute care settings. CMS has heard increasing complaints of MAOs terminating beneficiaries’ post-acute care coverage before they are healthy enough to return home. Discuss your experience with this, including the effect on patients and provider burden.]

P. Medicare Advantage (MA) and Part D Marketing (Subpart V of Parts 422 and 423)

[YOUR ORGANIZATION] applauds the proposed changes to MAO marketing and advertising regulations. [Include specific concerns that you have about misleading marketing and advertising. Try to include examples of how it harms beneficiaries.]

We urge CMS to finalize the proposed provisions to prohibit: MAO use of superlatives without supporting documentation; MAO use of the Medicare name, CMS logo, or any products or information from the federal government in a misleading way; and advertising benefits that are not available within a plan network.

[Include any experiences, concerns, or stories from beneficiaries on misleading marketing/advertising practices.]

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. If you would like additional information, please contact [YOUR NAME OR REPRESENTATIVE] at [EMAIL] or [PHONE NUMBER].

Sincerely,

[E-SIGNATURE]

Your Name

Your Title

Your Organization