Tips for Submitting Comments on Proposed Rule CMS-4201-P (CY 2024 Medicare Advantage Policy & Technical Changes)

CMS published a proposed rule on December 13, 2022 that outlines the rules that Medicare Advantage plans, Special Needs Plans and Part D and PACE programs must comply with for Calendar Year 2024. The proposed rules make significant changes to MA plans approach to approval of basic Medicare benefits such as post-acute care.

LeadingAge will be submitting comments on the proposed rule and we encourage members to do so as well. We have compiled the following tips and links to help.

How to Write Your Comments

Begin by introducing yourself and telling why this rule matters to you. You might tell a little about the organization for which you work, the residents/clients you serve, or the job you do. Just remember to get appropriate permissions before sharing any identifying information.

Don't feel obligated to comment on every aspect of the rule. Choose what matters most to you, whether that is 1 issue or all the listed issues. Identify the issue, tell why you support or oppose it, and offer an alternative to issues you oppose. Explain how your alternative will help meet the same objective more effectively.

Hit the sweet spot of concise and constructive. Provide enough information to make your point. Remember, you are shaping policy, not simply casting a vote.

How to Submit Your Comments

Comments must be received by CMS by **5 p.m. Eastern Time on Monday, February 13, 2023**. Remember to **reference file code CMS-4201-P** in your comments. Comments can be submitted 1 of 3 ways:

Electronically: Comments can be submitted electronically via the Federal Register. Access the rule here, then click on "Submit a Formal Comment" near the top of the page. You may type your comments directly into the text box, or you may attach a file containing your comments.

By regular mail: Comments may be submitted by mail but must be received before the close of the comment period. Mail written comments to:

Centers for Medicare & Medicaid Services

Department of Health and Human Services
Attn: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

By express or overnight mail: Comments may be submitted by express or overnight mail to:

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-4201-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Resources to Assist You as You Write

Find the proposed rule here. Key aspects of the rule begin on page

Read the CMS memo on this rule here.

Read the LeadingAge summary of provisions and analysis here.

For more tips on writing comments, check out this resource: Tips for Submitting Effective Comments

Please note that comments on the CY2024 MA Rules are due by 5p ET not 11:59 p.m. ET on February 13, 2023.

Main Points of the Proposed Rule

Every year, CMS proposes updates to how Medicare Advantage, Special Needs Plans, Part D Drug plans and PACE programs must operate in the coming plan year. CMS-4201- P proposes changes for Calendar Year 2024. Some of these changes address issues that LeadingAge and its members, as well as other stakeholders have raised regarding coverage determinations by plans related to basic benefits covered in the traditional Medicare program under Parts A and B. CMS seeks to clarify that plans must cover all medically necessary A and B benefits for their enrollees and cannot have additional internal coverage criteria for these benefits that restricts access to these benefits. The proposed rule also covers a number of other topics including limiting certain deceptive marketing practices by plans and their agents, updates to the MA star rating system, expanding plan culturally competent care requirements to additional populations, improving access to behavioral health, and improving affordability and access to Part D Drug for low-income individuals.

In the PACE section, CMS proposes provisions it deems necessary because of the growing scale and scope of the PACE program and many proposals cite analysis of recent audits of PACE Organizations (Pos) that support the need for a policy change. The detailed issues are described below but cover changes in timeframes for a variety of tasks, looking at past performance in approval process for new sites or geographic expansion, flexibility in medical clearance certification for staff through the optional

development of a risk assessment, additional requirements for care planning, goal setting, and inclusion of designated persons in the care planning and notification requirements already imposed on Pos.

Below we have highlighted only those issues we believe are of greatest impact to LeadingAge SNF, PACE, and Home Health members.

Issue: **Clarify that MA plans are required to cover medically necessary Medicare Part A & B benefits based upon the requirements within traditional Medicare.** In response from stakeholder input from LeadingAge and others, CMS seeks to clarify MA plans must cover traditional Medicare services based upon the same exact coverage criteria (they can't use their own criteria) and up to the same amount of care as is available in traditional Medicare, as long as the person still requires the care. The proposed language prohibits plans from using additional, plan-specific approval criteria to deny or limit access to basic Medicare benefits. Third party care management companies, such as NaviHealth, are also subject to these same critiera, which may preclude use of proprietary algorithms for these determinations. Additional internal plan criteria would only be permitted in cases where no coverage criteria exists for an item or service, such as supplemental benefits and those criteria must be based upon "widely-used treatment guidelines or clinical literature." CMS is also proposing to revoke prior language that allows plans to substitute care. If the rule is finalized, it would also prohibit plans from substituting care. For example, if SNF care is ordered by the discharging physician based on a need for daily, institutional skilled care, then the MA plan cannot deny SNF care and replace it with home health services unless the traditional Medicare coverage criteria aren't met for SNF care.

Comment: This is a very important clarification, and we applaud CMS for its efforts in the proposed rule to ensure MA enrollees have equitable access to medically necessary Medicare A & B benefits as those in traditional Medicare. We seek further clarification to ensure that for post-acute care services that this equitable access to Medicare coverage includes up to 100 days of skilled nursing care (when necessary) and coverage for 30-day home health episodes, as is the case in traditional Medicare. In addition, without any new enforcement provisions, we are concerned current denial practices will continue.

Issue: CMS proposes changes to the prior authorization process by limiting the reasons it can be used and requiring PAs to cover to an entire "course of treatment" in order to limit the need for repeat authorizations. Proposed language would limit prior authorizations (PAs) to be used only to confirm diagnoses or medical criteria to establish medical necessity for the services. Once a PA is approved, the MA plan would be prohibited from later denying coverage due to lack of medical necessity unless fraud is suspected. Also, once a PA is approved, it must be valid for the duration of the entire approved, prescribed or ordered course of treatment or service. The rule defines "course of treatment" as, "a prescribed order or ordered course of treatment for a specific individual with a specific condition, as outlined and decided upon ahead of time, with the patient and provider. (A course of treatment may but is not required to be part of a treatment plan)."

Comment: LeadingAge supports the proposed changes but thinks CMS should further clarify what is covered by a "course of treatment" to ensure that it includes the necessary services and duration of care provided by skilled nursing facilities and home health agencies. In addition, it is not clear why a prior authorization would be needed for basic benefits under Medicare Parts A and B if the service was ordered by a discharging physician who has assessed the person's needs. At a minimum, to reduce administrative burden and speed up approval times, prior authorizations for traditional Medicare

benefits should be requested on a standardized form developed by or approved by CMS. A standardized process is the quickest way to ensure that plans are complying with Medicare regulations and national and local coverage determinations for traditional Medicare benefits and to expedite approvals. We find in the current process PAC providers are required to submit reams of documentation and key factors for medical necessity are often missed by plan reviewers leading to inappropriate denials. A standardized form could remedy this cause for error and potentially reduce the administrative burden on providers.

Issue: Require MA plans to establish a Utilization Management Committee to annually ensure that UM policies and procedures align with traditional Medicare coverage decisions and guidelines. Plans would be required to establish a Utilization Management Committee led by the plan's medical director and made up of a majority practicing physicians (one of which who must be independent and conflict-free related to the MA organization and plan). The committee would be responsible for annually reviewing all of the plans' UM policies and procedures to ensure they are aligned with Medicare coverage decisions and guidelines, including national and local coverage determinations, and revised, as necessary. CMS also proposes to replace current requirements with new language requiring UM guidelines to be based on current widely used treatment guidelines or clinical literature. CMS seeks input on whether contracted (network) providers should be consulted in the work of the committee; whether the plans should communicate the practice guidelines and UM policies to providers and enrollees; and whether the UM Committee should have an ongoing oversight role ensuring all coverage decisions are consistent with the approved practices and policies. On or after January 1, 2024, only policies and procedures reviewed and approved by the UM Committee can be used for basic or supplemental benefits.

Comment: LeadingAge supports this required review of UM policies to ensure alignment with traditional Medicare coverage requirements but believes that the committee should include one or more practicing clinicians with experience in SNF and HH care. In addition, we believe plans should consult their contracted providers for input on the current policies and procedures.

Issue: Plans Encouraged to "Gold Card" compliant providers. The proposed rule merely encourages plans to use a gold carding process to relax or reduce prior authorization requirements for contracted providers who demonstrate compliance with plan policies and procedures. To date, we have heard from members who indicate the only providers who receive "gold card" status are those owned by the plan.

Comment: LeadingAge believes that if a plan is to use a "gold card" process that it must clearly identify the criteria that must be met, and all contracted providers should be eligible not just owned providers. If CMS is encouraging this practice, they should establish some guardrails about what criteria can be used to "gold card" a provider.

Issue: Prohibiting Deceptive Marketing Practices by MA plans and their agents. CMS responded to the **findings** of the Senate Finance Committee regarding deceptive marketing practices by prohibiting certain types of ads and use of imagery (e.g. Medicare logo, etc.) from being used. In addition, it will require agents to disclose all plans they represent. Agents will also be required to collect certain information from the prospective enrollees using a standardized list of questions prior to enrolling them into a plan and provide the prospect with information on how enrolling in a new plan will impact their current Medicare coverage.

Program of All-Inclusive Care for the Elderly (PACE)

Issue: CMS proposes to amend the contract year to allow for a longer initial contract year, extending the time from opening until the trial period audit.

Comments: This allows a longer lead time for POs to hire, train, and increase participation in the program. The extension would allow the program to grow adequately to provide a full and fair picture of the POs operations during their trial period. However, extending the trial period could significantly delay a POs opportunity to expand geographically, particularly for a well-established parent organization's new site.

Issue: CMS is proposing past performance review of POs submitting applications to open new sites, expand geographically, or both. In the proposal, CMS includes a 13-point scoring threshold based on prior citations and noncompliance that could limit large parent organizations from expansion. The threshold is not scaled for multiple sites, nor for participants served. As such- large, experienced, high-quality POs would be evaluated on the same fixed 13-point threshold as a small single site provider.

Comments: While review of past performance is reasonable and supported, the playing field must be leveled to promote fair opportunity for expansion of larger organizations through a scaled scoring of past performance across multiple sites. It is unclear, through the proposal, if state citations count in the point scale that would invoke CMS' denial of expansion applications. Clarification should be sought on this.

Issue: Proposal to eliminate the period of time POs have to remedy deficiencies prior to CMS issuance of fines and sanctions.

Comments: This move from collaborative to punitive without delineation of magnitudes of noncompliance leading to CMPs or enrollment/payment suspension is concerning.

Issue: POs would have the option to develop policies and procedures around staff and contractor medical clearances including the development and use of a risk assessment that could supplant annual physical exam requirements. If the risk assessment reveals likely exposure to high-risk pathogens following review by a physician, PA, NP, or RN then the staff or contractor would require a physical exam.

Comments: Through the development of policies, it would seem non-clinical staff could review risk assessments that indicate zero exposure. This flexibility is not allowed in the proposal but would decrease the burden on clinical staff with already demanding schedules serving participants.

Issue: Creates explicit parameters outlining IDTs' responsibilities across all settings, including for participants residing in NFs. This includes the IDT's responsibility to order, approve, and authorize all necessary care. CMS also proposes to impose maximum timeframes for IDTs to review, assess, and act on recommendations regarding a participant's care. For recommendations from emergency departments, hospitals, urgent-care, the PO must review, assess, and act no later than 24 hours post

discharge. For internal recommendations from staff or contractors, the IDT must review, asses, and act within 5 calendar days of the recommendation being made.

Comments: This provision is impractical for participants receiving care in an in-patient setting and could delay care to participants. For a participant residing in a NF, the IDT doesn't have purview to order services provided by the NF, though the IDT would and should consult with the NF about recommendations and maintain coordination efforts. The requirement for a full IDT review and assessment of recommendations from acute care within 24 hours is administratively burdensome, not feasible, and would be costly over weekends and holidays. In many instances, the discharge plans are not electronically available within 24 hours. CMS should consider extending this timeframe to a point after documentation is included in the medical record. 96 hours is feasible and recommended.

Issue: CMS proposes significant changes and additions to sections of the rule related to care planning: timing, minimum requirements, documentation of identified need, change in participant status, and goal setting. This section also includes that IDT-approved services must be coordinated (e.g., schedule the appointment, not conduct the appointment) within: 24 hours for medications and 7 calendar days for all other services.

Comments: By increasing requirements and required documentation, the process of care planning and the care plan itself could be less person-centered. The introduction of minimum care plan requirements limits participant ability to designate their own desires through care planning. Participant choice to not to have a service or identified need addressed in the care plan should be retained. The proposal, as written, doesn't seem to afford that option. Additionally, the proposal tightens requirements around timing for reevaluation of need from semi-annual to every 180 days and adds stipulations that initial care plans must be completed within 30 calendar days. Imposing timeframes on service coordination does not necessarily improve the timeframes in which services are delivered, though it does increase the administrative burden on the PO- especially as scheduling with many specialists can include multiple phone calls and repeated 'phone tag.'

Issue: CMS proposes to align grievance and documentation requirements with those already imposed on other Medicare Advantage plans. This includes administratively burdensome processes and procedures that categorize all 'concerns' as grievances.

Comments: By codifying strict definitions of grievances as "a complaint, either written or oral, expressing dissatisfaction…", with correlate processes for documentation and timeframes, the person-centered conversations around resolution, even if no resolution is requested, become bureaucratic and impersonal. The tact and experience of coordinated resolution and respect is lost as the PO works to maintain compliance with grievance documentation requirements. Simple complaints should be resolved more collaboratively and without documentation categorizing all complaints as grievances.

Issue: Require POs to disclose to current and prospective PACE participants information on the POs performance and contract compliance.

Comments: It is unclear how CMS is requiring this disclosure. LeadingAge suggests that the noted performance and compliance related information be available upon request of the applicant or participant. Transparency is always welcome, though consistency in standard administration must be achieved before true transparency is valuable.

Topics for Consideration

In discussion with our members, we are hearing common themes emerge. We have identified below points that you may wish to consider for inclusion in your comments.

- ***Support for CMS clarifying that MA plans must cover medically necessary traditional Medicare services but believe CMS should further clarify how it will monitor plan behavior and enforce these requirements. Without additional enforcement, we are concerned current erroneous denial practices will continue**.* Members have shared numerous examples of MA plans denying services that would be covered under traditional Medicare currently including individuals on IV medications that can only be administered in a SNF because the service is not available in the community, individuals who can ambulate 50 feet or less denied skilled care even though they have other reasons for needing it, and denials of continued coverage due to lack of progress or improvement in therapies. These are great examples to share with CMS about situations where plans should not be able to deny coverage for basic benefits.

- ***CMS should further clarify that plans cannot deny need for skilled care solely because the individual doesn't make progress. This is supported by CMS rules and the Jimmo v. Sebelius agreement indicating that lack of progress/improvement is not a reason plans can end skilled care.***

- ***Prior authorizations for "course of treatment" must include needed post acute services identified through SNF/HH assessments and an individualized care plan.*** Additional language is needed to clarify CMS's intent related to prior authorizations or plans will continue to require numerous re-authorizations from SNF providers for additional days of service and home health providers ability to provide additional in-home visits. At present, our members' experience is that MA plans are only authorizing days of skilled nursing care in small increments and requiring frequent reauthorization (e.g. every 2-days) for needed services to continue. This practice does not recognize the reality that when a patient is first admitted to skilled nursing facility (SNF) or home health (HH) that there are multiple assessments that occur to determine the scope and duration of service needed based upon the individual's specific set of circumstances.

- ***Prior authorizations (PA) pose an extraordinary administrative burden on providers and under the guise of "medical necessity" are used currently as a mechanism to limit MA enrollee access to certain basic Medicare post-acute care benefits.*** While CMS proposes to limit the purposes for which PAs can be used to medical necessity and diagnosis confirmation, the administrative burden on providers to submit reams of documentation to support the need for care remains. Nonetheless PAC providers are subject to each health plan asking for extensive information in a variety of

formats and communicated through plan-specific portals, fax, or phone call. To reduce administrative burden of prior authorizations on PAC providers, providers would like to see a single standardized PA form or portal for traditional Medicare A & B services that is used for all plans and includes only the information necessary for the plan to approve the PA. Members indicated although they submit significant documentation, it is clear not all information is read by the plan reviewer because key information that supports the need for skilled care is often missed. Members note that plans demand information with short turnaround times (e.g., sometimes only 2 hours) and yet plans are not required to review prior authorization requests over weekends or holidays. This can leave MA enrollees lingering in the hospital delaying needed PAC services or prevents safe transitions home when in-home services and equipment are not able to be scheduled during the transition window because of late notice of discharge (e.g., Friday 4 p.m. NOMNC ending coverage as of Sunday).

- ***Members are pleased to see that CMS proposes to prohibit plans from denying coverage due to lack of medical necessity for a service that received prior authorization but worry that plans will find another reason to kick back these claims and delay or deny payment for services rendered.*** Members note that some plans audit every single claim and retroactively deny coverage and payment even though they previously authorized the service. The plans will claim there is no documentation to support medical necessity but obviously the plan had such evidence when they initially approved the service. Providers are paying the price in administrative burden to fight these erroneous denials (e.g. hiring additional staff, time spent on hold with plans). Members note that these denials can go back for services provided 2-5 years earlier. There needs to be a limit placed on plans lookback in addition to this proposed requirement that a plan cannot deny a service if it has approved it through prior authorization.

- ***Current regulations permit MA plans to issue short notice for discharge/end of coverage without ensuring safe transitions.*** This is especially problematic when a plan issues a Notice of Medicare Non-Coverage(NOMNC) late on a Friday afternoon, which is increasingly happening. SNFs are unable to complete all the necessary referrals to ensure safe transitions through the initiation of home health and the arrival of needed Durable Medical Equipment (e.g. such as a hospital bed). Often these individuals return home with no or inadequate family caregiver support or if they are able, they pay privately to extend their SNF stay until needed services and equipment can be scheduled. In traditional Medicare, SNFs work with the patient and the family to identify a discharge date and then conducts the appropriate outreach to home health and other agencies to make sure it is scheduled before the person is discharged. This is possible because the SNF knows that discharge timing more than 2 days in advance.

- ***The proposed rule would require plans to cover a "course of treatment" once a prior authorization is approved. It is not clear if "course of treatment" includes post-acute care services provided by SNFs and home health (HH) agencies.*** CMS should ensure that "course of treatment" covers the full traditional Medicare benefit should a beneficiary need it, which includes up to 100 days of SNF and a 30-day episode of HH care and the estimated number of SNF days or HH visits required as identified in the individual beneficiary's care plan. Currently, plans approve SNF care for a certain number of days (e.g., 7 days) and then require authorization to continue coverage (e.g., typically continued coverage only lasts 2 days). MA plans and their third-party care management companies often

disagree with the provider's assessment of a beneficiary's need even though the plan often is only conducting a paper review or applying an algorithm based upon other individuals' experiences and has not seen the person for whom they are making coverage determinations. Providers want to make sure that plans approve a "course of treatment" and that this term includes the duration and services identified in the individual's care plan for post-acute care. Members are encouraged to explain in their comments the process for determining how much care someone needs in SNF and HH (e.g. standard assessments, therapy assessments, input from initial physician visit) and share examples of how MA plans preauthorize treatment in discrete increments.

- ***The prior authorization and appeals process adds stress to beneficiaries and their families at a time of illness. Members have found this to be resource-intensive and time-consuming process.*** *For these reasons, beneficiaries and providers often don't appeal.*

- ***Utilization management committee should include one or more MA enrollees or family caregivers, and health care professionals with experience working in a skilled nursing facility and home health. Current network providers should be included in the review process.***

- ***Examples:*** *Members have numerous examples of how MA plans approach coverage determinations currently. Please share an example or two of situations where an MA enrollee was denied care, including reasons (e.g. can ambulate 50 ft, not making progress) that would have been covered by traditional Medicare and a situation where care was approved including how long to obtain prior authorization for service, the duration the service was initially approved for and number of re-authorizations required to ensure person had all PAC services needed (as determined by PAC assessment). Include any details about reasons for denial, if an appeal was made, how long it took for the plan to complete appeal, authorize services, who has to pay for care while appeal process is pending, etc.*

Other proposed inclusions that support PO operations and can be included in your comments as acknowledgements:

- Allow flexibility in maintenance of medical records and communication records relating to participant care, preferences, health, and safety. These communications, so long as they are documented and maintained in compliance with HIPPA, would no longer need to be included in the participant's medical record.
- Allow extension of services through service determination requests to be approved either orally or in writing. (The current requirement: written only.)