HANYS®
Always There for Healthcare

Marie B. Grause, RN, JD • President

Headquarters
One Empire Drive, Rensselaer, NY 12144
518.431.7600

Washington, DC Office
499 South Capitol Street SW, Suite 410
Washington, D.C. 20003
202.488.1272

January 5, 2024

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically: regulations.gov

Re: Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specification (CMS-4205-P)

Dear Administrator Brooks-LaSure:

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on the proposed changes to the Medicare Advantage and Part D programs for contract year 2025.

HANYS appreciates CMS' efforts to strengthen beneficiary protections, promote access to behavioral health providers, advance coverage equity and improve supplemental benefits in the MA program.

Participation in MA plans continues to grow; in 2022, more than 30 million Medicare beneficiaries were enrolled in an MA plan — more than half of all Medicare beneficiaries. In New York, 54% of beneficiaries were covered by an MA plan that same year.

This trend shows no signs of slowing down, as the Congressional Budget Office projects total MA enrollment will reach 62% of all Medicare beneficiaries by 2033.

HANYS and our members have long supported consumer choice and innovation within a strong health insurance market. Although the MA program offers some apparent advantages to beneficiaries, it also comes with unintended limitations that are inconsistent with Medicare fee-for-service policy, causing confusion for beneficiaries who may not understand the differences between FFS and MA.

Far too often, MA plans' policies and practices harm Medicare beneficiaries by denying and delaying care, which drives up the cost of care and adds unnecessary administrative burdens for hospitals and health systems. In recent years, federal regulators have released reports examining concerning trends in the MA program.

The Health and Human Services Office of the Inspector General found that among requests MA plans denied, 13% of prior authorization denials and 18% of payment denials met Medicare FFS coverage rules, meaning the MA plan delayed or denied seniors access to services that would have likely been approved under traditional FFS.

The Medicare Payment Advisory Commission reported that seniors in MA plans who use more services are more likely to disenroll from an MA plan than healthier seniors, while the Government Accountability Office discovered that enrollees in MA plans are more than twice as likely as other enrollees to switch to FFS during their last year of life.

While the calendar year 2025 MA rule does not include greater direction or clarity around enforcement and compliance policies for the 2024 rules, we appreciate CMS' continued efforts to improve the MA program and advance important consumer and beneficiary protections.

Behavioral health access

The healthcare community is currently responding to a tremendous surge in behavioral health needs within a historically underfunded and under-resourced behavioral health infrastructure. Network adequacy is a major, longstanding obstacle to care for individuals with behavioral health needs. MA plans struggle to build an adequate network of behavioral health providers, despite CMS requiring a minimum number of behavioral health providers and encouraging the use of telehealth providers.

Disparate reimbursement rates and workforce shortages contribute to inadequate behavioral health networks. While limited provider networks can result in barriers to care in any field of medicine, they are particularly acute in behavioral health, impeding patient access to critical services. The need to invest in behavioral health and address network adequacy has never been more urgent.

CMS proposes several changes to strengthen the network adequacy standards for certain behavioral health provider types within the MA program. CMS seeks to create a new "Outpatient Behavioral Health" facility type for which CMS can set MA plan network adequacy standards. This category would include marriage and family therapists, mental health counselors, Opioid Treatment Program providers, Community Mental Health Centers, addiction medicine physicians and other providers that furnish addiction medicine and behavioral health counseling or therapy services.

CMS also proposes to add the Outpatient Behavioral Health facility type to the list of specialties that qualify MA plans for a 10% network adequacy credit if their contracted network includes one or more telehealth providers of that specialty type.

HANYS strongly supports these efforts to improve access to behavioral health services for MA enrollees and urges CMS to finalize them. However, significant shortages in the behavioral health workforce may challenge attempts to establish adequate networks. We urge CMS and

Congress to invest resources to support behavioral health workforce development. Maintaining a robust and stable healthcare workforce is the cornerstone of providing quality care.

Enrollee rights to appeal termination for certain post-acute care services

CMS proposes streamlining the process for an enrollee to appeal an MA plan's decision to terminate coverage for certain post-acute care services (skilled nursing facility, home health or comprehensive outpatient rehabilitation facility), including expanding the rights of MA beneficiaries to access an expedited appeal and aligning the process for an expedited review with Medicare FFS procedures.

Currently, MA enrollees do not have the same procedural access to a fast-track appeal as Medicare FFS beneficiaries. If finalized, the rule would grant MA enrollees access to an expedited appeal conducted by an independent Quality Improvement Organization and would eliminate an existing provision that requires forfeiture of an enrollee's right to appeal a termination of services decision once they leave the facility.

HANYS strongly urges CMS to finalize this proposal and expand the rights of MA beneficiaries to access the fast-track appeals process. We ask CMS to consider applying the same protections and appeal rights described above more broadly than SNFs, HH agencies and CORFs, and extend these protections to other hospital provider types including short-term acute, inpatient rehabilitation and long-term care hospitals.

Health equity analysis of MA plan utilization management policies

HANYS shares CMS' strong commitment to advancing health equity and we appreciate CMS' attention to health equity within the context of the MA program. HANYS and our members are committed to systematically and intentionally addressing social determinants of health and closing healthcare gaps in every New York community. HANYS believes that closing these gaps will enable every individual to achieve optimal health through the delivery of equitable healthcare services.

CMS proposes requiring MA plans to conduct an annual health equity analysis of their prior authorization and utilization management policies and procedures from a health equity perspective through their utilization management committees, which were required in the 2024 CY rule.

The proposed health equity analysis would require MA plans to look at eight specified metrics — including denial rates, appeal overturn rates and determination turn-around times — for enrollees with one or more of the following social risk factors: receipt of the low-income subsidy or is dually eligible for Medicare and Medicaid; or has a disability. CMS also proposes that the utilization management committee include at least one member with expertise in health equity. MA plans would have to publicly publish the results of this health equity analysis on their websites.

HANYS supports these proposals. To ensure equitable and independent representation on the UM committee, we recommend that CMS consider requiring the inclusion of additional stakeholders, such as current Medicare beneficiaries and other independent clinicians.

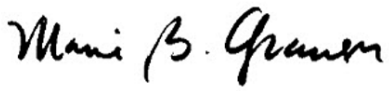
Enforcement and oversight

HANYS strongly believes that CMS needs to provide greater oversight of MA plan behavior. We have long advocated for CMS to exercise its authority and ensure that MA plans cover the same services and benefits as Medicare FFS. Without proper oversight and enforcement, MA plans have no determent to change their behavior and comply with CMS rules.

HANYS urges CMS to create a mechanism for providers and other stakeholders to identify and report suspected violations. We also ask CMS to establish meaningful penalties for MA plan non-compliance.

If you have questions, contact Victoria Aufiero, vice president, insurance, managed care and behavioral health, at 518.431.7889 or vaufiero@hanys.org.

Sincerely,



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