MEDICARE ADDICTION PARITY Project

Calendar Year (CY) 2024 Medicare Advantage Final Rule:
Substance Use Disorder and Mental Health Provisions

April 2023

The Centers for Medicare & Medicaid Services (CMS) released its CY 2024 Medicare Advantage (MA) final rule on April 12, 2023. Each year, CMS issues proposed regulations to make policy and technical changes to Medicare Part C (the Medicare Advantage Program) and Part D (the Prescription Drug Benefit Program) for the upcoming calendar year. For this proposed rule, CMS also solicited recommendations in a Request for Information on August 1, 2022, specifically with respect to advancing health equity and expanding access to coverage and care. The Legal Action Center (LAC) responded to the request for information with public comments and to this proposed rule with public comments. The following chart summarizes CMS's proposals, LAC's comments, the final rule, and our next steps.

CMS Proposal	LAC Comment	CMS Final Rule	Next Steps (if applicable)
Ensuring Equitable Access: Amend the list of populations for whom MA plans must provide equitable access to care to include people (1) with limited English proficiency or reading skills; (2) of ethnic, cultural, racial, or religious minorities; (3) with disabilities; (4) who identify as lesbian, gay, bisexual, or other diverse sexual orientations; (5) who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex; 6) who live in rural areas and other areas with high levels of deprivation; and (7) otherwise adversely affected by persistent poverty or inequality.	LAC supported this proposal.	CMS finalized the rule as proposed at § 422.112(a)(8). (p. 22152-53).	

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Provider Directories – Health Equity: Require MA organizations to include providers' cultural and linguistic capabilities (including ASL) in their provider directories, consistent with Medicaid managed care standards.	LAC supported this proposal.	CMS finalized the rule as proposed at § 422.111. (p. 22153-57).	
Provider Directories – Prescribers of MOUD: Require MA organizations to identify office-based providers who are waivered to treat patients with medications for opioid use disorder (MOUD) in their provider directories.	LAC supported this proposal and recommended that CMS still require MA organizations to identify providers who offer MOUD even though Congress eliminated the requirement that these providers receive a waiver to do so as of December 29, 2022 and after publication of the proposed rule.	CMS withdrew this proposed rule based on the recommendation in the majority of comments it received, since Congress eliminated the waiver requirement and no industry standard exists for tracking such providers. (p. 22157). CMS will consider developing guidance on best practices for provider directories to identify the wide variety of providers with expertise to treat patients with opioid use disorder (OUD). (p. 22158).	Work with CMS to identify best practices for identifying providers with expertise to treat patients with OUD and designating them in provider directories and advocate that such identification be required, rather than a best practice.
Digital Health Education: Require certain MA organizations to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist them with accessing medically necessary covered telehealth benefits.	LAC supported this proposal and encouraged CMS to continue to address additional aspects of the digital divide, including access to devices, data plans, and high-speed broadband.	CMS finalized the rule with a modification to apply the new requirement to all MA organizations, instead of just those offering coordinated care plans, at § 422.100(n). (p. 22158-60).	Continue advocacy to CMS and Congress to adopt policies and strategies to address barriers to telehealth adoption for those who wish to use it and ensure privacy protections.

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Behavioral Health Specialties in MA Networks: Add (1) clinical psychology, (2) clinical social work, and (3) prescribers of MOUD (including both opioid treatment programs [OTPs] and individual providers with a waiver to prescribe MOUD) as provider specialty types in MA networks for which MA organizations must meet minimum network adequacy standards. These new provider types would also be subject to the 10% credit towards the MA plans' time and distance network adequacy standards if they provide additional telehealth benefits.	LAC supported this proposal and recommended that CMS still require MA organizations to include providers who offer MOUD even though Congress eliminated the requirement that these providers receive a waiver to do so.	CMS finalized the rule to add (1) clinical psychology and (2) clinical social work as specialty types at §§ 422.112 and 422.116, with the 10% telehealth credit towards network adequacy. (p. 22168-71). CMS withdrew the proposed rule to add prescribers of MOUD due to an inability to track individual prescribers with the removal of the waiver requirement and the insufficient number of OTPs to create meaningful access standards as a facility type. CMS will monitor the appropriateness of setting such standards in future rulemaking as OTPs continue to expand. (p. 22170).	Continue advocacy to CMS to adopt network adequacy standards for substance use disorder treatment, including prescribers of MOUD and OTPs.
Care Coordination for Behavioral Health Services: Add behavioral health services to the types of services that MA organizations that offer MA coordinated care plans must have programs in place to ensure continuity of care and integration of services.	LAC supported this proposal and encouraged CMS to use the terms "mental health and substance use disorder" rather than "behavioral health."	CMS finalized the rule as proposed at § 422.112(b)(3). (p. 22171-72).	

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Emergency Behavioral Health Services: Clarify that MA organizations must cover and reimburse for emergency services for behavioral health conditions without prior authorization and regardless of the provider's contractual relationship with the MA organization.	LAC supported this proposal and encouraged CMS to clarify that a substance use-related emergency is included, as the examples and proposed language only related to mental health.	CMS finalized the rule as proposed at § 422.113(b), but stated that it interprets the scope of the definition to pertain to "behavioral health conditions." (p. 22172-73).	
Appointment Wait Time Standards: Adopt minimum appointment wait time standards for mental health and substance use disorder services that are comparable to primary care and based on the type of services and level of need: (1) urgently needed or emergency – immediately; (2) requiring medical attention but not emergency or urgently needed – within 1 week; and (3) routine and preventative care – within 30 days.	LAC supported this proposal.	CMS finalized the rule as proposed with a modification to clarify that the standards are based on business days (such that appointments for urgently needed or emergency services must be available immediately, those requiring medical attention must be available within 7 business days, and routine and preventative care must be available within 30 business days) at § 422.112. (p. 22173-75).	
Network Adequacy – Access to Services: Require certain MA plans to arrange for and cover out-of-network care and only charge in-network cost-sharing when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs.	LAC supported this proposal and recommended CMS further amend the regulation to protect enrollees against balance billing.	CMS finalized the rule as proposed at § 422.112(a). (p. 22175-79).	Continue advocacy to CMS to develop policies that ensure non-network providers are reimbursed appropriately and do not balance bill enrollees.

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Enrollee Notification Requirements: Require MA plans to notify enrollees by writing and phone at least 45 days before their current or former behavioral health or primary care provider leaves the network.	LAC supported this proposal.	CMS finalized the rule with modifications (1) that notice by phone is one attempt and (2) only enrollees who have been a patient of the provider within the past 3 years, at § 422.111(e). (p. 22179-85).	
Utilization Management – Coverage Criteria: Require MA plans to use coverage criteria that are no more stringent than those used in Traditional Medicare (standalone Parts A and B) as specified in Medicare statutes, regulations, and National and Local Coverage Determinations. MA plans must make medical necessity determinations based on that coverage criteria, and may not deny coverage based on any other criteria. MA organizations must also consider the enrollee's medical history, physician recommendations, and clinical notes. When Traditional Medicare coverage criteria are not fully established, MA plans' internal clinical criteria must be based on current evidence in widely used treatment guidelines or clinical literature (such as the ASAM Criteria) and provide a publicly accessible summary of the evidence, sources, and rationale for such criteria.	LAC supported this proposal and recommended CMS (1) continue to review its coverage criteria for Traditional Medicare benefits to ensure they are consistent with generally accepted standards of care; (2) specify that the internal coverage criteria must be consistent with current generally accepted standards of care developed by nonprofit professional associations for the relevant clinical specialty; and (3) require MA plans to make their internal coverage criteria publicly available.	CMS finalized the rule as proposed at § 422.101(b) and (c). (p. 22187-200). CMS made modifications to § 422.101(b)(6) to (1) clarify circumstances in which MA plans may use internal coverage criteria, (2) clarify that they only need to make the internal criteria in use publicly accessible, and (3) enhance transparency requirements related to the use of internal coverage criteria (p. 22199).	

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Utilization Management – Prior Authorization: Limit certain MA plans' use of prior authorization (1) to confirm the presence of diagnoses or medical necessity criteria, (2) for basic benefits, to ensure an item is medically necessary (as specified above), and (3) for supplemental benefits, to ensure clinical appropriateness, and not operate to deny or delay care. Plans may also not later deny care due to lack of medical necessity that was previously approved in a prior authorization.	LAC supported this proposal, recommending also that MA plans defer to the treating provider for what care is medically necessary and that MA plans publicly disclose utilization management requirements. LAC also recommended MA plans notify the provider before denying care and issue detailed notices.	CMS finalized the rule as proposed at § 422.138(b) and (c), with the clarification that prior authorization processes include all policies and procedures used in prior authorization. (p. 22200-05).	
Continuity of Care: Require that the approval of prior authorization be valid for the entire duration of the approved course of treatment and that MA plans provide a minimum 90-day transition period when an enrollee currently undergoing an active course of treatment switches to a new MA plan.	LAC supported this proposal.	CMS finalized the rule as proposed at § 422.112(b)(8). (p. 22205-11).	
Utilization Management Committees: Require MA organizations to establish Utilization Management (UM) committees led by the plan's medical director to review and approve UM policies.	LAC supported this proposal.	CMS finalized the rule as proposed at § 422.137 (p. 22211-16).	