National Rural Health Association

January 5, 2024

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

RE: CMS–4205–P; Medicare Program; Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Program.

Submitted electronically via regulations.gov.

Dear Administrator Brooks-LaSure,

The National Rural Health Association (NRHA) is pleased to offer comments on the Centers for Medicare and Medicaid Services (CMS) proposed rule for contract year (CY) 2025 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, and we look forward to our continued collaboration to improve health care access throughout rural America.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

III. Enhancements to the Medicare Advantage and Medicare Prescription Drug Benefit Plan.

A. Expanding Network Adequacy Requirements for Behavioral Health.

As Medicare Advantage (MA) enrollment rapidly grows in rural areas, NRHA strongly supports CMS' efforts to ensure MA beneficiaries have equitable access to providers compared to their counterparts in traditional Medicare.[1] **NRHA commends the efforts that CMS has undertaken to address challenges in building MA behavioral health networks, and NRHA is broadly supportive of proposals that strengthen rural beneficiaries' access to behavioral health services**, including access to substance use disorder prevention and treatment services.

NRHA supports CMS' proposal to add Outpatient Behavioral Health as a new specialty-facility type at § 422.116(b), requiring MA plans to ensure adequacy of Outpatient Behavioral Health facilities in networks and to add corresponding time and distance standards at § 422.116(d)(2).

[1] Edmer Lazaro, Fred Ullrich, & Keith Mueller, *Medicare Advantage Enrollment Update 2023*, RUPRI CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF IOWA COLLEGE OF PUBLIC HEALTH (Nov. 2023), 1 ("the rate of growth continues to be higher in nonmetropolitan counties [10.5 percent] than in metropolitan counties [7.2 percent]") https://rupri.public-health.uiowa.edu/publications/policybriefs/2023/Medicare%20Advantage%20Enrollment%20Update%202023.pdf.

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NRHA applauds CMS' recognition of the importance of the full range of behavioral health providers, including the newly Medicare covered mental health counselors (MHCs) and marriage and family therapists (MFTs) in meeting the needs of all beneficiaries, including those in rural communities. MHCs and MFTs are important rural providers because rural communities often rely on behavioral health professionals who are not physicians or doctorate-level individuals, particularly for behavioral health care.

NRHA supports CMS' inclusion of opioid treatment programs (OTPs) in the Outpatient Behavioral Health specialty facility type. The rural U.S. has been disproportionately impacted by the opioid crisis, and despite this, the rural U.S. still faces a troubling insufficiency of OTPs. According to NRHA's internal analysis, only about 220 of 1,900 Substance Abuse and Mental Health Services Administration (SAMHSA)-certified OTPs are located in rural zip codes. This lack of rural OTPs becomes even more acute depending on the state. For example, out of 168 OTPs in California, 2 are available in rural areas and only 1 out of 17 OTPs in Minnesota is rural. Some MA plans may be unable to contract with even one OTP in its service area due to provider availability in rural areas of certain states. This would result in rural beneficiaries in a plan being unable to access methadone and other substance use disorder (SUD) treatments.

Separate Categories for Outpatient Mental Health and Outpatient Substance Use Disorder.

Importantly, both mental health providers and OTPs are in significant shortage in rural areas. In order to optimize CMS and stakeholder ability to observe trends and identify areas of need, **NRHA recommends that CMS require tracking of this new facility type by separately reporting metrics for "Outpatient Mental Health" and "Outpatient Substance Use Disorder" providers, rather than requiring tracking through a combined category**.

As proposed § 422.116(b)(2)(xiv) is written, an MA plan could contract exclusively with MHCs and MFTs, not contract with any OTPs or SUD providers, and still meet the proposed network adequacy standards. Further, while some Community Mental Health Centers provide SUD treatment, there are no conditions of participation that these facilities have staff to treat or do treat SUD. OTPs are the only health care facilities that can offer patients all three forms of FDA-approved medication for opioid use disorder: methadone, buprenorphine, and injectable extended-release naltrexone.[2] Additionally, OTPs are the only setting where patients can receive methadone. Again, MA plans may contract with other outpatient behavioral health providers, but not OTPs, thus their beneficiaries would not have access to methadone, a lifesaving treatment for opioid use disorder. **NRHA submits that the specialty facility type, "Outpatient Behavioral Health," as written, is too broad to achieve its aim of ensuring in-network outpatient behavioral health access and treatment through MA plans.** This specialty type should be disaggregated into two new types, "Outpatient Mental Health" and "Outpatient Substance Use Disorder."

Additionally, NRHA recommends that the "Outpatient Substance Use" category be further disaggregated into an OTP category and a separate "Outpatient Substance Use" category for all other practitioners who deliver these services. There are unique challenges associated with accessing OTPs that are distinct from accessing mental health services. For instance, prior to the COVID-19 Public Health Emergency, beneficiaries who receive methadone for opioid use disorder at OTPs were required to travel to the OTP nearly every day for several years to receive their

[2] Issue Brief, *Overview of opioid treatment program regulations by state*, PEW, Sept. 19, 2022, https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2022/09/overview-of-opioid-treatment-program-regulations-by-state.

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medication. It is accordingly critical that MA plans include in-network OTPs, as measured separately from other SUD facility types.

Maximum Time and Distance Standards.

NRHA, in general, supports the sentiment behind network adequacy or composition standards in improving access to mental health or SUD providers in rural areas. NRHA supports the maximum time and distance standards, as set forth in the proposed rule. While NRHA appreciates that shortening the time and distance standards may, on paper, increase the ease with which beneficiaries on MA plans can access mental health and SUD providers at the frequency at which these services are often delivered, NRHA is concerned that overly strict standards around network composition may disincentivize plans from operating in certain rural communities because there are not enough providers to meet the standards. This is more likely to happen in rural areas where there is a dearth of mental health and SUD practitioners. Again, NRHA believes that mental health and SUD networks should be as robust as medical networks in plans, but oftentimes this is a difficult standard for plans offering coverage in rural areas.

Percentage Point Credit for Telehealth Providers.

NRHA takes particular interest in CMS' proposal to add the new Outpatient Behavioral Health facility-specialty type to the list at § 422.116(b)(5) of the specialty types that will receive the existing 10-percentage point credit for behavioral health specialty types if the MA organization's contracted network of providers includes one or more telehealth providers of that specialty type that provide additional telehealth benefits, as defined in § 422.135, for covered services.

As noted by CMS, Medicare fee-for-service claims data shows that telehealth was the second most common place of service for claims with a primary behavioral health diagnosis in 2020. Among residents of the rural U.S., reliance on telehealth to access outpatient mental health and SUD treatment is particularly high. Between March and August 2021, 55% of rural residents' outpatient mental health and SUD visits were delivered via telehealth, compared to 35% of urban residents' outpatient mental health and SUD visits.[3] This significant telehealth use included outpatient visits across major mental health and SUD diagnoses.

The most recent Health Professional Shortage Area (HPSA) report shows that around 67% of all mental health HPSA designations are in rural or partially rural areas.[4] By incentivizing the use of telehealth, CMS and MA plans may help to ease the barriers around workforce shortages and continue to increase remote behavioral health care for rural residents that otherwise lack a nearby provider. In addition, rural and urban patient retention in OUD treatment is higher when telehealth is used.[5] **As such, NRHA supports adding Outpatient Behavioral Health to the specialty types eligible for the 10-percentage point credit.**

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[3] Justin Lo, et al., *Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic*, KAISER FAMILY FOUNDATION, Mar. 15, 2022, https://www.kff.org/mental-health/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/.

[4] Bureau of Health Workforce, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics: Fourth Quarter of Fiscal Year 2023* (Sept. 30, 2023) https://data.hrsa.gov/default/generatehpsaquarterlyreport.

[5] Noa Krawczyk, et al., *Pandemic telehealth flexibilities for buprenorphine treatment: a synthesis of evidence and policy implications for expanding opioid use disorder care in the United States*, 1 HEALTH AFFAIRS SCHOLAR 1, 7 (2023) https://academic.oup.com/healthaffairsscholar/article/1/1/qxad013/7203714?login=false.

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C. Mid-Year Notice of Unused Supplemental Benefits (§§ 422.111(l) and 422.2267(e)(42)).

NRHA supports the proposed revised enrollee notification requirements at §§ 422.111(l) and 422.2267(e)(42), which will require MA organizations to provide a notification to enrollees of supplemental benefits they have not yet accessed as of mid-year. **NRHA appreciates CMS' recognition of low utilization of supplemental benefits, especially as these are often used to entice beneficiaries into enrolling in an MA plan rather than traditional Medicare.** NRHA believes that the proposed targeted outreach with respect to supplemental benefits that have not been accessed is a positive step in equipping and empowering MA beneficiaries with the information necessary to make healthcare decisions and to take full advantage of the benefits available to them. NRHA further appreciates that the proposed rule denotes that this notice would be delivered by mail, which is important in ensuring that rural residents, including elderly rural MA beneficiaries who are less likely to have regular access to internet, receive these proposed mid-year notices.[6]

D. Annual Health Equity Analysis of Utilization Management Policies and Procedures.

Rural Americans face numerous health disparities compared with their urban counterparts. The rural health providers who serve them face unique structural challenges in delivering access to high quality care to all rural residents. In standing with rural Americans and the providers who serve them, NRHA is committed to the advancement of health equity in rural America and is generally supportive of measures that promote the same.

It follows that NRHA supports the spirit of the proposal that incorporates health equity into the responsibilities of MA organizations' Utilization Management (UM) committees. **Specifically, NRHA applauds the proposal that the UM committees be tasked with conducting and publishing results of an annual health equity analysis of the use of prior authorization.** NRHA members have consistently expressed serious concerns over the prior authorization practices of MA organizations, and this analysis of prior authorization's impact is a positive step. In fact, while NRHA recognizes the importance of specifically examining the impact of prior authorization on enrollees with one or more social risk factors, **NRHA suggests broadening of the scope of the proposal to include an annual health equity analysis that evaluates the impact of the use of prior authorization on all rural beneficiaries.**

As such, NRHA supports the proposal that the health equity analysis include specific examination of the impact of prior authorization on beneficiaries with social risk factors, including being low-income, Medicare/Medicaid dual eligible, or disabled. This is particularly relevant to rural areas, as rates of rural poverty have consistently exceeded urban poverty rates (in 2019, ACS reported nonmetro poverty rate at 15.4% compared with 11.9% for metro areas), and there are higher proportions of disabled individuals in the rural U.S. compared to urban U.S. (in 2021, 14.7% of rural residents reported experiencing a disability, while 12.6% of urban residents reported experiencing a disability).[7]

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[6] Hee Yun Lee et al., Rural and non-rural digital divide persists in older adults: Internet access, usage, and perception, Innov Aging. 2020; 4(supple 1): 412-13. Doi: 10.1093/geroni/igaa057.1329. (Compared to older adults living in urban areas, those residing in rural areas had 29% lower odds of internet access.)

[7] Policy Brief, *Many rural areas are still "left behind,"* UNIVERSITY OF WISCONSIN INSTITUTE FOR RESEARCH ON POVERTY, Jan. 2020, https://www.irp.wisc.edu/resource/many-rural-americans-are-still-left-behind/; Report, *Rural*

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NRHA is also generally supportive of the proposed UM committee composition requirement that a member of the UM committee have expertise in health equity. NRHA asks that in finalizing its rule that CMS would clarify the definition of "expertise" in health equity, and NRHA recommends that a background and experience, professional or lived, in rural health equity be required for UM committees of MA plans that serve rural beneficiaries.

VI. Medicare Advantage/Part C and Part D Prescription Drug Plan Marketing and Communications.

B. Agent Broker Compensation.

NRHA commends CMS' proposal to specify in its regulations at § 422.2274 a specific maximum compensation amount that may be paid to agents and brokers for initial enrollment and renewals, regardless of the plan that the MA beneficiary enrolls in. NRHA recognizes the evidence supporting concerns of increased anti-competitive and anti-consumer steering among MA organizations, as outlined by CMS in this proposed rule. NRHA commends the proposed guardrails in order to improve consumer protection.

Other Medicare Advantage Issues.

Rural areas are seeing MA penetration increase at higher rates compared to urban areas.[8] NRHA is concerned about trends in practices by MA plans as enrollment in these plans continues to grow, surpassing enrollment in traditional Medicare.[9] **This growth in MA plans, which are considered commercial payers, is contributing to higher administrative burden for rural providers and a dismantling of the critical rural provider designations.**

MA plans are not required to adhere to Medicare provider designations and are treated as commercial payers. For rural cost-based providers, like critical access hospitals (CAHs), MA reimbursement can be less than their traditional Medicare rate of 101% of reasonable costs. Rural Health Clinics (RHCs) face similar reimbursement challenges with an estimated 55 – 60% of RHCs receiving significantly less from MA plans than traditional Medicare. CAHs and RHCs have fewer resources to negotiate payment with plans and have rates that are typically below what traditional Medicare pays. The difference in reimbursement degrades the value of these safety net designations as MA beneficiary shares grow. Federally Qualified Health Centers (FQHCs) are largely protected from inadequate MA payment. FQHCs receive wrap-around payments from Medicare to make up for the discrepancy between MA plans' rates and their traditional Medicare rate. Rural safety net providers require a similar payment arrangement to protect their viability. Another option is to mandate floor payments that MA plans must pay to rural cost-based providers to ensure parity between MA and traditional Medicare reimbursement. Further, MA patient days should be considered as Medicare days on CAH, RHC, Medicare-Dependent Hospital, and Low-Volume Hospital cost reports and settlements.

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poverty & well-being, ECONOMIC RESEARCH SERVICE, U.S. DEPARTMENT OF AGRICULTURE, Nov. 15, 2023, https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/; Katrina Crankshaw, *Disability rates higher in rural areas than urban areas*, UNITED STATES CENSUS BUREAU, June 26, 2023, https://www.census.gov/library/stories/2023/06/disability-rates-higher-in-rural-areas-than-urban-areas.html.

[8] Lazaro, Ullrich, & Mueller, *supra* note 1.

[9] *Id.*

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Rural providers are currently expending significant time and resources on MA-related issues, taking away valuable time from already limited staff. Small, rural providers do not have the bandwidth or leverage to negotiate properly with MA plans to get adequate reimbursement. Beyond low reimbursement rates, rural providers struggle to be paid in a timely manner. Medicare pays providers within 30 days; however, MA plans do not have to abide by a timeline. NRHA members have noted that they may wait as long as 90 days – or three times as long – to receive payment from MA plans. For rural safety net providers that are operating on thin margins, this lag in payment is unacceptable. Even after receiving prior approval and providing services to beneficiaries, NRHA members have noted that MA plans are denying claims. Bigger, more well-resourced facilities likely have dedicated staff to deal with these complexities, but rural providers do not.

For rural patients, navigating prior authorization processes is difficult and time consuming. NRHA greatly appreciates the progress that CMS made in its final CY 2024 Medicare Advantage Policy & Technical Changes rule to curb prior authorization abuses. Yet there have been reports that MA plans are refusing to comply with the new regulations that would increase patient access to needed care and reduce prior authorization burdens.[10] NRHA urges CMS to closely monitor compliance with the rules finalized last year, particularly as plans have issued guidance indicating that they will continue to use internal prior authorization criteria beyond that used in traditional Medicare.[11]

Last, NRHA has heard complaints that MA plans steer beneficiaries away from local care. MA plans often limit beneficiary choice by steering them to certain providers, disrupting historic patterns of care. Oftentimes the providers chosen by MA plans are not local and therefore more inconvenient for rural beneficiaries seeking care. Keeping care local is a key goal in rural health care delivery and MA plans should not drive beneficiaries to urban settings to receive care or treatment.

NRHA encourages CMS to work within its authority and alongside Congress to address the issues with MA that rural patients and providers are facing. We also reiterate our response to the August 2022 Medicare Advantage Request for Information put forth by agency.[12]

Thank you for the chance to offer comments on this proposed rule and for your consideration of our comments. We look forward to continuing our work together to ensure our mutual goal of improving quality and access to care for rural residents. If you would like additional information, please contact Alexa McKinley at amckinley@ruralhealth.us.

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association

[10] Alison Bennett, *Medicare Advantage plans ducking new coverage rules, AHA claims*, MODERN HEALTHCARE, Nov. 21, 2023, https://www.modernhealthcare.com/politics-policy/health-plans-2024-medicare-advantage-rule-aha-cms-unitedhealthcare; Press Release, Federation of American Hospitals, MA Beneficiaries Should Not Be Shortchanged (Nov. 20, 2023), https://www.fah.org/blog/ma-beneficiaries-should-not-be-shortchanged-fah-leader-calls-out-unlawful-unitedhealthcare-policies/; Letter from American Hospital Association to CMS, Nov. 20, 2023, https://www.aha.org/system/files/media/file/2023/11/AHA-Urges-CMS-to-Swiftly-Correct-Medicare-Advantage-Plan-Policies-That-Appear-to-Violate-CY-2024%20Rule.pdf.
[11] Letter from AHA, *supra* note 3.
[12] https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/2022-08-31-Medicare-Advantage-RFI.pdf

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