

Summary of Final 2024 Medicare Advantage and Part D Rule: Important Consumer Protections Regarding MA Prior Authorization, Marketing and Other Issues

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I. BACKGROUND

On December 14, 2022, the Centers for Medicare & Medicaid Services (CMS) released a [proposed rule](#) for Medicare Advantage and Part D for 2024 which included significant improvements to consumer protections including provisions that would rein in MA plans' use of prior authorization and additional limits on marketing misconduct. CMS also published a [press release](#) and accompanying [fact sheet](#) addressing the proposed rule. As discussed in our [CMA Alert](#) (Feb. 16, 2023), the Center submitted extensive [comments](#) to this proposed rule. Note that a proposed interoperability rule, which, among other provisions, proposed to shorten Medicare Advantage organization determination time periods (effective 2025), is still pending as of early May 2023.

On April 5, 2023, CMS released the final rule, as discussed in this CMS Fact Sheet titled "[2024 Medicare Advantage and Part D Final Rule \(CMS-4201-F\)](#)." The final rule was published in the Federal Register on Wednesday, April 12, 2023 (88 FR 22120), and is available [here](#).

The summary below focuses, in turn, on Medicare Advantage (MA) Prior Authorization, Marketing Provisions and Other Provisions. Note that page numbers refer to the Federal Register.

II. MEDICARE ADVANTAGE PRIOR AUTHORIZATION

The final rule includes a number of **significant improvements** to the rules surrounding Medicare Advantage plans' use of prior authorization to restrict access to services. The rule indicates a clear intent by CMS to limit plans' ability to inappropriately deny care to enrollees. As with most consumer protections, however, the efficacy of these new rules will depend on plan compliance and CMS oversight and enforcement.

In summary, the new rules include the following requirements:

- Prior authorization may only be used for one or more the following purposes:
 1. To confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service; or
 2. For basic benefits, to ensure an item or service is medically necessary based on standards specified in § 422.101(c)(1), or
 3. For supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.
- When Medicare coverage rules are clearly established, plans cannot deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in traditional Medicare coverage policies.

- Continuity of care and course of treatment guidelines: Approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient’s medical history, and the treating provider’s recommendation. Further, plans must provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan.
- Plans must disclose internal criteria they rely upon to make decisions.

The following summary provides more details of the prior authorization provisions, roughly corresponding with the discussion in the preamble to the final rule, under the headings “Coverage Criteria for Basic Benefits”, “Appropriate Use of Prior Authorization – Medical Necessity Determinations” and “Continuity of Care”.

Coverage Criteria for Basic Benefits

NOTE: CMS distinguishes scenarios in which Medicare coverage criteria is “fully established and “not fully established.” With the former, plans cannot deny coverage based on an any “internal, proprietary, or external clinical criteria that are not found in Traditional Medicare coverage policies.” With the latter, however, plans can rely on “widely used treatment guidelines or clinical literature” external to Medicare rules.

Application of Coverage Criteria (When “Fully Established” Under Medicare)

CMS states: “[W]hen an MA organization is making a coverage determination on a Medicare covered item or service with fully established coverage criteria, the MA organization cannot deny coverage of the item or service on the basis of internal, proprietary, or external clinical criteria that are not found in Traditional Medicare coverage policies [...] certain utilization management processes, such as clinical treatment guidelines that require another item or service be furnished prior to receiving the requested item or service, would violate the [new] requirements at § 422.101(b) and (c), and thus, their use by an MA organization would be prohibited unless specified within the applicable NCD [National Coverage Determination] or LCD [Local Coverage Determination] or Medicare statute or regulation.” (p. 22188)

In the preamble, CMS states that when Medicare coverage criteria “expressly include flexibility that allows coverage in circumstances beyond the specific coverage or non-coverage indications that are listed” in the Medicare coverage criteria, MA plans are instructed as follows: “When deciding whether an item or service is reasonable and necessary for an individual patient, we expect the MA plan to make this medical necessity decision in a manner that most favorably provides access to services for the beneficiary and align[s] with CMS’s definition of reasonable and necessary as outlined in the Medicare Program Integrity Manual, Chapter 13, section 13.5.4.” (p. 22188-9)

[NOTE]: The new regulatory language at §422.101(b)(2) removes reference to sub-regulatory guidance, including the Manuals, as authority that MA plans must rely upon. In discussing this revision, however, CMS notes in the preamble (at p. 22196) that:

“we are not diminishing the content and value that these manuals and instructions provide in interpreting and defining the scope of Part A and Part B benefits. These manuals contain significant explanations and interpretations of Traditional Medicare laws governing Part A and

Part B benefits, most of it longstanding, to provide instructions and procedures for day-to-day operations for those responsible for administering the Medicare program and making coverage decisions on individual claims, so we expect that MA plans will consult the Medicare Benefit Policy Manual, Medicare Program Integrity Manual, and similar CMS guidance materials” [emphasis added].

When Coverage Criteria “Not Fully Established”

CMS states that when coverage criteria are not fully established in Medicare statute, regulation, NCD, or LCD, “MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature. We are also clarifying that coverage criteria are not fully established when additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently; NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD, or there is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.” (p. 22122)

New language at §422.101(b)(6)(i)(A) states: “The MA organization must demonstrate that the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.”

CMS further notes that internal coverage criteria must be “publicly accessible” and notes that these new policies “provide MA organizations with limited discretion to interpret Traditional Medicare coverage rules and must not create barriers to access to care in a way that is not aligned with access in Traditional Medicare.” (p. 22193)

Further, CMS clarifies “that if an MA organization denies care based on internal criteria, that criteria must be clearly stated in the denial notice, just as other applicable Medicare coverage criteria must be stated under § 422.568(e)(2), when used as the basis for a denial of coverage.” (p. 22194)

NOTE: While CMS does not explicitly prohibit MA plans’ use of **AI or algorithmic-driven tools** altogether, they state that MA plans may not use such products “to change coverage or payment criteria already established under Traditional Medicare laws.” (p. 22194). They further note that “MA organizations must ensure that they are making medical necessity determinations based on the circumstances of the specific individual, as outlined at § 422.101(c), as opposed to using an algorithm or software that doesn’t account for an individual’s circumstances [... and] [f]or an MA plan to use the coverage criteria in these tools, the MA plan will need to understand the external clinical evidence relied upon in these products and how that evidence supports the coverage criteria applied by these tools. The MA plan must make the evidence that supports the internal criteria used by (or used in developing) these tools publicly available, along with the internal coverage policies themselves. (p. 22195) (Emphasis added.)

Appropriate Use of Prior Authorization – Medical Necessity Determinations

CMS is finalizing that “prior authorization policies for coordinated care plans may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary based on standards specified in this rule.” (p. 22121-2)

At revised §422.101(c)(1), CMS is also codifying that a plan's medical necessity determination must be based on "The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes." As noted in the preamble, "physician recommendations are required to be considered when making medical necessity determinations about the specific enrollee and requested services. This will apply in all contexts, not only when an enrollee is being transferred from one level of care to another or being admitted on an inpatient basis." (p. 22198)

Continuity of Care

CMS notes that through revisions to §422.112(b)(8)(i), it is "finalizing that an approval granted through prior authorization processes must be valid for as long as medically necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation, and that plans provide a minimum 90-day transition period when an enrollee who is currently undergoing an active course of treatment switches to a new MA plan." (p. 22122)

At §422.112(b)(8)(ii), CMS offers the following definitions:

(A) Course of treatment means is 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.

(B) Active course of treatment means a course of treatment in which a patient is actively seeing the provider and following the course of treatment.

CMS states that an MA plan may, however, deviate from care ordered by the treating provider: "An MA plan may approve and authorize treatment for a different period of time than the treating provider's ordered course of treatment if the plan has determined that what was ordered or prescribed by the treating provider was not medically necessary or appropriate based on the enrollee's condition or diagnosis." (p. 22208)

CMS further explains that MA plan discretion to deviate from ordered care is limited: "However, MA plans should not shorten authorization periods that are outlined in Traditional Medicare coverage criteria. The only instances where an MA plan may use a shorter (or different) periodicity or frequency of evaluation or other such review would be if the change were consistent with the relevant coverage criteria, and supported by the evidence in the patient's medical record, and by treatment guidelines or clinical literature that is widely available. This must be clearly documented and referenced by the MA plan in the prior authorization decision. Moreover, in all instances, we expect the MA plan and its contracted provider to coordinate care to ensure that the prior authorization is approved for a period that ensures that care is delivered for as long as is medically necessary and that minimizes disruptions in care for the enrollee. In other words, the MA plan may not establish blanket rules for the duration of an authorization associated with course of treatment decisions for purposes of convenience or simplicity; the duration of a prior authorization must be valid for as long as medically necessary to avoid disruptions in care and not in conflict with applicable coverage criteria." (p. 22208) (Emphasis added.)

CMS also finalizes a proposal requiring MA plans to "establish a **Utilization Management Committee** to review all utilization management, including prior authorization, policies annually and ensure they are consistent with the coverage requirements, including current, traditional Medicare's national and local coverage decisions and guidelines. These changes will help ensure MA enrollees have consistent access to medically necessary care, without unreasonable barriers or interruptions," (p. 22122).

Further, CMS revises an existing rule at §422.590(h) that requires a **physician with expertise in the field of medicine that is appropriate for the service at issue to reconsider an adverse organization determination**. CMS clarifies this requirement “does not require the physician to be of the exact same specialty or subspecialty as the treating physician. This is a longstanding requirement in the MA program, which has demonstrated that enrollees are adequately protected by requiring the reviewer to have expertise in the field of medicine appropriate to the service at issue. The reviewer could satisfy the expertise standard in a number of ways including, but not necessarily limited to, specialized training, a certification in the applicable or related field of medicine, or related clinical experience,” (p. 22221)

III. MARKETING PROVISIONS

The final rule makes a number of important changes to Medicare Advantage (MA) and Part D Communications and Marketing requirements. As noted in the preamble to the final rule, these provisions are “applicable for all contract year 2024 marketing and communications beginning September 30, 2023.” (p. 22120)

CMS is finalizing the following changes:

- **Placing discrete limits around the use of the Medicare name, logo, and Medicare card.**
 - CMS is “specifically prohibit[ing] the misleading use of the Medicare name, CMS logo, and products or information issued by the Federal Government, as well as prohibiting the use of the Medicare card unless previously approved by CMS” (p. 22237).
- **Prohibiting the use of superlatives (for example, words like “best” or “most”) in marketing unless the material provides documentation to support the statement, and the documentation is based on data from the current or prior year.**
- **Prohibiting marketing of benefits in a service area where those benefits are not available, unless unavoidable because of use of local or regional media that covers the service area(s).**
 - CMS notes that the “unless unavoidable” standard is “only applicable to advertising that is occurring in a limited area” and not to national advertising which “cannot be tailored to only market benefits available to specific service areas” (p. 22240).
- **Requiring third-party marketing organizations (TPMOs) to list or mention all of the MA organizations or Part D sponsors that they represent on marketing materials.**
 - Note that this applies to television, print, online, radio/voice-only marketing – in other words, marketing that mentions additional benefits such as dental, hearing, vision but doesn’t identify which product/plan is being advertised is prohibited (p. 22241).
- **Prohibiting the marketing of information about savings available that are based on a comparison of typical expenses borne by uninsured individuals, unpaid costs of dually eligible beneficiaries, or other unrealized costs of a Medicare beneficiary.**
- **Clarifying that the prohibition on door-to-door contact without a prior appointment still applies after collection of a business reply card (BRC) or scope of appointment (SOA).**
 - CMS affirms that “contacting a beneficiary at the individual’s home is unsolicited door-to-door contact unless an appointment at the beneficiary’s home at the applicable date and time was previously scheduled.” (p. 22242)

- **Notifying enrollees annually, in writing, of the ability to opt out of phone calls regarding MA and Part D plan business.**
 - CMS “defer[s] to plans on how best to communicate this [...] and is] not proposing the specific written format that plans must utilize [...] nor specifying when the plan must provide this information during each contract year,” (p. 22243)
- **Prohibiting the collection of Scope of Appointment cards at educational events.**
 - CMS highlights the distinction between educational events and marketing events, noting that the former “events are meant to provide generic, factual, non-biased information about different coverage options, rather than information designed to persuade beneficiaries to enroll in a particular type of plan (for example, MA–PD or Medigap), or in a plan offered by a specific organization.” Noting an increase in reports of unsolicited contacts, CMS notes that a “likely contributor [...] is a beneficiary not realizing the contact form they have completed at an educational event gives an agent permission to contact the beneficiary in the future” (p. 22244). Notwithstanding this concern, CMS modified the proposal to allow agents to still collect business reply cards (BRCs) at educational events, while prohibiting agents from setting up future marketing appointments at such events (p. 22245).
- **Prohibiting a marketing event from occurring within 12 hours of an educational event at the same location.**
 - By requiring a separation in time and distance between educational and marketing events, CMS is reinstating policy in effect prior to 2018. CMS notes: “Beneficiaries attending an educational event directly followed by a marketing event may believe that they are being pressured, at the conclusion of the educational event, into staying for the marketing event [...] By separating educational events from marketing events, beneficiaries are afforded the time to consider all their questions and options before making any decisions about their health care and without any pressure to decide on the spot with the agent present.” (p. 22245)
- **Requiring 48 hours between a Scope of Appointment (SOA) and an agent meeting with a beneficiary, with exceptions for beneficiary-initiated walk-ins and the end of a valid enrollment period.**
 - CMS is modifying its initial proposal to prohibit meetings less than 48 hours after the SOA is signed to allow exceptions when: 1) SOAs are completed during the last four days of an election period (Annual Election Period, MA-Open Enrollment Period, Initial Coverage Election Period or a Special Enrollment Period); and 2) for beneficiaries “who walk into an agent’s office, a kiosk, a plan’s office or any other walk in [...] which is considered] an unscheduled in-person meeting initiated by a beneficiary.” (p. 22248)
- **Limiting the time that a sales agent can call a potential enrollee to no more than 12 months following the date that the enrollee first asked for information.**
 - CMS initially proposed to limit the time period that Scope of Appointment (SOA) forms and Business Reply Cards (BRCs) are valid to six months from the beneficiary’s signature date or the beneficiary’s request for more information; in the final rule, CMS “determined that a 12-month timeframe is the appropriate timeframe for the validity of these documents.” (p. 22249)
- **Requiring plans to have a searchable provider directory.**

- MA organizations are currently required to have a searchable provider directory on their website; CMS now will require that such directories “be searchable by every element, such as name, location, and specialty, required in CMS’ model provider directory” and must also “include providers’ cultural and linguistic capabilities.” (p. 22249)
- **Requiring agents to explain the effect of an enrollee’s enrollment choice on their current coverage whenever the enrollee makes an enrollment decision.**
 - CMS noted that their review of complaints lodged with 1-800-MEDICARE, among other things, “revealed numerous beneficiary complaints that they were not aware their current coverage, such as an existing MA plan, a Medigap plan, or their Tri-care plan, would end once they enrolled in an MA plan.” Thus, the agency finalized their proposal to add “effect on current coverage” to the list of information plans must provide to prospective enrollees in the Pre-Enrollment Checklist (PECL). In addition to requiring the PECL be provided along with hard-copy enrollment forms, CMS is now requiring that agents review the PECL during telephonic enrollments; while “[i]t is CMS’s expectation that the agent ensures the beneficiary understands the items in the PECL”, CMS leaves it to plans to decide “whether they would require their contracted agents and brokers to read the PECL in its entirety or to require that each item contained on the PECL be discussed.” CMS adds: “Agents may confirm this understanding by receiving an affirmative answer to whether the prospective enrollee understands the information provided, as well as asking the prospective enrollee if she or he has any questions.” (p. 22250) (Also see discussion below re: requirement that agents/brokers discuss list of required elements prior to enrollment.)
- **Simplifying plan comparisons by requiring medical benefits be in a specific order and listed at the top of a plan’s Summary of Benefits (SB).**
 - As noted by CMS, “By requiring all plans to list certain benefits in the same location and in a specified order, beneficiaries will be able to more easily compare benefits across different plans and in a more standardized way. The ability for beneficiaries to review and compare benefits across different MA plans will assist beneficiaries in making a more informed health care choice.” (p. 22250)
- **Clarifying that plan Non-Renewal Notices are standardized notices, limiting plans’ discretion to make changes from CMS’ model language.**
- **Modifying the Third Party Marketing Organization (TPMO) disclaimer to add State Health Insurance Assistance Programs (SHIPs) as an option for beneficiaries to obtain additional help, and to disclose the number of all entities the TPMO represents.**
 - The agency notes: “In CMS’s review of hundreds of sales, marketing, and enrollment audio calls, CMS found over 80 percent of the calls only discussed one plan option from one MA organization. The audio reviews CMS conducted also showed that agents rarely, if ever, informed the beneficiary that there were multiple plans available in the service area.” (p. 22251) CMS is requiring a new disclaimer that “would need to be provided within the first minute of [a] call” and “would need to be electronically conveyed when communicating with a beneficiary through email, online chat, or other electronic means, prominently displayed on the TPMO’s website, and included in any TPMO marketing materials, including print materials and television advertising,” (pp 22251-2) CMS had proposed to require TPMOs to list the names of all the plans they sell in a given area, but

will now only require that the number of plans they sell to be disclosed. For TPMOs that do not sell for all MA organizations or Part D sponsors in a service area, the disclaimer is:

- “We do not offer every plan available in your area. Currently we represent [insert number of organizations] organizations which offer [insert number of plans] products in your area. Please contact Medicare.gov, 1–800–MEDICARE, or your local State Health Insurance Program (SHIP) to get information on all of your options.”(p. 22253)

- **Requiring MA organizations and Part D sponsors to have an oversight plan that monitors agent/broker activities and reports agent/broker non-compliance to CMS.**
 - CMS states that “we are concerned about the level of oversight that MA organizations and Part D sponsors maintain over their contracted agents and brokers [...] we have determined that MA organizations and Part D sponsors appear to be reactive instead of proactive in addressing inappropriate agent and broker behavior.” (p. 22253) CMS states that it will provide additional information about the type of non-compliance the agency expects plans to report in the Medicare Communications and Marketing Guidelines.
- **CMS list of required elements agents and brokers must discuss with beneficiaries prior to enrollment in an MA or Part D plan.**
 - CMS notes that in over 80% of marketing and enrollment audio calls they have reviewed, “agents and brokers failed to ask pertinent questions to help a beneficiary enroll in a plan that best meets the individual’s needs.” (p. 22254) “To properly assist a beneficiary in choosing a Medicare health and/or drug plan, the agent or broker must have sufficient information about the beneficiary’s needs and goals.” (p. 22254) Rather than requiring agents and brokers to “read standardized questions or statements” CMS is requiring that “certain required topics are addressed, prior to the enrollment, specifically topics about providers and whether a beneficiary’s current or preferred providers or pharmacies are in-network, costs and premiums for prescription drug coverage and health care coverage, benefits, and the beneficiary’s specific health care needs and current medications.” (p. 22254) CMS will provide, in sub-regulatory guidance, more detailed questions and areas to covered. Note that this requirement is separate from the Pre-Enrollment Checklist (PECL, discussed above), because the latter “does not contain the level of detail required to ensure an agent receives all of the information necessary to assist a beneficiary in making a decision that is best for their health care needs.” (p. 22254)
 - The final rule adds new language at 42 CFR §422.2274(c)(12) (for Part D, see §423.2274(c)(12)); MA organizations must: “(12) Ensure that, prior to an enrollment, CMS’ required questions and topics regarding beneficiary needs in a health plan choice are fully discussed. Topics include information regarding primary care providers and specialists (that is, whether or not the beneficiary’s current providers are in the plan’s network), regarding pharmacies (that is, whether or not the beneficiary’s current pharmacy is in the plan’s network), prescription drug coverage and costs (including whether or not the beneficiary’s current prescriptions are covered), costs of health care services, premiums, benefits, and specific health care needs.”
- **Limiting the requirement to record calls between third-party marketing organizations (TPMOs) and beneficiaries to marketing (sales) and enrollment calls.**

- **Clarifying the requirement to record calls between TPMOs and beneficiaries, such that it is clear that the requirement includes virtual connections such as video conferencing and other virtual telepresence methods.**

NOTE: CMS did not finalize a proposed requirement that personal data collected by a TPMO may not be distributed to other TPMOs. In the proposed rule, CMS noted that “We do not believe beneficiaries knowingly give their permission to receive multiple calls from multiple different entities on the basis of a single call made by a beneficiary.” (p. 79535) Without explanation, however, CMS stated in the preamble to the final rule that “We are not addressing our proposal to prohibit TPMOs from distributing beneficiary contact information in this final rule and may address it in a future final rule.” (p. 22235)

IV. OTHER PROVISIONS

In addition to Medicare Advantage prior authorization and marketing provisions, the final rule includes a number of other important provisions impacting beneficiaries. These provisions include implementing certain provisions of the Consolidated Appropriations Act (CAA) of 2021 and the Inflation Reduction Act (IRA) of 2022. Below is a summary of some, but not all, such provisions.

Health Equity in Medicare Advantage

In order to further CMS’ goal of “advancing health equity for all, including those who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality” (p. 22121), CMS is taking a number of actions, including:

- Amending the list of populations to whom MA plans must provide services in a culturally competent manner, including those:
 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.
- Codifying best practices in developing provider directories, including cultural and linguistic capabilities;
- Finalizing policies that require MA plans to develop and maintain procedures to identify and offer digital health education to enrollees with low digital health literacy to assist with accessing medically necessary covered telehealth benefits.

Strengthening Translation and Accessible Format Requirements for Medicare Advantage, Part D, and D-SNP Enrollee Marketing and Communication Materials

CMS is “finalizing a requirement that MA organizations, cost plans, and Part D sponsors must provide materials to enrollees on a standing basis in any non-English language that is the primary language of at least 5 percent of the individuals in a plan benefit package service area or accessible format upon receiving a request for the materials or otherwise learning of the enrollee’s primary language and/or need for an accessible format. [CMS is] also finalizing the application of this requirement to individualized plans of care for special needs plans. In addition, [CMS is] finalizing a requirement that fully integrated dual eligible special needs plans (FIDE SNPs), highly integrated dual eligible special needs plans (HIDE SNPs), and applicable integrated plans (AIPs) as defined at § 422.561, translate required materials into any languages required by the Medicare translation standard at § 422.2267(a) plus any additional languages required by the Medicaid translation standard as specified through their Medicaid capitated contracts.” (p. 22123) These requirements apply to materials produced for CY 2024.

Behavioral Health in Medicare Advantage (MA)

CMS is finalizing network adequacy requirements to “reaffirm MA organizations’ responsibilities to provide behavioral health services” (p, 22167), including:

- Adding Clinical Psychology and Licensed Clinical Social Work as specialty types that will be evaluated as part of the network adequacy reviews under §422.116, and make these new specialty types eligible for the 10-percentage point telehealth credit as allowed under §422.116(d)(5);
- Amending CMS’ general access to services standards in §422.112 to include explicitly behavioral health services;
- Codifying, from existing guidance on reasonable wait times for primary care visits, standards for wait times that apply to both primary care and behavioral health services;
 - Per revisions to §422.112, 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 preventive care must be available within 30 business days. (p. 22173-5)
- Clarifying that some behavioral health services may qualify as emergency services and, therefore, must not be subject to prior authorization; and
- Extending current requirements for MA organizations to establish programs to coordinate covered services with community and social services to behavioral health services programs to close equity gaps in treatment between physical health and behavioral health.

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

Existing rules under §422.112(a)(3) require that an MA organization provide or arrange for necessary specialty care and arrange for specialty care outside of the plan’s provider network when network providers are unavailable or inadequate to meet an enrollee’s medical needs.

CMS notes in the preamble, “[h]istorically, CMS has interpreted these statutory and regulatory requirements to mean that in the event an in-network provider or service is unavailable or inadequate to meet an enrollee’s medical needs, the MA organization must arrange for any medically necessary covered benefit outside of the plan provider network at in-network cost sharing for the enrollee.” (p. 22175) In

other words, such requirement is not limited to specialists, and “[e]nrollees should not bear a financial burden because of the inadequacy of the MA plan’s network.” (p. 22175)

In order to ensure that regulatory language is consistent with “current, longstanding sub-regulatory policy” and implementation of the Medicare Act (p. 22176), CMS has revised §422.112 accordingly to “ensure adequate access to medically necessary covered benefits for enrollees when the plan network is not sufficient by both arranging or covering the out-of-network benefits and only charging in-network cost sharing for those out-of-network benefits.” (p. 22175)

Enrollee Notification Requirements for Medicare Advantage (MA) Provider Contract Terminations

CMS is finalizing amendments to § 422.111(e) that establish specific enrollee notification requirements for no-cause and for-cause provider contract terminations and add specific and more stringent enrollee notification requirements when primary care and behavioral health provider contract terminations occur.

- For contract terminations that involve a primary care or behavioral health provider, plans must provide written notice and make one attempt at telephonic notice at least 45 calendar days before the termination effective date. This applies to all enrollees who are currently assigned to that primary care provider and to enrollees who have been patients of that primary care or behavioral health provider within the past three years.
- For contract terminations that involve specialty types other than primary care or behavioral health, MA plans must provide written notice at least 30 calendar days before the termination effective date to enrollees who are assigned to, currently receiving care from, or have received care within the past three months from a provider or facility being terminated.

CMS is also amending § 422.2267(e)(12) to specify the content and additional procedural requirements for the notification to enrollees about a provider contract termination. These requirements will generally increase enrollee protections when MA network changes occur and will raise the standards for the stability of enrollees’ primary care and behavioral health treatment.