January 27, 2025

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4208-P
P.O. Box 8013
Baltimore, MD 21244

Re: Calendar Year (CY) 2026 Medicare Advantage and Part D Proposed Rule

Dear Administrator Brooks-LaSure:

On behalf of the American Society of Addiction Medicine (ASAM), a national medical specialty society representing more than 7,000 physicians and associated health professionals who specialize in the prevention and treatment of addiction, thank you for the opportunity to provide comments to the CY 2026 Medicare Advantage (MA) and Part D proposed rule.

ASAM welcomes several proposals set forth in this rule aimed at expanding beneficiary access to mental health and substance use disorder (SUD) services in Medicare Advantage and cost plans through efforts to limit beneficiary cost sharing, streamline provider directories, improve network adequacy, clarify rules on internal coverage criteria, and advance health equity.

In our comments set forth below, ASAM recommends that CMS:

- Finalize proposals to limit cost-sharing in MA and Medicare cost plans (cost plans) to no more than the amounts allowed in traditional Medicare in contract year 2026;
- Collect data on the impact of these cost-sharing limits on plan contracting arrangements with clinicians;
- Determine whether the proposed cost-sharing limits may be applied to medications to treat addiction;
- Finalize proposal to ensure MA provider directories are included in the Medicare plan finder by 2026 and be updated on a regular basis; and
- Finalize proposed updates to regulations governing internal coverage criteria.

ASAM is also supportive of CMS considerations to require plans to submit network adequacy information at the plan level rather than contract level, as well as adding "having a mental health or substance use

disorder diagnosis" to the list of social risk factors that MA plans must use to conduct annual health equity analyses.

Limitations on Cost-Sharing

CMS is proposing to limit cost-sharing for certain services and is seeking comments on whether to implement these changes in 2026 or 2027. Specifically, the agency proposes to limit cost-sharing in MA and cost plans for inpatient hospital psychiatric services, mental health specialty services, outpatient substance use disorder (SUD) services, psychiatric services, partial hospitalization, intensive outpatient services, and opioid treatment program (OTP) services to cost-sharing amounts allowed under traditional Medicare. If finalized, these changes would limit cost-sharing in MA and cost plans to either specific dollar limits, 20% coinsurance, or zero-dollar cost sharing in the case of OTPs. According to CMS' analysis, the most pronounced impact would be on outpatient SUD services and OTPs where almost 42% and 71% of MA plans respectively impose beneficiary cost-sharing that is greater than proposed standards.

ASAM supports this proposal and encourages CMS to finalize it for the 2026 contract year. While making treatment more affordable for more people as quickly as possible as opposed to waiting until 2027, this will also allow CMS an opportunity to discern and update their assumptions and actuarial analyses that underly these proposals, as well as update these policies for the 2027 contract year with any new information acquired by the agency. Notably, this proposal, if finalized, will shift some of the cost-sharing burden to MA and cost plans. As a result, plans will need to consider how these changes will impact business operations, including provider contracting arrangements. **Therefore, ASAM encourages CMS to collect data during the 2026 contract year on what impact, if any these changes may inflect on clinician contracting arrangements with MA and cost plans.** CMS should use this data to reflect on additional regulatory updates that may be necessary in the 2027 contract year to ensure access to behavioral health clinicians.

Finally, ASAM also encourages CMS to analyze whether existing statute/regulations allow the agency to apply similar cost-sharing regulations to medications for the treatment of addiction.

Internal Coverage Criteria

CMS is proposing several updates to regulations governing the use of internal coverage criteria, including:

- Defining internal coverage criteria **as** "any policies, measures, tools, or guidelines, whether developed by an MA organization or a third party, that are not expressly stated in applicable statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or CMS manuals and are adopted or relied upon by an MA organization for purposes of making a medical necessity determination."
- A minor change to note that internal coverage criteria must supplement or interpret the "plain language" of applicable traditional Medicare criteria, not add new or unrelated criteria. This is a change from the wording "general provisions" to provide more clarity that CMS is referring to the "plain language" in statutes, regulations, NCDs, LCDs, or CMS manuals.
- Changing a requirement pertaining to internal coverage criteria that plans "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" with "MA organizations must demonstrate through evidence that the additional criteria explicitly support patient safety."
- Clarifying that utilization management (UM) itself is not subject to internal coverage rules, but internal coverage criteria applied during one of these interventions (i.e., prior authorization) are subject to internal coverage policies.
- Explaining that MA organizations must understand whether any internal coverage criteria have been built into an automated system, and if so, the specific details of the criteria that are built into the tool must be publicly accessible and meet evidentiary standards.

- A prohibition on the use of internal coverage criteria when there is no clinical benefit and exists to reduce utilization, or when internal criteria is used as a blanket coverage denial without an individualized assessment of medical necessity.
- Publicly post internal coverage criteria on plan websites.

ASAM welcomes these proposals that clarify plan obligations, limit the use of non-evidence-based coverage criteria, and build on previous CMS efforts to address the improper use of UM and medical necessity determinations, especially those policies targeting the use of automated systems to determine medical necessity that have become more common and may improperly deny care. **We encourage CMS to finalize these proposals.**

Provider Directories

CMS proposes to ensure MA provider directories are included in the Medicare plan finder by 2026, would require plans to update them on a regular basis, and attest that the information is accurate and consistent with network adequacy standards. **ASAM supports this proposal and encourages CMS to finalize it.**

Other Comments

CMS is considering (but not proposing) adding "having a mental health or substance use disorder diagnosis" to the list of social risk factors that MA plans must use to conduct annual health equity analyses, concerning prior authorizations requests, including approvals and denials. ASAM notes that this information could have implications for addressing mental health and addiction parity in terms of determining whether plans may be applying non-quantitative treatment limitations (NQTLs). ASAM also believes this information would be pertinent to identifying any trends that may provide insight into whether plans are appropriately applying prior authorization. **We do not see any harm in proposing this approach and we encourage CMS to consider this for** future rulemaking.

Finally, CMS is considering building upon the agency's previous work bolstering network adequacy standards to require plans to submit information at the plan level rather than contract level. **Given that insights at the plan level may have more useful information about network adequacy and time/distance standards, ASAM supports this policy consideration and encourages CMS to consider it for future rulemaking.**

Thank you for the opportunity to provide comments and for CMS' relentless focus on bolstering regulations to improve access to mental health and addiction treatment for Medicare beneficiaries. If you have any questions, please do not hesitate to contact Corey Barton, Director of Advocacy at cbarton@asam.org.

Sincerely,

Brian Hurley, MD

Brian Hurley, MD, MBA, FAPA, DFASAM
President, American Society of Addiction Medicine