define price concession to include all forms of discounts, direct or indirect subsidies, or rebates that serve to reduce the costs incurred under Part D plans by Part D sponsors. The proposed definition would note that price concessions include but are not limited to discounts, chargebacks, rebates, cash discounts, free goods contingent on a purchase agreement, coupons, free or reduced-price services, and goods in kind.

We believe the proposed approach would be consistent with the statute, support consistent accounting by Part D sponsors of amounts that are price concessions, and ensure that certain forms of discounts are not inappropriately excluded from being considered price concessions. An alternative would be not to define "price concession" at all. However, this option would not support consistent accounting of amounts that are price concessions among Part D sponsors, which we believe is particularly important in light of the proposed change to the definition of negotiated price.

We note that adopting the proposed definition of price concession would not affect the way in which price concessions must be accounted for by Part D sponsors in calculating costs under a Part D plan. Defining the term "price concession" as proposed would not require the renegotiation of any contractual arrangements between a sponsor and its contracted entities. Therefore, the proposed definition of price concession has no impact under the federal requirements for Regulatory Impact Analyses.

III. Requests for Information

A. Request for Information: Prior Authorization for Hospital Transfers to Post-Acute Care Settings during a Public Health Emergency

We are committed to ensuring that hospitals, post-acute care facilities (including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), and skilled nursing facilities (SNFs)), physicians, and MA organizations have the tools necessary to provide access to appropriate care to patients without unnecessary delay during a public health emergency (PHE). Throughout 2020 during the Coronavirus Disease 2019 Public Health Emergency

(COVID-19 PHE), we consistently issued guidance to address permissible flexibilities for MA organizations as part of an ongoing effort to help MA enrollees, and the health care systems that serve them, avoid delays and disruptions in care. We recognize that any delays or disruptions in care that might transpire within the MA program could have a ripple effect and also negatively impact the timely provision of appropriate care to patients covered under payer systems external to MA (for example, employer-sponsored insurance). Additionally, we recognize the positive impact that payers in general can have through the adoption of flexibilities that support hospitals' ability to effectively manage resources when a hospital experiences a substantial uptick in hospitalizations.

As a result of the guidance and clarification that we issued throughout 2020, a large proportion of MA organizations opted to relax or completely waive their prior authorization requirements with respect to patient transfers between hospitals and post-acute care facilities during plan year 2020, consistent with our guidance encouraging flexibility to ensure access to care. However, as the PHE continued into 2021, many MA organizations reinstated prior authorization requirements, which some stakeholders reported contributed to capacity issues and delays in care within hospital acute care settings. For example, one stakeholder reported that only 5 percent of intensive care unit (ICU) beds were open in their state during the month of August 2021, and stated that the scarcity of available beds could be mitigated if more MA organizations reinstated waivers on prior authorization requirements for patient transfers. Another stakeholder reported that it was not uncommon for a hospital to wait up to 3 business days to receive a decision from an MA organization for a request for a patient transfer – a delay which prevented hospitals from moving patients to the next appropriate care setting in a timely manner and forced the unnecessary use of acute-care beds. The same stakeholder reported that a high rate of initial denials from MA organizations also contributed to delays in patient transfer. We acknowledge our responsibility to ensure that our programs' policies do not hinder access to care, especially during a public health emergency. Therefore, in response to these reports and

the uptick in COVID-19 hospitalizations across the country, we are seeking information from stakeholders in order to assess the impact of MA organizations' use of prior authorization or other utilization management criteria during certain PHEs. Through this request for information (RFI), CMS seeks additional information from all affected stakeholders, especially MA organizations, hospitals, post-acute care facilities, professional associations, states, and patient advocacy groups regarding the effects of both the relaxation of and reinstatement of prior authorizations on patient transfers during a PHE.

We remain mindful of the impact the MA program's policies have on the health care system as a whole, and strongly encourage MA organizations to continuously re-assess the need for flexibilities in their utilization management practices. We note that with regard to prior authorization and other utilization management practices, we permit MA organizations the choice to uniformly waive or relax plan prior authorization requirements at any time in order to facilitate access to care, even in the absence of a disaster, declaration of a state of emergency, or PHE. Generally, MA organizations are required to ensure that enrollees are notified of changes in plan rules of this type in accordance with § 422.111(d); however, when the provisions under § 422.100(m)(1) go into effect during a disaster or emergency as they did during the COVID-19 PHE, MA organizations are permitted to immediately implement plan changes that benefit enrollees, including a waiver of prior authorization requirements, without the 30-day notification requirement at § 422.111(d)(3).

We invite the public to submit comments for consideration as CMS assesses the impact of MA organizations' prior authorization requirements for patient transfer on a hospital's ability to effectively manage resources and provide appropriate and timely care during a PHE. The primary objective of this RFI is for us to glean information from stakeholders about the effects of MA organizations' prior authorization requirements for patient transfers on a hospital's ability to furnish the appropriate care to patients in a timely manner in the context of a PHE. This is a general RFI related to prior authorizations on patient transfers during any PHE. While many

commenters may choose to provide information in the context of the COVID-19 PHE, we welcome and encourage commenters to provide information in the context of any PHE.

Responses to this RFI may include, but are not limited to the following:

- The overall impact of both the relaxation and reinstatement of prior authorization requirements for patient transfer by MA organizations on the provision of appropriate patient care in hospital systems.
- The overall impact of both the relaxation and reinstatement of prior authorization requirements for patient transfer on MA organizations.
- Wait times for receiving a response from an MA organization about the authorization of a patient transfer.
- Information pertaining to industry guidelines that are used to inform prior authorization, including the extent to which such guidelines are evidence-based, the degree of transparency that exists for such guidelines, and the extent to which such guidelines are standardized.
- With respect to MA organizations, the denial rates and associated burden, including rates at which denials are upheld and overturned, for prior authorizations for patient transfer from hospitals to post-acute care facilities.
- Any consequences of delayed patient transfer from hospitals to post-acute care facilities.
- Recommendations for how CMS can accommodate hospital systems that face capacity issues through policy changes in the MA program.
- Examples of any contrast in a state's policies for payers (for example, Medicaid managed care) with respect to prior authorizations for patient transfer that do not pertain to MA organizations, and the effects of such policies on hospitals systems' ability to effectively manage resources.

We request that all respondents provide complete, clear, and concise comments that include, where practicable, data and specific examples.

B. Request for Information: Building Behavioral Health Specialties within MA Networks

CMS is dedicated to ensuring that MA beneficiaries have access to provider networks sufficient to provide covered services in accordance with our standards described in section 1852(d)(1) of the Act and in §§ 422.112(a) and 422.114(a)(1). Accordingly, CMS strengthened network adequacy rules for MA plans by codifying our network adequacy standards at § 422.116 through the June 2020 final rule.

Currently, we require MA organizations to submit data for behavioral health providers, specifically psychiatry (provider-specialty type) and inpatient psychiatric facility services (facility-specialty type), using the Health Service Delivery (HSD) tables. The HSD tables are submitted to CMS during an organization's formal network review and are utilized to demonstrate compliance with network adequacy standards. The HSD tables must list every provider and facility with a fully executed contract in the organization's network, and are uploaded to the Health Plan Management System (HPMS) for an automated review. MA plans must have sufficient providers with a certain time and distance of 85 or 90 percent of beneficiaries residing the plan's service area, depending on the type of counties in the service area, under § 422.116. We also encouraged plans to provide more choices for enrollees to access care using telehealth for certain specialties, including psychiatry, through our policy under § 422.116(d)(5), while maintaining enrollees' right to access in person care for these specialty types. To encourage and account for telehealth providers in contracted networks, § 422.116(d)(5) provides MA plans a 10-percentage point credit towards the percentage of beneficiaries that reside within published time and distance standards when the plan includes in its network telehealth providers for certain specialties. However, despite requiring a minimum number of behavioral health providers and encouraging use of telehealth providers, CMS understands that