VIA ELECTRONIC SUBMISSION

January 15, 2019

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4185-P
P.O. Box 8013
Baltimore, MD 21244-8013

RE: Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021 (CMS-4185-P/RIN 0938–AT59)

Dear Administrator Verma:

The Bipartisan Policy Center (BPC) appreciates the opportunity to submit select comments on the proposed rule on 42 CFR Parts 422,423,438, and 498 Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care programs for Years 2020 and 2021 (CMS-4185-P).

We support ongoing efforts to better integrate Medicare and Medicaid services, and commend CMS and its Medicare-Medicaid Coordination Office for the work they are doing to improve care for Medicare-Medicaid beneficiaries, and to lower health care costs for beneficiaries, the federal government, and states.

Founded in 2007 by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell, BPC is a non-profit organization that combines the best ideas from both parties to promote health, security, and opportunity for all Americans. BPC health policy leaders have released dozens of recommendations in recent years aimed at improving:

- **Access** to quality, affordable health insurance coverage, long-term care financing options, and safe and effective medical treatments;
- **Value** – better care at lower costs – in health care delivery and payment, supported by interoperable health information technology; and the
- **Health** of individuals and communities, including through prevention, care coordination and integration of non-clinical services for chronically ill individuals.

These BPC staff-developed comments reflect staff expertise and input from BPC leaders, experts, and stakeholders from across every sector of health care. They do not represent official positions of BPC's founders or board of directors.

Below we offer comments on various proposals as they appear in each subsection of the proposed rule.

Implementing the Bipartisan Budget Act of 2018 Provisions

1. Medicare Advantage Plans Offering Additional Telehealth Benefits

As part of the Bipartisan Budget Act of 2018 (BBA), Medicare Advantage (MA) plans were allowed to begin offering "additional telehealth benefits" that were not included under traditional Medicare. In the proposed rule, CMS proposes the ability for MA plans to allow such benefits as part of the basic benefit package and for MA plans to offer supplemental benefits via remote access technologies beginning in PY2020.

BPC commends CMS for its patient-centered approach in proposing the implementation of additional telehealth benefits for MA enrollees. This move will help bring needed care to more areas of the country, both rural and urban, through advanced technologies. The proposed rule will also allow more flexibility for how payment is structured for MA plans. We would caution CMS, however, in creating disparity of benefits between MA plans and traditional Medicare. We would encourage CMS offer an expansion of telehealth benefits in both programs and implement them in a similar fashion.

CMS solicited comment on how to implement the statutory provision that if an MA plan covers a Part B service as an additional telehealth benefit, it must also provide the enrollee access to the same benefit through an in-person visit. The BPC supports this provision for MA plans. We would also direct CMS to our October 2018 report on *Improving Care for Patients with Serious Illness: Part One*[1] in which we highlight the disparities that still exist among Medicare programs. Specifically, Medicare's restrictions, especially in fee-for-service, prohibit certain patients, including those who may be seriously ill, from accessing telehealth. Policymakers can build on the progress of the BBA in all three payment programs and move toward expanding Medicare's reimbursement for telehealth while ensuring this coverage does not increase health care spending.

2. Definitions of a "Dual Eligible Special Needs Plan," "Fully Integrated Dual Eligible Special Needs Plan," and "Highly Integrated Dual Eligible Special Needs Plan"

As a result of the BBA, CMS proposes at least two changes to support their classification of plans by the degree and manner to which there are involved in the integration of Medicare and Medicaid benefits. The agency proposes changes to:

- The exiting definition of D-SNP and FIDE-SNP and the creation of a new form of integrated plan, highly integrated dual-eligible special needs plan (HIDE-SNP)

[1] Bipartisan Policy Center. *Improving Care for Patients with Serious Illness: Part One*. October 2018.

- Changes to the interpretation of the phrase "arrange for benefits" in the D-SNP definition

CMS interprets the statutory phase "clinical and financial responsibility" for all Medicare and Medicaid benefits to mean that such a D-SNP would always satisfy the requirement of being a FIDE-SNP or HIDE SNP. In states where the Medicaid program makes LTSS and other health care services available through fee-for-service, operating a D-SNP to coordinate the delivery of the Medicare and Medicaid benefits. A D-SNP operating in this manner offers a minimum degree of coordination of Medicare and Medicaid benefits.

BPC agrees that SNPs operating as a FIDE or HIDE would satisfy the integration requirements as outlined in the proposed rule. As the number of dual-eligible individuals with complex needs grows access to health plans that fully integrate Medicare and Medicaid benefits is essential to archiving better health outcomes for these individuals.

Where Medicaid managed care is used to coordinate benefits, a D-SNP may operate as a FIDE SNP, offering fully integrated care to those duals eligible enrolled. BPC commends CMS regulatory reforms that maintain a FIDE SNPs ability to fully integrate care for dual-eligible individuals. As proposed, the HIDE-SNP accommodates the interests of individuals with complex care needs enrolled in distinct health plans offered by a plan described in the preamble of the rule as having "clinical and financial responsibility" for an individual's Medicare and Medicaid benefits. BPC supports the creation of this category of integrated health plan as stakeholders and CMS strive to provide fully integrated health care to dual-eligible individuals.

BPC believes the creation of the HIDE SNP is an incremental step toward fully integrated care when the environment in a state requires that a D-SNP operate a less than fully integrated health plan. Stakeholders should continue to pursue greater integration of all Medicare and Medicaid benefits for dually eligible individuals.

CMS will face additional challenges from health plans that elect to operate a D-SNP in a state where integration of Medicare and Medicaid benefits has not been a priority. Medicare Advantage plans should not use the D-SNP authority if they are not able to play a meaningful role in coordinating Medicare and Medicaid benefits for dual-eligible individuals. CMS should take additional steps to discourage health plans from operating a D-SNP when there is no clear indication that the plan is pursuing the coordination of benefits for this population.

BPC supports CMS's interpretation of "arranging for benefits" should be broadly construe so that D-SNPs consider a range of activities that promote access to Medicaid benefits that their members are eligible to receive them. CMS should consider issuing sub regulatory guidance on this matter.

3. Interpretation of the phase "consistent with state policy" permits CMS to accommodate certain service and/or population carve outs

CMS interpreters the phrase "consistent with state policy" to allow D-SNPs to operate in states where state policy carve-outs of certain populations or services while continuing to pursue different methods of integrating care dually-eligible individuals. Given that the policy environment in a number of states

would not permit D-SNPs to satisfy the requirements of a FINE SNP, or the proposed HIDE SNP, this interpretation allows D-SNP to pursue greater integration.

BPC supports the agency's interpretation of the phase "consistent with state policy" as it allows D-SNPs to operate in states where the policy environment presents certain challenges to delivering fully integrated care. BPC believes the interpretation allows states to make incremental progress toward full integration. However, BPC believes states would benefit from additional incentives to pursue full integration where the policy environment is not conducive to full integration today.

The move toward greater integration is critical for populations that rely on LTSS, as carving out these services, or populations, from broader efforts to integrate care can result in barriers to getting needed services to those with Medicare and Medicaid and complex care needs. Delays in getting the appropriate community based LTSS has profound effects on the long-term ability of individuals with functional needs remain attached to their community-based supports and avoid costly institutional care.

In states where behavioral health services are carved out and operating under a separate managed care arrangement, those individual's receiving services for substance use disorder must explicitly consent to having information shared about the SUD services they receive before effective care coordination can occur. Given that this population can be an extraordinarily vulnerable group with serious behavioral and physical health needs, which is often deprived of care coordination that could improve their health and reduce unnecessary utilization of health care resources, we encourage CMS and other policymakers to explore options that would facilitate data sharing and better care coordination for this population. The privacy protections found at 42 CFR Part 2 go beyond the HIPAA protections. Given that these protections become a barrier to people in desperate need of care coordination, we believe the HIPAA protection should be sufficient.

At the same time, promoting integration will require additional incentives to states. For example, as part of the Financial Alignment Initiative (FAI), CMS permitted states to share in a portion of Medicare savings. While this was done as part of a demonstration under the Center for Medicare and Medicaid Innovation, BPC would encourage the Secretary to use authority granted to the agency under section 1115A to implement aspects of the FAI that were successful in improving quality and lowering cost, as permanent authority. Other examples of policies that would improve integration include:

- Additional supplemental benefit flexibilities for FIDE/HIDE SNPs to address social determinants of health;
- Expanding passive enrollment options for transitioning dual eligible members to FIDE/HIDE SNPs, with consumer opt-out as permitted under the FAI;
- Allowing special enrollment period exceptions for dual enrollment into FIDE/HIDE SNPs at any time; and
- Aligning Medicare and Medicaid enrollment and other processes.

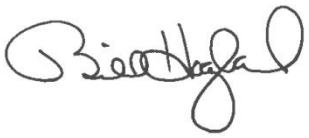
4. Dual Eligible Special Needs Plans and Contracts with States

Under the agency's proposed regulation, D-SNPs unable to satisfy the requirements of a HIDE or FIDE SNP must notify the state Medicaid agency when a dual eligible beneficiary belonging to a "high risk" group, as determined by the state, is admitted to a hospital or a skilled nursing facility (SNF).

The BPC supports the establishment of these minimum requirements. However, CMS should consider creating a timeliness standard in association with the reporting requirement to ensure it increases the possibility for meaningful care coordination associated with these admissions.

Again, thank you for the opportunity to submit comments. Please contact us if you have questions.

Sincerely,



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