December 21, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

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)

Dear Ms. Verma:

On behalf of the American Hospital Association’s (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule that would set forth policy changes for the 2020 and 2021 Medicare Advantage (MA) plan years. We are particularly pleased with the Administration’s proposal to expand access to telehealth services for MA beneficiaries.

The agency proposes a number of changes to the MA program for 2020 and 2021. Specifically, the rule proposes changes in policies to implement provisions of the Bipartisan Budget Act of 2018 related to expanded coverage of telehealth services through the MA program, better integration of coverage for Medicare and Medicaid dual-eligible beneficiaries, updates to how CMS creates and manages the provider preclusion list, changes to the Quality Rating Program, and significant changes to how the agency intends to verify the accuracy of payments.

Our specific comments on several of these provisions follow.
Ability for Plans to Offer Additional Telehealth Benefits

The rule proposes an approach to implementing the provision in the Bipartisan Budget Act of 2018 that authorized MA plans to offer telehealth benefits not otherwise covered under the fee-for-service Medicare program under the basic health plan benefit package. The rule would allow plans to increase access to telehealth services regardless of whether a patient was in an urban or rural area, including if the individual is in his or her home. CMS specifically seeks comment on several elements of this provision, including whether the agency should consider limits on the providers and/or services that can be delivered via telehealth and whether beneficiaries should retain a choice to receive a service that is available via telehealth in-person.

Innovation in technology has the potential to increase Medicare beneficiaries’ timely access to services, which enhances quality of care, improves patient satisfaction and reduces costs for the health care system. The AHA strongly supports expanded coverage of these services, and we commend CMS for the flexibility it has proposed to give MA plans as they incorporate telehealth functionality into their benefit designs. We urge the agency not to restrict the types of providers or services that may be delivered via telehealth at this time. We do believe, however, that it is important that beneficiaries retain access to in-person services, and we are pleased that CMS has not proposed to allow MA plans to meet network adequacy requirements solely using telehealth. We believe this is an important area to monitor and recognize that this policy should be revisited as technology and medical care evolves. Finally, we urge CMS to work with Congress to consider how it can help MA plans and their contract providers finance the infrastructure costs associated with telehealth and to bring these same flexibilities and reimbursement opportunities to the traditional Medicare program.

Increased Integration for Medicare and Medicaid Dual Eligible Beneficiaries

The rule proposes several policy changes to improve integration of benefits and care for dual eligible beneficiaries. Specifically, Dual Eligible Special Needs Plans (D-SNPs), at the direction of the state, would need to either cover long-term services and supports or behavioral health services through their capitated arrangement, or have the ability to notify the state or its designee of any hospital or skilled nursing facility admission. In addition, CMS proposes an approach for implementing the provision in the Bipartisan Budget Act of 2018 that requires unified grievance and appeals procedures for D-SNPs and their affiliated Medicaid managed care plan.

The AHA supports increased integration of benefits for these vulnerable populations. In particular, we support the agency’s incorporation of provider rights as part of the unified grievance and appeals. However, we are concerned that other elements of this proposal would increase provider burden by allowing plans to offload their reporting requirements on providers who already face increasing burdens to comply with many administratively imposed requirements, either by Medicare contractors or by insurers. This is especially
true in the case of reporting burdens for which hospitals are not adequately compensated. These plans have contracted with the state to manage benefits for vulnerable populations and, therefore, should be positioned to both know when one of their enrollees has been admitted to a hospital or skilled nursing facility and alert the state in a timely manner.

Thank you for the opportunity to comment. Please contact me if you have questions, or feel free to have a member of your team contact Molly Smith, vice president of policy, at (202) 626-4639 or mollysmith@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President