advocacy | action | answers on aging

National Association of Area Agencies on Aging

1730 Rhode Island Avenue, NW
Suite 1200
Washington, DC 20036

P 202.872.0888
F 202.872.0057

www.n4a.org

March 1, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov.

RE: CMS-2018-0154 Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage Call Letter

Dear Administrator Verma:

On behalf of the National Association of Area Agencies on Aging (n4a), which represents the country's 622 Area Agencies on Aging (AAAs) and serves as a voice in the nation's capital for the more than 250 Title VI Native American aging programs, **we are writing in response to the proposed guidance around Special Supplemental Benefits for the Chronically Ill in the Medicare Advantage Draft CY 2020 Call Letter.**

AAAs and Title VI programs are on the frontlines of the country's unprecedented demographic shift as 10,000 baby boomers turn 65 each day. Congress established AAAs in 1973 under the Older Americans Act (OAA) in order to create a local planning, development and delivery infrastructure to respond to the home and community-based services (HCBS) needs of Americans age 60 and over in every community in the country. AAAs have a 45-year history of developing, coordinating and delivering a wide range of service options to connect older adults with the HCBS they need to age successfully in the home and community. Examples of this assistance include core services such as in-home supports (e.g., homemaker/chore services), home-delivered and congregate meals, transportation, case management and elder rights activities.

However, as the populations of older adults and their caregivers have increased, driving higher levels of demand and a wider array of

needs, AAAs have evolved and broadened their service portfolios to include evidence-based healthy aging programs (e.g., A Matter of Balance Falls Prevention, Chronic Disease Self-Management Program, Enhanced Fitness), caregiver support, care transitions and care coordination, insurance counseling, benefits outreach and enrollment, eligibility determination, medication management and other primarily health-related social services. Many of the older adults and people with disabilities served by AAAs, Title VI programs and other aging and disability community-based organizations (CBOs) are Medicare beneficiaries or dually eligible for Medicare and Medicaid, including high-need individuals who may have significant functional and cognitive impairments.

The Aging Network's Ability to Address the Social Determinants of Health of Medicare Advantage Beneficiaries

We applaud the Centers for Medicare & Medicaid Services (CMS) for recently taking a closer look at how social needs affect consumers' health—particularly those with chronic conditions or other complications, who are often the most expensive to manage. These social determinants of health (SDOH) include, but are not limited to, access to housing, employment, nutritious food, community services, transportation and social support, and addressing these factors has been shown to improve long-term health and wellness outcomes.

The need to address these SDOH is not new to our members, however. Historically, AAAs and Title VI Native American aging programs have fostered the development and coordination of HCBS for older adults and their caregivers. Maximizing public-private partnerships, AAAs work with tens of thousands of local providers and vendors to deliver these critical HCBS to millions of older adults and caregivers annually. This collective, nationwide community is known as the Aging Network, and the resulting system, which has been functioning efficiently and effectively for more than four decades, supports people at home and in the community where they want to age.

AAAs and other CBOs within the Aging Network have addressed the SDOH through the provision of HCBS funded by the OAA and states' Medicaid waivers. Because they are experts at providing services that address SDOH, AAAs are increasingly working with health care partners on innovative models to improve the health of older adults, often funded by Medicaid managed long-term services and supports (LTSS).

While Medicare has not traditionally paid for primarily health-related supports and services beyond acute-care medical providers, there have been innovative efforts by CBOs in partnership with Medicare Advantage (MA) plans, hospitals, ACOs and other integrated systems to pilot primarily health-related social supports for Medicare beneficiaries. The results of these efforts have been encouraging.

That is why n4a strongly supports CMS's proposed guidance for the new Special Supplemental Benefits for the Chronically Ill (SSBCI), as detailed in the CY 2020 draft Call Letter.

The guidance, based on the chronic care improvements legislation passed as part of the Bipartisan Budget Act of 2018 (P.L. 115-123), rightly recognizes the value that services that are not primarily-health-related can bring to Medicare Advantage beneficiaries with serious, chronic conditions and functional needs. Many types of HCBS, some detailed in the call letter, would meet the requirement of having "a reasonable expectation of improving or maintaining the health or overall function of the enrollee."

The few examples of such services given in the call letter are an excellent start to the list. Given that MA plans, on the whole, are not expert in coordinating or delivering these social supports and services, we believe **it would be helpful if CMS would provide additional examples to further the education and awareness of all stakeholders.**

We offer the following examples for inclusion in the final call letter, some of which were included in last year's guidance on the initial MA supplemental benefits.

- Supplemental Services plan development and coordination (consumer-facing; includes needs assessment and case management)
- Evidence-based health and wellness programs (e.g., Chronic Disease Self-Management Program, falls prevention programs, others not already covered by Medicare)
- Adult day care
- Supports for family caregivers (assessments, respite care, training, etc.)
- Home safety assessments and/or falls risk assessments
- Minor home modifications* (installation of grab bars and other assistive devices, weatherization, etc.)
- Nutrition services (inclusive of the "home-delivered meals, food and produce" examples cited in the call letter; would also include meals provided in a congregate setting (such as an adult day or senior center), grocery provision and nutrition counseling)
- In-home personal care to assist with ADLs, IADLs

*The restriction on "capital or structural improvements," (page 162-163) however, may create some logistical challenges for other, less ambitious home modification efforts under the SSBCI guidelines. The type of home modifications made to support the seriously ill are unlikely to add significantly to a home's value and in fact may lower the resale value, depending on how easily the modifications are removed. While we appreciate CMS's concern, we hope the final call letter will provide clear and objective guidance on this point, perhaps with a value threshold to help plans and providers safely navigate the home modification waters and not unintentionally cause MA plan reluctance to offer these valuable services for fear of non-compliance with this provision.

We also strongly support and appreciate CMS's guidance on how such supplemental services should be coordinated with existing community and social services (page 163), while noting that those existing resources available in the community may not be used in lieu of plan-funded benefits. That point can't be overstated, as there are insufficient resources available to social service providers to deliver any of these vital services for free or below cost to MA plans.

Additionally, **the express permission for MA plans to contract out these supplemental benefits or the coordination of such to community-based organizations (CBOs) is a critical portion of this section and must be retained**. Current HCBS experts—such as AAAs or other aging and disability CBOs—are a natural fit to contract with health plans to deliver these supplemental services and represent a significant investment by the federal government. As a result, partnerships between MA plans and this experienced, social supports nationwide infrastructure should be strongly encouraged in the final Call Letter. We also believe that our decades of experience with this work will make for the best possible health and quality of life outcomes for plan members.

Thank you for also making explicit that plans may also contract with CBOs to "help determine whether an individual meets the eligibility requirements for SSBCI" (page 163). Again, AAAs have copious experience in working with older adults to determine their eligibility for a program or benefit, as well as assessing the needs of consumers for HCBS and other services (both initially and over time). We are encouraged that CMS recognizes the experience and value of CBOs in both assessment and service provision and the value of MA plans contracting with them to play this dual role. We would also observe that smooth functioning and a clear and consistent industry understanding of this option may depend on additional CMS guidance to explicitly state the agency's understanding and allowance for AAAs and other CBOs to provide both assessment services and service provision, as well as the ability of AAAs to play an eligibility determination role, given current restrictions on enrolled providers of an MA plan. There's a precedent in federal policy that may prove helpful. AAAs (as well as Aging and Disability Resource Centers and Centers for Independent Living) are authorized Veterans Administration CHOICE providers, screening veterans for home and community-based services and assisting them in securing such services.

There is a question posed in the letter (page 163) on whether CMS should consider **specific limits to these supplemental benefits, such as financial need**. On that specific example, n4a would answer no. These benefits should not be limited or otherwise restricted based on the financial status of the beneficiary—our position is based in the fact that this is a Medicare program, and not the means-tested Medicaid. Requiring use of means testing would also add significant administrative costs since such information is not a natural part of the Medicare program or maintained within MA plan systems. The delays necessary to perform means testing would also seriously restrict the MA plan and service providers' ability to respond to often time-sensitive beneficiary needs. If CMS considers a duration limit on SSBCI, we urge you to not require plans to institute such time limits on the duration of receiving

SSBCI. Those decisions should be based at the plan level and driven by the particular needs and health outcomes of the individual and not an arbitrary limitation.

We also believe it would be helpful for CMS to provide additional guidance on the definition of "**intensive care coordination**," which is the final criteria for SSBCI eligibility in the law (page 162; Section 1852(a)(3)(D)(ii)). We believe such coordination must go well beyond a telephonic touch or streamlined appointment system, and truly meet the beneficiary where they are and provide person-centered care. This may involve in-person visits, meetings with the beneficiary's family caregiver, or other hands-on coordination that the social services world provides on a regular basis. AAAs focus on person-centered care because that's what ultimately drives the best outcomes—particularly for the vulnerable older adults who would benefit from SSBCI.

Therefore, we recommend that intensive care coordination for SSBCI beneficiaries be defined, in part, as support that

- takes a person-centered approach to assessment, care planning and coordination of SSBCI, including the ability to address urgent changes, including temporary adjustments in services;
- is conducted in the community, preferably in the beneficiary's home, as often as possible, with required in-person assessments and reassessments;
- takes into consideration the contributions and needs of family caregivers; and
- is provided by professionals
    - with the experience, training and expertise necessary to also connect Medicare beneficiaries with community resources (beyond what is provided by the MA plan), and
    - who can assess needs, determine eligibility and assist with enrollment in any appropriate programs and services (beyond SSBCI) for which the beneficiary is or may be eligible.

We applaud CMS' decision to create a **technical advisory panel** to vet the determination of chronic conditions criteria and we encourage the involvement of social services experts on the panel. Representatives from the Administration for Community Living and home and community-based services providers, for example, would make important contributions to the panel based on their knowledge of non-medical supports and person-centered care coordination, as well as their experience in serving individuals with serious chronic diseases in managing their health-related social needs.

Finally, we will note that these new social services–health care partnerships may need additional CMS support along the way. For example, in comments to CMS's request for feedback on the Health Insurance Portability and Accountability Act (HIPAA) in February of this year, n4a raised the need for additional flexibility or guidance around covered entities' sharing restrictions when working with contracted partners in the community. For instance, safe harbor guidance that clarifies the agency's expectations and communicates that

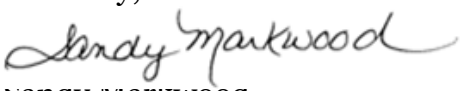
SSBCI contracting does not represent delegation unless certain, specified responsibilities are transferred to the CBO, would be helpful. That's just one example of the inadvertent barriers and learning opportunities ahead, as the health and social services worlds advance new models and better integrate care.

In conclusion, we believe the call letter offers new opportunities for MA beneficiaries who are struggling with serious chronic conditions to gain access to critical home and community-based services that evidence shows improve the health care outcomes of high-need patients. We hope that MA plans also see the value in working with community partners to develop SSBCI strategies that help drive improved outcomes, both health and fiscal.

n4a appreciates the opportunity to comment on the Draft FY 2020 Medicare Advantage Call Letter and looks forward to additional opportunities to expand and support Medicare programs that promote beneficiary health and well-being in the home and in the community. As the value of these services are increasingly being recognized and promoted by HHS, CMS and public and private payers, it's essential that the vital roles of traditional community-based health and health-related services providers, such as AAAs, continue to be recognized and funded.

We look forward to working with you to achieve these worthy goals.

Sincerely,



Sandy Markwood
Chief Executive Officer