NASUAD
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United for Aging and Disabilities

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Seema Verma, Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Submitted Electronically via Regulations.gov

Dear Administrator Verma:

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am submitting comments on the *Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Call Letter*. NASUAD represents the 56 officially designated state and territorial agencies on aging and disabilities. Each of our members oversees the implementation of the Older Americans Act (OAA), and many also serve as the operating agency in their state for Medicaid waivers and managed long-term services and supports programs that serve older adults and individuals with disabilities. Together with our members, we work to design, improve, and sustain state systems delivering home and community-based services (HCBS) and supports for people who are older or have a disability and for their caregivers.

Based on our members' roles, we will limit our comments to those topics that directly impact state agencies and/or community-based organizations in the aging and disability networks.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

NASUAD appreciates that CMS is working to implement SSBCI in a thoughtful and encompassing manner. We strongly believe that the opportunity to provide limited but targeted supports and services to Medicare-eligible individuals with chronic conditions can result in reduced health care costs in the future. Many of our state long-term services and supports (LTSS) programs serve dual eligible individuals who entered the Medicaid system after an acute event that led to challenges with activities of daily living and a resulting need for community-based services. Interventions that could be provided more rapidly to Medicare beneficiaries before they spend down to Medicaid eligibility and/or experience further loss in functioning could reduce the number of individuals who require more comprehensive and costly LTSS. It would also benefit the individuals, as they would not be required to exhaust their personal savings before entering the Medicaid system. Additionally, due to this dynamic, we do not believe that financial criteria should be used in order to determine eligibility for SSBCI. SSBCI should be based upon the needs of the individuals, given that they have already qualified for

Medicare on the basis of age or disability and should not be subject to additional tests for specific services beyond medical necessity.

The call letter describes allowable SSBCI as those with "a reasonable expectation of improving or maintaining the health or overall function of the enrollee." We agree that this is an appropriate way to address the needs of many individuals with chronic conditions; however, we also believe that services and supports can be provided to individuals in order to slow the decline of an individual's condition. For example, some older adults with Alzheimer's may continue to experience a reduction in cognitive functioning even with adequate and appropriate supports. However, despite the fact that certain services do not fully ameliorate the condition or halt the development of the disease, there is value in providing supports such as Adult Day Services, home-delivered meals, and transportation. These services can lead to an overall increase in the quality of life of the individual, an increase in social connectedness, and a resulting slowdown in the disease's progression that would still have positive impacts on both the individual and the health care system. We therefore strongly encourage CMS to clarify that "maintaining the health or overall function of the enrollee" can include interventions to reduce or slow the progression of the chronic condition.

We also believe that there are many different conditions, diagnoses, and diseases that may result in an individual meeting the three criteria used to evaluate for a chronic condition in order to determine SSBCI eligibility. We are concerned that the CMS proposal to consider "any enrollee with a condition identified as a chronic condition in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual to meet the statutory criterion of having one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee" may inadvertently and inappropriately limit the availability of SSBCI and exclude individuals who would significantly benefit from these supports. Conditions referenced in 20.1.2 of Chapter 16b are extremely clinical in nature and do not account for overall functional abilities of the individuals. It is unclear whether this proposal would require plans to provide SSBCI *solely* to individuals who meet one of these conditions or whether this proposal creates a baseline for eligibility that plans could exceed. Regardless, creation of such a list to determine eligibility for these services is likely to lead to *exclusion by default* of conditions that are not explicitly on this list.

We recommend an identification process takes into both medical and functional status information, where available. MCOs should be permitted to expand SSBCI to other individuals who have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; have a high risk of hospitalization or other adverse health outcomes; and require intensive care coordination. One example of such an individual may be a participant who meets the clinical criteria for a Medicaid HCBS option but is ineligible for Medicaid due to income or assets that exceed the Medicaid financial eligibility limits. Such clinical criteria could include meeting the *level of care* for institutional services and section 1915(c) waivers; meeting the *needs based criteria* for section 1915(i) state plan HCBS; or meeting the *medical necessity criteria* for section 1905(a)(24) personal care services. Lastly, Alzheimer's disease and related dementias do not appear to be included in the list of conditions posted in the online Medicare Manual.[1] We strongly

[1] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c16b.pdf

encourage CMS to establish broader criteria that truly encapsulates the varying conditions that may result in the need for SSBCI.

We applaud CMS for recognizing the limitations of the current criteria proposed to determine whether an individual is eligible for SSBCI and we particularly appreciate the proposed creation of a technical advisory panel to review and update the list of qualifying chronic conditions. We encourage CMS to include a broad range of representatives from provider groups, beneficiary and advocacy organizations, community-based services organizations, as well as state aging, disability, and Medicaid agencies on this panel. We also believe that the panel would benefit from participation of the Administration for Community Living and the CMS Disabled and Elderly Health Programs group.

We note that there are additional services not explicitly recognized in the call letter that would be extremely beneficial to a number of individuals who meet the three chronic condition criteria included in the Act. We appreciate the inclusion of nutrition supports and transportation services, as our work continues to demonstrate the high demand for these supports; the value of providing them to individuals we serve; and the challenges that individuals face in accessing these services. We note, however, that there are a wide range of other supports and services that are extremely valuable to older adults who have chronic conditions and persons with disabilities. This could include Adult Day Services, respite, personal care services, and related supports in the community. While we believe that this proposal would allow plans to include such services, and recognize that they have been included in prior discussions of SSBCI, we believe that a clear reference to these types of services would provide useful guidance to plans as they determine their benefit offerings.

We also are concerned about the explicit exclusion of home modifications (ie: installation of ramps or widening of doorways). Many individuals enter long-term care facilities because of a lack of affordable, accessible housing in the community. In fact, a 2015 HUD study showed that about a third of housing in the U.S. is potentially modifiable for a person with a mobility disability; currently less than five percent is accessible for individuals with moderate mobility difficulties; and less than one percent of housing is accessible for wheelchair users.[2] When an individual experiences a condition that results in reduced mobility, limited interventions such as those excluded in the call letter could enable the participant to stay at home and avoid a much more costly institutional placement. If CMS is concerned about potential kick-back implications as indicated in the letter, we suggest an additional review process to ameliorate those concerns. Alternatively, perhaps a per-person limit on the dollar amount of modifications could ease concerns about the potential for abuse of these types of supports.

Lastly, we appreciate CMS' recognition of the benefit that community-based organizations can provide in assessing participants' needs and eligibility for supports. We agree that these entities are well suited and have long history with providing assessments, case management, and certain supports and services to participants in the community. We encourage CMS and plans to leverage the expertise of the aging and disability networks, including area agencies on aging, centers for independent living, aging and disability resource centers, and other related organizations for both determining need of these services as well as, where appropriate, for assisting with the intervention(s).

[2] https://www.huduser.gov/portal/pdredge/pdr_edge_research_101315.html

D-SNP Administrative Alignment Opportunities

NASUAD appreciates the work that the Medicare and Medicaid Coordination Office (MMCO) has done to engage stakeholders, educate plans and providers, and work with states to improve coordination across Medicare and Medicaid. We particularly appreciate the work done to integrate summary of benefits and member materials. As you well know, the amount of information that is provided to participants can be overwhelming and result in significant amounts of confusion for the beneficiaries. We believe that any efforts to reduce, streamline, and simplify information provided to program enrollees has value. We therefore encourage CMS to continue working with the three states mentioned in the call letter on ways to improve and integrate these materials. We recommend that CMS use the lessons learned from these efforts to provide guidance, templates, and/or technical assistance to other states as they seek to improve materials developed for dual-eligible participants.

SNP Look-Alikes

NASUAD agrees with CMS' proposal to increase monitoring of marketing materials in order to ensure that plans are adhering to fair practices and are not potentially misleading beneficiaries. We believe that there is value in allowing participants to have choice and in promoting competition in the Medicare Advantage marketplace; however, our members share CMS' concerns regarding plans that may implicitly market themselves as serving dual eligible beneficiaries but that may not meet the Medicare Improvements for Patients and Providers Act (MIPPA) contract requirements. For example, a number of our members seek to promote care coordination and integration of services and supports by leveraging the MIPPA contract to ensure that SNPs are integrated with the Medicaid system. Enabling look-alike plans to operate in a state but to skirt the D-SNP requirements could create challenges with broader state care coordination and improvement initiatives. Furthermore, as the Bipartisan Budget Act of 2018's minimum Medicaid integration standards for D-SNPs become effective, we believe that there will be greater need to ensure that there is a clear distinction between plans that are true D-SNPs vs. MA plans that do not hold a MIPPA agreement.

We appreciate the opportunity to comment and would be happy to discuss our feedback in more detail. Please feel free to contact Damon Terzaghi of my staff at dterzaghi@nasuad.org with any questions about these comments.

Sincerely,

Martha A Roherty

Martha A. Roherty
Executive Director
NASUAD