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March 5, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2017-0163
P.O. Box 8016
Baltimore, MD 21244-8016

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

RE: CMS-2017-0163 Advance Notice of Methodological Changes for
Calendar Year (CY) 2019 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 recent proposals in the Medicare Advantage Draft CY 2019 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 40-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., Matter of Balance Falls Prevention, Chronic Disease Self-Management Program, Enhanced Fitness), caregiver support, care transitions and care coordination, insurance counseling, 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 services, including high-need individuals who may have significant functional and cognitive impairments.

Addressing the Health-Related Needs of Medicare Advantage Beneficiaries

In recent years, as health care costs have continued to grow, the Centers for Medicare & Medicaid Services (CMS) has taken a closer look at how social issues 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.

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 home and community-based services to millions of older adults and caregivers annually. This collective community is known as the National Aging Network, and the resulting system, which has been functioning efficiently and effectively for over 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 federal Older Americans Act (OAA) and states' Medicaid HCBS waivers. Because they are experts at providing services that address the 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). Because Medicare has not traditionally paid for primarily health-related supports and services beyond acute-care medical providers, there has been limited opportunity to integrate primarily health-related social supports into the Medicare system.

That is why n4a supports CMS's proposed expansion of access to Health-Related Supplemental Benefits (pg. 182) as defined in the Medicare Managed Care Manual (Section 30.1), and increasing flexibility in the Medicare Advantage Uniformity Requirements §422.100(d) (pg. 184) as proposed in the CY 2019 draft Call Letter.

We support CMS's Call Letter proposal to expand the scope of the primarily health-related supplemental benefit standard to interpret the term more broadly than in the past, and to allow Medicare Advantage (MA) plans to offer supplemental benefits that “diagnose, prevent or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.” We believe that under this expanded definition, MA beneficiaries may gain access to critical HCBS that evidence shows improve the health care outcomes for high-need beneficiaries who may not otherwise have access to these services.

As CMS expands the scope of health-related supplemental benefits, we specifically hope the agency will consider incorporating and promoting the cost-saving potential of care transitions programs in the panoply of available primarily health-related services and supports, which assist consumers as they leave acute care or institutional settings and head home. Often, making the transition from hospital or skilled nursing facilities to home can be difficult and cause problems if not managed properly. Unnecessary re-hospitalizations and negative health outcomes are frequently the result, driving up

health care costs. AAAs have demonstrated their ability to partner effectively with health care systems and Medicare quality improvement organizations to administer care transitions initiatives. These programs have demonstrated improved health outcomes and fewer re-hospitalizations by providing assistance with nutrition, transportation, caregiving and other in-home supports.

We also appreciate that CMS proposes reinterpreting the definition of the MA Uniformity Requirement to allow MA organizations to offer specific, tailored supplemental benefits to similarly situated enrollees. We agree that this increased flexibility may help MA plans better manage health care and supplemental services—and thus health care outcomes—for beneficiaries with complex needs. However, the rationale for giving beneficiaries access to items and services that diminish the impact of health conditions and reduce avoidable utilization is equally compelling for all Medicare beneficiaries, not just the roughly one-third who enroll in MA plans. We encourage CMS to maintain an even playing field between traditional Medicare Fee-for-Service and Medicare Advantage to ensure that effective interventions are equally available to all Medicare beneficiaries.

Finally, it is critical that CMS acknowledge and support the role of existing social services CBOs in delivering these supplemental benefits. We appreciate that awareness is increasing among leaders within CMS and the MA sector that meeting health-related social needs can reduce acute health care costs while also preserving, promoting and improving health. However, physicians and other health care providers often do not know how to connect their patients to these health-related support options. According to the Robert Wood Johnson Foundation, nearly 90 percent of physicians surveyed indicated they recognize their patients' need for additional supports, but unfortunately 80 percent of these doctors said they do not fully know how to help their patients access these networks.

There is still a wide gap to bridge between these very different social services and medical systems, and it is imperative that new intersections, partnerships and coordination processes are created between the systems to capitalize on the value of each rather than allowing social services to become medicalized, which will undoubtedly lead to higher costs and reduced consumer satisfaction.

As CMS issues and implements sub-regulatory guidance to MA organizations regarding the expanded scope of the primarily health-related supplemental benefit standard and uniformity of benefits flexibility, we encourage the agency to direct plans to integrate—and appropriately compensate—already existing supports and services available through the Aging Network.

Expanding Disease Management and Prevention Opportunities

We support the proposed expansion of evidence-based Enhanced Disease Management (EDM) benefits to improve care coordination and the experience of care for beneficiaries who are part of the Special Needs Plan population (pg. 183). AAAs have historically been on the cutting edge of implementing community-based disease self-management and prevention programs, including the Stanford Chronic Disease Self-Management Program (CDSMP), the Diabetes Self-Management Training (DSMT) program, A Matter of Balance falls prevention program and others, including for those Medicare beneficiaries with Alzheimer's disease and other dementias. While funding for those efforts have historically come from the Older Americans Act or otherwise through the U.S. Administration on Community Living, AAAs are increasingly contracting with health care entities and other payers to deliver these evidence-based community interventions.

Therefore, we strongly urge CMS to encourage MA plans offering these EDM services to partner with existing CBO networks currently administering these or similar programs.

n4a also appreciates CMS's efforts to improve and expand programs, such as the Medicare Diabetes Prevention Program (MDPP) effective April 2018. We support that the CY 2019 Call Letter proposes to allow MA plans to offer MDPP-like services as a supplemental benefit (pg. 185) under MA via a virtual format. ***As CMS implements the national MDPP and MDPP-like programs, we again encourage the agency to consider and enable involvement by all appropriate potential community-based providers, including AAAs.*** Substantial thought must be given to policies that foster, instead of hinder, CBO implementation of EDM and MDPP to ensure that evidence-based disease management and prevention programs can be effectively and efficiently scaled to realize the full cost-and-life-saving potential of these efforts.

Ensuring Adequate, Unbiased Medicare Education Resources as Plan Choice Increases

While we support the overall intent to ensure that MA enrollees have access to MA benefits that best address their specific health and health-related needs, we are concerned that the proposal to eliminate the meaningful difference standard (pg. 170) could increase beneficiary confusion and potentially leading to poorer health outcomes. By removing the requirement that MA organizations offering more than one plan in a given service area ensure the plans are substantially different so that beneficiaries can easily identify differences, the Call Letter proposal could increase the number of consumer choices to an unwieldy level. Medicare is already complicated and consumers have to evaluate plans carefully to ensure the best personal choice in terms of coverage and cost. If there are too many options, as the Aging Network saw first-hand when Medicare Part D was first implemented, consumers struggle to compare plans and make the best choice for their situations. Frustration and confusion drive poorer choices, which have a range of possible consequences for consumers: higher out-of-pocket costs, reduced access to certain therapies or providers, and less efficient use of health care.

The reality of Medicare plan selection is why unbiased, objective resources are so important, and we implore the Administration to maintain these counseling resources to ensure that beneficiaries fully understand their coverage choices. In all 54 states and territories, State Health Insurance Assistance Programs (SHIPs) provide impartial, in-depth, individual counseling to millions of Medicare beneficiaries on all their Medicare coverage choices. Nearly two-thirds of AAAs administer the local SHIP. SHIPs play a critical role in ensuring that beneficiaries understand their choices. Choosing among plans that offer differing premium costs, cost-sharing arrangements and provider networks can be an overwhelming experience—especially for medically and/or cognitively vulnerable older adults—and studies in numerous states show that SHIP services can save Medicare beneficiaries millions of dollars a year collectively. Given that nearly half of all Medicare beneficiaries live on incomes below \$25,000 annually, even a few hundred dollars saved is well worth the investment. Unfortunately, the Administration has repeatedly proposed eliminating this unique source of unbiased Medicare counseling even while simultaneously promoting proposals to increase the complexity of consumers' Medicare Advantage options.

It is essential that these Medicare counseling resources continue to be available and are adequate to meet beneficiaries' needs, most especially if the Administration moves forward with eliminating the meaningful difference standard.

Conclusion

n4a appreciates the opportunity to comment on the Draft FY 2019 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. However, at precisely the time when the value of these services are increasingly being recognized and promoted by public and private payers, it's essential that the vital roles of traditional community-based health and health-related services providers, such as AAAs and other CBOs, continue to be recognized and funded.

There is continued opportunity for CMS to improve care by considering and capitalizing on the traditional HCBS infrastructure and supporting the inclusion of AAAs and other CBOs. As trusted resources with a long history in the community, AAAs have important knowledge of the targeted population and skill sets that can complement those of MA plans and traditional health care providers and help CMS achieve goals to expand beneficiary choice and improve access to health-related supplemental benefits and disease prevention programs. We look forward to working with CMS to ensure that these goals are met, and that the critical role of AAAs and other CBOs in improving beneficiary health through health-related community services and supports is preserved and strengthened.

Sincerely,

A handwritten signature in cursive script that reads "Sandy Markwood".

Sandy Markwood
Chief Executive Officer