NASUAD
National Association of States
United for Aging and Disabilities

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Demetrios Kouzoukas
Principal Deputy Administrator and Director, Center for Medicare
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted Electronically to regulations.gov

Dear Director Kouzoukas,

On behalf of the National Association of States United for Aging and Disabilities (NASUAD), I am writing to you in response to the Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter (the Call Letter). NASUAD represents the nation's 56 state and territorial agencies on aging and disabilities and supports visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and individuals with disabilities. Our members oversee the implementation of the Older Americans Act (OAA) across the country, and many also serve as the operating agency in their state for Medicaid waivers 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.

NASUAD would like to specifically express our support for two proposals contained within the call letter: the expansion of allowable supplemental benefits, and the option for Special Needs Plans (SNPs) to provide enhanced disease management services. Based on our experience serving older adults and individuals with disabilities with medical and functional limitations, we believe that these new options will represent an incremental but important improvement for Medicare beneficiaries.

The proposed changes to allowable supplemental benefits in Medicare Advantage plans will increase the plans' ability to provide more options and new benefits to Medicare beneficiaries, meeting their unique health needs and improving their quality of life. With these changes, CMS is proposing to redefine health-related supplemental benefits to include services that increase health and improve quality of life, including coverage of non-skilled in-home supports, portable wheelchair ramps and other assistive devices and modifications when patients need them. This change could allow plans to begin providing modest but important home and community-based services to participants.

Currently, after a Medicare-eligible individual experiences an acute event that results in a hospital stay, rehabilitation and other post-acute services are generally provided in an institutional setting such as a Skilled Nursing Facility (SNF) or an Inpatient Rehabilitation Facility (IRF). The experience of our members indicates that many of these individuals never return home, particularly those older Medicare beneficiaries with significant health care conditions. These individuals often stay in the facility after their Medicare post-acute stay ends, either as a Medicaid-funded resident or as an individual who spends down their assets on the path to Medicaid eligibility. In many cases, this post-acute and spend down period has led to a deterioration of the person's community supports (both formal and informal) as well as their housing situation. The end result is that many individuals first enter Medicaid when they are in a facility with little opportunity to return to the community.

We believe that the modified supplemental benefits will give MA plans the option to experiment with short-term HCBS in lieu of these institutional rehabilitation options. Although we have concerns that plans may not have sufficient resources or ability to provide the range of supports needed for many of these individuals, we think that even modest investments in HCBS infrastructure will result in positive outcomes. We therefore encourage CMS and MA plans to identify cost-effective ways to deliver the widest range of community-based supports available to those who require them. We also encourage CMS to evaluate the outcomes of this policy change, in hopes that the results will support a more robust HCBS benefit that would be available to all Medicare beneficiaries who require such services. Evaluation of state initiatives to reduce SNF and IRF stays in favor of HCBS indicate that this would have positive effects on quality of care, quality of life, and overall cost of services. Congress passed legislation that allows this change in the recent continuing resolution, and we encourage CMS to implement this policy in an expedited and robust manner.

We also support CMS' proposal that would allow SNPs to provide enhanced disease management as a supplemental benefit to improve care coordination for many individuals with significant health care needs. The populations served in institutions and those who are dual eligible, which are the groups targeted by this proposal, generally have significant health care needs and functional limitations. Enhanced disease management services can provide positive benefits for these individuals and result in lower overall costs to the system.

We appreciate the opportunity to comment on this proposal, and ask that CMS work closely and collaboratively with state agencies on identifying and improving policies and programs that can improve the lives of older adults and participants with disabilities. If you have any questions, please contact Damon Terzaghi of my staff at dterzaghi@nasuad.org or (202) 898-2578.

Sincerely,

Martha A Roherty

Martha A. Roherty
Executive Director
NASUAD