March 1, 2019

Seema Verma  
Administrator, Centers for Medicare and Medicaid Services (CMS)  
Department of Health and Human Services, P.O. Box 8010  
Baltimore, MD  21244

Submitted electronically at Regulations.gov


Dear Administrator Verma:

The National Association of Nutrition and Aging Services Programs (NANASP) welcomes the opportunity to comment on the 2020 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part D Payment Policies and Draft Call Letter.

NANASP is a professional organization with nearly 1,100 members who interact with older adults every day through providing meals served in either congregate or home-delivered settings and other aging services. We advocate on behalf of these providers, older adults, and their families.

We are pleased to see that CMS intends to implement the Bipartisan Budget Act of 2018 in Part II of this year’s plan reimbursement schedule, particularly the “Special Supplemental Benefits for the Chronically Ill” section. As a professional organization focusing on nutrition and other aging services, our members will be specifically impacted by these reimbursement decisions.

CMS has asked certain specific questions:

- Whether plans should have flexibility to determine what is a chronic condition that meets the statutory standard (“is life threatening or significantly limits the overall health or function of the enrollee”) and if CMS should consider alternative approaches to determining what meets this criterion;
- What the limits are on these supplemental benefits discussed here;
- Whether we should permit consideration of other factors, like financial need, in determining permissible supplemental benefits for chronically ill enrollees.
Below, we offer our thoughts on these questions, as well as other topics raised by this section of the call letter.

**What Chronic Conditions Should Be Considered?**
NANASP supports the 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” as being eligible to meet criterion 1 of Section 1852(a)(3)(D)(ii) of the Bipartisan Budget Act of 2018. This list of chronic conditions is wide-ranging and should be sufficient to cover beneficiaries in need. However, we do support allowing exceptions to be made if a condition is not on this list but is severe enough to be considered a chronic condition that is “life-threatening” or “significantly limiting.”

For criteria 2 and 3, we support allowing MA plans to have the flexibility to “develop and document mechanisms to identify chronically ill enrollees” who would benefit from the special supplemental services based on this proposal.

**What Services Should Be Offered?**
We support home-delivered meals, food, and produce as examples of supplemental benefits as described in this proposed call letter. We commend CMS for including these important benefits as examples.

For home-delivered meals, we ask CMS to clarify and/or provide definition criteria for a home-delivered meal that would be allowed for reimbursement under this proposal. One example CMS may wish to follow is that set by the Older Americans Act (OAA) nutrition programs. Statutorily, meals eligible for reimbursement under OAA funding must meet at least one-third of the dietary reference intake for older adults.

We also support coverage for in-home nutrition counseling, another service specified by the OAA; with this benefit, chronically ill beneficiaries will have the knowledge to make better food choices for their conditions, promoting wellness.

We note that we would directly oppose any proposal that would disallow coverage for home-delivered meals, food and produce if a home health aide is present; a home health aide has multiple responsibilities in providing care, which may or may not include food preparation. Even if the aides prepare food, there is no guarantee of its nutritional value. A home-delivered meal provides an extra component of care to homebound beneficiaries that should not be denied due to the presence of an unrelated aide.

In connection to the proposal of covering food and produce, we also support future reimbursement for congregate meals providers, particularly those participating in the OAA nutrition program which also provide meals meeting at least one-third of the dietary reference intake for older adults. These programs offer nutrition, nutrition counseling and education, socialization, and often exercise activities, and are a cost-effective way to provide Medicare Advantage beneficiaries with food and other supplemental services. Like the safety checks
provided by home-delivered meals volunteers and staff, congregate meals sites encourage social interaction, a known health benefit. Encouraging physical activity is also crucial for the health of chronically ill beneficiaries.

Further regarding coverage for produce, one program that has been successful in this regard is the Senior Farmers Market Nutrition Program, which provides coupons to low-income seniors to be used at local farmers’ markets. We suggest an additional comment period to ascertain what is already being done to provide food and produce and what could be built on.

Further, we support coverage for non-medical transportation, especially as it is tied to home-delivered meals and access to food and produce. This could include transportation to a grocery store, a farmers’ market, or a senior center serving congregate meals.

**Who Should Provide These Benefits?**

We highly recommend that CMS maintain language urging plans to “contract with community-based organizations to provide new supplemental benefits…. These organizations may already be providing services in the community and, in some cases, have contractual arrangements with Medicaid managed care or MA plans.”

We particularly recommend that CMS specify that these organizations, if possible, should be tied to the already-existing OAA aging network, comprised of Area Agencies on Aging (AAAs) and local nutrition service providers. These programs already can serve most Medicare-eligible beneficiaries since their eligibility age is 60 and older. We also recommend that CMS specify that plans should directly contract with AAAs and/or local nutrition service providers depending on their capacity.

However, this contracted funding should supplement, not replace, OAA funding, since these meals served and services offered would be on top of what is already being served with current funding and would take extra funding to provide.

Further, we recommend that CMS specify that reimbursement rates must be fair and sufficient for nutrition service providers and tied to local costs for food provision.

**What Should the Limits Be?**

NANASP supports no fewer than 30 days of home-delivered meals per plan year as an allowable benefit. This duration is what is used in the Coleman model for care transitions, which has been proven to make a difference for beneficiaries and help reduce hospital readmissions. (We would also like to ensure that home-delivered meals and other food supplemental benefits will be offered to beneficiaries who are not recently released from the hospital.)

As noted in a fall 2018 letter sent to CMS by Meals on Wheels America, Aetna, and other organizations, including NANASP, we would support a cap on home-delivered meals benefits at 90 days per plan year for beneficiaries. However, as with the definition of an eligible
beneficiary, we also support allowing exceptions on a case-by-case basis, as decided by CMS and plans.

Should Other Factors Be Considered?
NANASP strongly urges CMS to provide these benefits to all beneficiaries meeting the general supplemental services benefits criteria. This should be considered a benefit like all other plan services, not limited to those with financial need. Though we recognize that the issue of social determinants’ effect on general health is a more prominent one in lower-income populations, providing supplemental benefits like home-delivered meals reduces general health care costs in all populations.

We commend you for your important interpretation of the chronic care provisions in the Bipartisan Budget Act of 2018, and for making the link between nutrition and health in older adults. Thank you for considering our comments. If you have questions about our comments, you may reach our Policy and Advocacy Director Meredith Whitmire at mponder@nanasp.org.

Sincerely,

Bob Blancato
Executive Director
NANASP