



NCOA Health Care Priorities for the Presidential Transition

The National Council on Aging (NCOA) is a national voice for older Americans -- especially those who are vulnerable and disadvantaged -- and the community organizations that serve them. Since 1950, NCOA has led advocacy and service efforts to turn creative ideas into pragmatic, cost-effective policies and programs that help millions of seniors live independently, find jobs and benefits, manage their health and remain active. NCOA brings together non-profit organizations, businesses, and government to develop creative solutions that improve the older American's lives.

Under the leadership of President and CEO James P. Firman, EdD, our health care work is strategically focused on three critical Impact Areas in which we have specific expertise, both in the public policy arena and in the field working with thousands of community organizations and leaders:

- **Healthy Aging** – Improving health and reducing disability (led by Nancy Whitelaw);
- **Long-Term Services and Supports** – Enhancing capacity to live in communities with dignity, choice and financial security (led by Jay Greenberg); and
- **Access to Benefits** – Increasing access to public and private benefits and resources (led by Wendy Zenker)

Without question, our nation faces enormous health care challenges. For people over age 65, the central challenges concern the future of the Medicare program, improving access to home and community services, and promoting healthy aging. NCOA is a leader in each of these areas and brings real world service and decades of staff expertise that can assist in providing evidence-based, innovative, bipartisan answers to these pressing national problems.

Chronic Care and Prevention: NCOA believes that the nation can improve outcomes and efficiencies through prevention and self management of chronic conditions to reduce the risk of disability and the progression of disease. NCOA is the Administration on Aging's designated technical assistance center for community-based healthy aging programs in 27 states. These evidence-based programs include falls prevention, chronic disease self management (CDSMP), and mental health [See <http://www.healthyingprograms.org>]. These programs provide great value and meet high standards, as they have been proven to work through rigorous scientific evaluation and peer review, and have measurable results. Research shows that if older adults maintain healthy habits they can significantly delay the onset of disability by as much as 10 years, use fewer healthcare resources, and reduce the period of disability prior to death. CDSMP has been proven to be a particularly high value, low-cost intervention for those with multiple chronic illnesses.

Such evidence-based community interventions are an important component of the broader effort to reform health care (e.g., patient-centered medical homes). As we work to improve prevention and care for those with chronic illness, NCOA approaches these issues with a unique perspective:

- A focus on vulnerable/disadvantaged older adults – those with multiple chronic conditions, dual eligibles and others with low incomes, and populations that have experienced detrimental health disparities;
- An emphasis on self management, consumer direction, empowerment, informed and activated families, and a holistic approach to chronic care and falls prevention; and
- Expertise with evidence-based models that enhance the interface between primary care and community services.

The increased focus on prevention must also include injury prevention. Falls are the leading cause of injury-related deaths among seniors, accounting for 1.85 million emergency room visits, and 460,000 hospitalizations in 2005. Unless we address contributing factors, the lifetime cost of senior falls is expected to rise from \$19 billion in 2000 to nearly \$43 billion in 2020. NCOA is a founding member of the National Falls Free Coalition and spearheaded the development of a Falls Prevention National Action Plan. Our priority is to secure adequate funding within the Centers for Disease Control and other areas for falls prevention activities.

Long-Term Services and Supports (LTSS): Health care reform efforts should not discriminate against millions of frail seniors and persons with disabilities by failing to address their LTSS needs. We face a growing crisis and need a national strategy to help them to maintain their independence and dignity. Most seniors must currently impoverish themselves and exhaust their hard-earned life savings before receiving help under Medicaid, and too many enter expensive nursing homes prematurely, despite their preference for home care. NCOA co-chairs the Leadership Council of Aging Organizations (LCAO) LTSS Committee and supports:



- Senator Kennedy's *Community Living Assistance Services and Supports (CLASS) Act*, cosponsored by Senator Obama, which would promote choice and independence, provide for voluntary participation in a broad risk pool, be fiscally responsible and reduce Medicaid spending, retain a role for private insurance, and promote personal responsibility. The bill embodies the principles developed by LCAO and the Consortium of Citizens with Disabilities <http://www.lcao.org/docs/lc/112008pr.pdf>;
- The Kerry/Grassley *Empowered at Home Act*, which would address the Medicaid institutional bias by improving access to cost effective home and community services in a variety of important ways;
- Addressing dangerously high rates of vacancies and turnover among direct care workers; and
- Increasing supports for family caregivers who are struggling with enormous financial, emotional and physical burdens to try to keep loved ones out of institutions.

Medicare Low-Income Protections: Enrolling low-income seniors in needs-based benefits programs is critical to their health and independence. Unfortunately, participation rates for these programs are very low, due to lack of awareness, complicated application forms, and insufficient resources dedicated to outreach and enrollment. NCOA created the Access to Benefits Coalition and My Medicare Matters program, directs the National Center on Benefits Outreach and Enrollment, developed and maintains the comprehensive on-line screening tool www.benefitscheckup.org, and helped to lead efforts this past year to enact into law significant improvements to the Medicare prescription drug Low-Income Subsidy (LIS) and Medicare Savings Programs (MSPs). Additional legislative improvements NCOA supports include:

- Raising asset eligibility levels for LIS and MSP benefits, so that low-income seniors who did the right thing in creating a modest nest egg of savings are not penalized;
- Simplifying and aligning the LIS and MSP programs so that if an individual is eligible for one, he/she would automatically be eligible for the other;
- Making permanent the Qualified Individual (QI) MSP program, which pays Medicare premiums for beneficiaries with incomes between 120 and 135 percent of poverty. The program is due to expire on December 31, 2009; and
- Providing meaningful additional funding to the aging network for low-income outreach and enrollment efforts.

In general, we are supportive of recommendations from the nonpartisan, expert Medicare Payment Advisory Commission (MedPAC) to help pay for these and other Medicare improvements.

Administrative and Regulatory Recommendations

- **Part D LIS application form (SSA):** On Oct. 28, 2008, the Social Security Administration requested comments on the Medicare Part D Low-Income Subsidy application form. We support the following changes: (1) allow applicants to appoint a third party to assist them throughout the enrollment process; (2) provide further instruction and clarity for jointly owned assets; and (3) provide space and allow applicants to explain their answers to specific questions.
- **Spousal protections under Medicaid Home and Community-Based Services (CMS):** Clarify that states can provide impoverishment protections to spouses of HCBS Waiver enrollees. Even though HCBS recipients are more likely to be married, such protections are mandatory for spouses of nursing facility residents and the current administration has restricted states' discretion under HCBS waivers, further exacerbating Medicaid's institutional bias.
- **Targeted case management (CMS):** An interim final rule was issued in Dec. 2007 making changes to Medicaid targeted case management, now subject to a moratorium until April 2009. The rule went well beyond the statutory changes and would unduly restrict access to these important services. The rule should be withdrawn and revised in a manner that removes the provisions that would harm Medicaid enrollees.
- **Intelligent assignment for low-income beneficiaries in Part D plans (CMS):** The statutory requirement for "random" assignment should be interpreted with the best interest of the beneficiary in mind, to require that assignment be random among those plans best suited to an individual's needs. States have found that such "intelligent" assignment is feasible and saves money for both the beneficiary and the government.
- **Part D plan churning and disruption among low income beneficiaries (CMS):** Each year, more than a million low-income beneficiaries must change prescription drug plans in order to avoid paying premiums because their plans did not qualify as benchmark plans for the following year. To alleviate this churning and disruption, CMS should: (1) reinstate its "de minimus" rule; (2) allow all non-enhanced PDPs the option of offering their plan to LIS beneficiaries for no premium; and (3) calculate the benchmark premium without consideration of rebates applied by MA-PDs.
- **Notice for Part D Appeals (CMS):** Medicare Part D regulations should be changed to require that the official coverage determination be provided to each affected beneficiary at the pharmacy and that CMS develop a standardized electronic submission for plans that explains the reason for a denial and how to seek an exception.
- **Part D Tiering Exceptions (CMS):** The regulations should be changed to clarify that a tiering exception is available for all drugs, including specialty drugs.
- **Giving Weight to Physician's Opinion on Exceptions (CMS):** Part D regulations at 42 C.F.R. §423.578(f) conflict with clear statutory language at S.S.A. §1860D-4(g)(2) by precluding deference to the physician's support for an exception. This regulatory provision should be repealed.

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