

March 5, 2018

VIA ELECTRONIC MAIL

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

RE: CMS-2017-0163; Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies

Dear Administrator Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Request for Information on its Advance Notice of Methodological Changes to Medicare Advantage (MA) for Calendar Year (CY) 2019. Our organization is the policy voice for five Seventh-day Adventist affiliated health systems that include 83 hospitals and more than 300 other health facilities in 17 states and the District of Columbia.

Our organization includes 45 hospital campuses located across nine states and represents the entire continuum of care, including Home Health Agencies (HHAs), Skilled Nursing Facilities (SNFs) and Inpatient Rehabilitation Facilities (IRFs). AHPA provides inpatient, outpatient and emergency room care for four million patient visits each year.

Below, please find AHPA's general comments regarding MA plans and policies that CMS could seek to improve the availability of these plans in the market.

Health Related Benefits

CMS proposes an expanded definition of the primarily health-related supplemental benefit standard. According to CMS, this expansion will increase the number of allowable supplemental benefit options available to beneficiaries, which may lead to improvements in their quality of life and health outcomes. Currently, CMS defines a supplemental health care benefit as an item or service (1) not covered by Original Medicare, (2) that is primarily health related, and (3) for which the MA plan must incur a direct medical cost. Under the proposal, CMS would interpret the term more broadly to include items or services that can "diagnose, prevent, or treat an illness or injury." These may include fall prevention devices and other items or services used for a patient's daily maintenance.

AHPA lends full support to the expanded definition of health-related supplemental benefits proposed by CMS. However, we urge the Agency to also include in the definition of supplemental benefits any items or services provided to address an individual's social determinants of health.

These services may include transportation to medical appointments, access to healthy foods and safe housing. We believe that addressing these social determinants of health will help improve the health of patients, particularly vulnerable and low-income Medicare beneficiaries. CMS could also incorporate services provided by Community Health Workers into the definition of supplemental benefits. This would

allow MA plans to link plan members with community-based resources that could help improve their health.

MA Network Adequacy

AHPA commends the Agency for its efforts to expand the availability of MA plans. As recognized by the Advance Notice, MA plans facilitate private sector innovation and have the potential to reduce costs and improve quality. Due to the efficiencies of MA plans, enrollment has been consistently growing. As of 2017, one in three people with Medicare (33% or 19.0 million beneficiaries) is enrolled in an MA plan.¹

Although network adequacy is not addressed in the Advance Notice, we believe changes to the standards should be considered as part of CMS' effort to expand the availability of MA plans and simplify the program. To help remove existing market entrance barriers, AHPA recommends providing flexibility within the MA network adequacy standards to recognize for differences in population density within a county.

Currently, an MA network adequacy is assessed at the county level, and counties are classified into five county type designations: Large Metro, Metro, Micro, Rural, or CEAC (Counties with Extreme Access Considerations). CMS uses a county type designation method that is based upon the population size and density parameters of individual counties. These parameters are based on information provided by the Census Bureau in its classification of "urbanized areas" and "urban clusters," as well as by the Office of Management and Budget (OMB) in its classification of "metropolitan" and "micropolitan." Each county level designation corresponds with specific quantitative time and distance parameters that MA organizations must meet to ensure beneficiaries within those counties have adequate access to health care services. Accordingly, network adequacy standards vary from county to county based on their designation.

To encourage the offering of more MA plans, we recommend that CMS adjust its network adequacy standards to account for population differences within a county. We believe this is necessary because even within a large metro county, there may be rural, low-population areas. The lack of flexibility within the current county designation method limits the ability of MA organizations to offer products in areas where there is a greater need for such services. An example of a rural area within a larger metro county is Orange county, Florida. The city of Orlando has a population of nearly 280,000 people. Just 18 miles east of Orlando is the unincorporated city of Bithlo, which has a population of just 8,000. Although these cities are both within Orange county, Bithlo is very much a rural area within the larger metropolitan county. Examples like these give cause for exceptions within the county designation methodology. Therefore, we urge CMS to allow a county to have more than one designation (i.e. metro, large metro, rural) based on the population density of the area in which a product is offered.

Risk Adjustment Model

In the Advance Notice, CMS proposes to add mental health, substance abuse disorders, and chronic kidney conditions to the risk adjustment model of MA plans for 2019. These changes were mandated by the 21st Century Cures Act and seek to reduce costs and improve care for patients with those conditions.

To more accurately reflect the costs associated with those conditions, AHPA recommends that CMS adjust its quality measures in accordance with population and age. Quality measures have been developed

¹ Kaiser Family Foundation. Retrieved from: <https://www.kff.org/medicare/issue-brief/medicare-advantage-2017-spotlight-enrollment-market-update/view/footnotes/#footnote-221043-9>

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for the general population and therefore may not always apply to beneficiaries with several chronic conditions. For example, appropriate glucose levels for a 98-year-old patient may vary from the appropriate glucose levels of a 68-year-old. Additionally, we believe that CMS should account for the number of conditions that a patient may have in the risk-adjustment model

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of AHPA, at Julie.Zaiback@AHPAs.org.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jeff Bromme', with a long horizontal flourish extending to the right.

Jeff Bromme
President
Adventist Health Policy Association