

March 1, 2019

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for the Medicare Advantage (MA) CMS-HCC Risk Adjustment Model- Pts 1 and 2

Dear Ms. Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on these proposed call letters in regard to their effect on those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

We have several comments on the proposed call letters as various sections will impact the care of those with advanced illness. Specifically:

Risk Adjustment Model- Number of Illness

We support the methodology change required by the 21st Century Cures Act as it confirms our experience that many with advanced illness have with multiple illnesses which complicate their care exponentially. Regarding the model specifications, *we are in support of the alternate that includes additional HCCs for dementia and pressure ulcers*. Dementia is a challenging and, unfortunately, costly condition that can now be clearly diagnosed. Therefore, it should be included in the risk adjustment methodology. We recommend that CMS select and then phase in this alternate methodology on an accelerated timing.

We also recommend that future MA risk adjustment calculations also include functionality, as recommended in the recent GAO Report on this topicⁱ. Many with advanced illness also have functional limitations and such limitations should be included as part of the MA risk adjustment since, otherwise, even the proposed changes here underweight those with poorer function.

Potential New Measure Concepts-

- Exclusions for Advanced Illness-We agree that the exclusions for advanced illness should be expanded to allow clinical data to be used to identify those individuals with advanced illness and frailty.
- Supplemental benefits overlapping with hospice- We raise the issue of how the metrics for the new MAO supplemental benefits will be handled for those beneficiaries enrolling in fee-for-service (FFS) hospice. If the MAO supplemental benefits overlap with FFS hospice, will they continue to be tracked by the MAOs? If so, how will this happen?

Non-opioid Pain management supplemental benefits

We support these supplemental benefits as non-opioid pain therapies can be beneficial adjuncts to pharmacologic pain management. The examples listed in the proposed rule, massage, acupuncture, counseling, are used by palliative care and hospice teams who have access to them, and patients find them helpful.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

We are grateful to the CHRONIC Act and to CMS for recognizing that those with chronic illness can particularly benefit from various supplemental benefits. Such benefits will make a real difference in the quality of life for them and their families. Here is what we support in this section:

- Chronic illness definition- We appreciate the definition of chronic illness as it overlaps C-TAC's definition of advanced illness. Our only suggestion is that CMS consider defining more specifically what is meant by the third point in the definition, "intensive care coordination." Developing guidance on care coordination will help MAOs to better identify enrollees who can benefit most from these SSBCIs.
- MAO flexibility- We support giving MAOs flexibility in defining the population to receive these benefits so as to best tailor it to those enrollees' needs. We acknowledge that this will be challenging to beneficiaries trying to choose the right MA plan and unaware of whether they will or will not qualify for some of these new benefits. MAOs will gain some experience and learning with this over time and learn to optimize their marketing materials.
- Contracting with community-based organizations- We support MAOs contracting with community-based organizations to provide these benefits as there are many excellent community resources across this county and it would be inefficient and unproductive for MAOs to develop or duplicate their efforts. Facilitating separate community services will also let enrollees and their families not be confused that

such services are now being offered through their MA plan.

Here are our comments on the limits of these benefits:

- Functionality- We are concerned that the CHRONIC statute unfortunately limits these new SSBCIs to only those that “have a reasonable expectation of *improving or maintaining* the health or overall function of the enrollee”. As you are aware, improving or maintaining overall function is an unrealistic goal for many with chronic illness as such illness are typically progressive and, therefore, decline from them is inevitable. These parameters also somewhat contradict the definition of a supplemental benefit in the call letter as something that seeks “to ameliorate the functional/psychological impact of injuries or health conditions.” We would therefore encourage CMS to adopt a similar approach as from the Jimmo settlementⁱⁱ and include slowing decline as a valid reason for offering SSBCIs and also consider comparing any outcomes from such benefits to those of enrollees with chronic illness who did not receive them.
- Home repairs- We support such repairs as an example of not only improving the lives of enrollees but allowing MAOs to play a more active role in improving the communities where they operate. For that reason, we disagree with the limitation that such home repairs cannot include capital or structural improvements since it is exactly such improvements that will help enrollees stay in their homes. Having edged into this helpful territory, let us now not be penny wise but pound foolish. Upgrading enrollees’ homes to permit them to age in place will be a benefit for them and the community and also a savings versus the federal government and the state having to pay for long term care via Medicaid when enrollees can no longer manage in homes without such improvements.
- Other factors- We are in support of expanding consideration of other factors to include things like financial need and caregiver support, since we know these are a burden with advanced illness that harm peoples’ health and quality of life and may justify additional benefits.

Naloxone Co-Prescribing

While we appreciate that co-prescribing naloxone is an important safety measure to address the opioid crises, we have a couple of concerns. First, we are not sure what the feasibility issues would be for providers and enrollees. An automatic second medication could add to the cost to the enrollee and discourage them from refilling needed opioid prescriptions. Also, we urge CMS to provide education for those enrollees with cancer or receiving hospice or palliative care that naloxone should be used only in the case of accidental overdose by a family member and not on the enrollee, so as to avoid inadvertent opioid withdrawal or physical distress.

Medicare Part D Opioid Overutilization Policy

We appreciate the reiteration of the exclusion of those receiving palliative care from these policies. However, we are in agreement with draft recommendations from the HHS Pain Management Best Practices Inter-Agency Task Forceⁱⁱⁱ that aspects of the CDC pain management guidelines should not be mandatory, and that personalized care should be promoted. We are also concerned by increasing evidence^{iv} that such policies are not appropriately identifying beneficiaries at risk but instead causing suffering and distress among those with chronic pain who appropriately need these medications.

New Draft 2020 Call Letter Proposals to Address the Opioid Epidemic

We are concerned about the proposal to implement the revised PQA opioid overuse measures that better align with the CDC Guideline for Prescribing Opioids for Chronic Pain. As noted in the HHS Pain Management Best Practices Inter-Agency Task Force draft recommendations^v, the CDC guidelines are meant for primary care settings and exclude patients with cancer and on hospice or palliative care, nuances that are lost in the measures being considered here. We are particularly concerned that people with advanced illness who legitimately need opioid doses higher than 90 MME will be flagged as “especially high-risk beneficiaries” which could harm their access to these appropriate and needed medications.

Future Changes to the Overutilization Monitoring System (OMS) Criteria

As CMS considers future changes, we would reiterate our previously expressed concerns that some of the opioid dose ceilings and lengths of treatment will be problematic for those living with painful advanced illnesses and CMS should explore exempting these populations from future monitoring systems.

Opioid Potentiator Drugs

While we understand that combining potentiator drugs with opioids has risks, we must point out that some beneficiaries with advanced illness may appropriately be on such combinations. An example might be someone with chronic arthritic pain and an anxiety disorder. The HHS Pain Management Best Practices Inter-Agency Task Force draft recommendations^{vi} promote exploring both the benefits and burdens of opioid potentiator drugs as part of personalized care and recommends that those with an appropriate need for such combinations should be able to receive them without hindrance. In addition, people receiving palliative or hospice care may also appropriately use potentiator drugs like Ativan and Haldol with opioids, and so we suggest that future restrictions or monitoring of such combinations with opioids exempt these populations.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

Marian Grant

Marian Grant, DNP, CRNP, ACHPN, FPCN
Senior Regulatory Advisor

Coalition to Transform Advanced Care (C-TAC)
1299 Pennsylvania Ave, Suite 1175
Washington, DC, 20008

ⁱ <https://www.gao.gov/assets/700/694425.pdf>

ⁱⁱ <https://www.cms.gov/center/special-topic/jimmo-center.html>

ⁱⁱⁱ <https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html>

^{iv} <https://jamanetwork.com/journals/jama/article-abstract/2688548>

^v <https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html>

^{vi} <https://www.hhs.gov/ash/advisory-committees/pain/reports/2018-12-draft-report-on-updates-gaps-inconsistencies-recommendations/index.html>