June 24, 2019

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

Re: Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Acute Care Hospital (LTCH) Prospective Payment System Proposed Rule and Request for Information

Dear Ms. Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects 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.

Our specific comments on this proposed rule are:

Hospital Inpatient Quality Reporting (IQR) Program

- Safe Use of Opioids – Concurrent Prescribing eCQM (NQF #3316e) – We support the exemption of those with cancer or receiving palliative care from this measure as the concurrent use of opioids and benzodiazepines can be appropriate in those populations. Thank you for confirming these groups should be exempted from any opioid measures or guidelines based on the 2016 CDC’s Guidelines for Prescribing Opioids for Chronic Pain1.
• Hospital Harm – Opioid-Related Adverse Events eCQM- We support this measure’s purpose to assess an acute care hospital’s administration of naloxone as this can be an indicator of inappropriate opioid prescribing. However, we also support the exemption of those requiring palliative care as naloxone could be administered to such patients by over-cautious clinicians and cause further suffering to them.


We do not support the removal of the Pain Management questions from the PCHQR program. We strongly disagreed with their removal from the Hospital IQR or VBP Program as that decision was apparently not based on any evidence we are aware of. Pain is a key reason for hospital admission and is certainly a prevalent symptom among those with cancer. Not to measure it at all makes no sense and no evidence is provided in the proposed rule that questions about pain communication do indeed promote opioid overuse.

Rather than removing these questions, we agree that CMS should aggressively pursue measures that adequately capture a hospital’s performance on pain management and determine whether any such questions do indeed encourage opioid overuse. Until such evidence is confirmed, however, the current questions should remain.

Medical Condition and Comorbidity Data Elements

We agree with adding the measurement of “Pain Interference (Pain Effect on Sleep, Pain Interference with Therapy Activities, and Pain Interference with Day-to-Day Activities)” since this measure addresses an important aspect of care for those with advanced illness. The concerns for opioid overuse notwithstanding, those who receive care in any of the covered hospital types should have “Pain Interference” measured and treated with whatever treatment is effective, including opioids when appropriate.

Long-Term Care Hospital Quality Reporting Program (LTCH QRP)

• Proposed Transfer of Health Information to the Provider–Post-Acute Care (PAC) Measure- We support the addition of this measure as many of those with advanced illness have complicated medication regimens and it is critical to assess whether or not a current reconciled medication list is given to the subsequent provider when a patient is discharged or transferred from a long-term care hospital. These transitions are often when mistakes and deletions occur and that jeopardizes the care and safety of such vulnerable patients.

• Proposed Transfer of Health Information to the Patient–Post-Acute Care (PAC) Measure- We support the addition of this provision from the IMPACT Act as it is also helpful and assessing “whether or not a current reconciled medication list was
provided to the patient, family, or caregiver when the patient was discharged from a PAC setting to a private home/apartment, a board and care home, assisted living, a group home, transitional living or home under care of an organized home health service organization, or a hospice will help ensure that patients and their families have the latest and correct medication information in their new setting.

LTCH QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years: Request for Information

- **Standardized Data Elements**
  We support both the move to standardized data elements and the ones provided in this proposed rule. Our only concerns regard the following two data elements:
  
  - *Functional maintenance outcomes*: While we agree with the inclusion of data elements to assess function, we want to note that maintaining function is eventually not possible for those with many advanced illnesses which are typically progressive and, ultimately, result in debility and death. Therefore, this data element should not penalize facilities caring for patients who will not be able to maintain function.
  
  - *Opioid use and frequency*: While monitoring opioid use is important, we do not want such a data element to in any way discourage the appropriate use of opioids for pain or dyspnea management in beneficiaries.

Proposed Social Determinants of Health Data Collection to Inform Measures and Other Purposes

We support the use of the seven proposed SDOH elements, “race, ethnicity, preferred language, interpreter services, health literacy, transportation, and social isolation.” We also suggest CMS explore family caregiver assessment as a possible future social risk factor as the health and capability of the family caregiver for someone with advanced illness can have a significant impact on their health and medical interventions. While this is less an issue in those people receiving care in an acute hospital, many with advanced illness need assistance in making decisions, which is where the presence of social risk factors of their family caregivers can be an issue.

Request for Information (RFI) on NQF and CDC Opioid Quality Measures

- **NQF Quality Measures**
  The three measures listed evaluate patients without cancer with prescriptions for opioids in combination with benzodiazepines, at high-dosage, or from multiple prescribes and pharmacies (#2940, #2950, and #2951 respectively). While these behaviors could suggest an opioid misuse problem, it is possible that some patients without cancer might appropriately be taking high dose opioids or in combination with benzodiazepines under the management of a hospice, pain, palliative care or
advanced illness team. Therefore, we would recommend that further development work be done to exempt those receiving hospice, palliative care or with advanced illness from the measures’ denominators so as not to discourage appropriate use for such patients.

- **CDC Quality Improvement (QI) Opioid Measures**
  
  We do not have comments on which of the 16 CDC QI opioid measures have value for potential consideration for the Promoting Interoperability Program other than to note that any measures selected should exclude those receiving active cancer treatment, palliative care, and end-of-life care as per the CDC Guidelines\(^\text{viii}\). As noted in the CDC’s recent clarification of the Guidelines, their implementation can, unfortunately, overlook these important elements\(^\text{ix}\).

Thank you for the opportunity to comment on this draft strategy. 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*

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\(^1\) https://www.cdc.gov/drugoverdose/prescribing/guideline.html

\(^2\) https://www.mypcnnow.org/fast-fact-328

\(^3\) https://academic.oup.com/painmedicine/article/11/12/1859/1943985

\(^4\) https://www.jspmjournal.com/article/S0885-3924(16)30048-3/fulltext

\(^5\) https://www.ncbi.nlm.nih.gov/pubmed/27382268

\(^6\) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5278805/

\(^7\) https://www.ncbi.nlm.nih.gov/pubmed/20336554

\(^8\) https://www.cdc.gov/drugoverdose/prescribing/guideline.html