

January 16, 2018

Ms. Seema Verma

Administrator, Centers for Medicare and Medicaid Services

Room 445-G, Hubert H. Humphrey Building

200 Independence Avenue, SW

Washington, DC 20201

Re: CMS-4182-P, RIN 0938-AT08, Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program

Greetings:

On behalf of Elder Care and Advanced Illness at Altarum, we appreciate the opportunity to provide comments on this proposed rule with respect to those areas that would affect people living with advanced illness. Our team is working in the public interest to catalyze reforms in service delivery so that elders living with advanced illnesses and disabilities can live as meaningfully and comfortably as possible at a sustainable cost to their families, their communities, and the nation. We are working on a comprehensive reform to ensure reliable, affordable care for elderly people living with disabilities, titled MediCaring Communities (<https://medicaring.org/book>)

Medicare Advantage (MA) enrollment has been steadily growing; so, this proposed rule has the potential to impact an increasing proportion of Medicare beneficiaries. Overall, we are supportive of this proposed rule and have comments on the following areas.

Flexibility in uniformity requirements

CMS has determined that it has the authority to permit MA organizations to 1) reduce cost sharing for certain covered benefits; 2) offer specific tailored supplemental benefits; and 3) offer lower deductibles for enrollees that meet specific medical criteria, provided that similarly situated enrollees, that is, all enrollees who meet the identified criteria in the county segments involved, are treated the same. We think this could be a good development, as those with advanced illnesses and disabilities often have needs that go beyond those of people with less serious conditions. Such needs also span the medical and social spheres and can include assistance with food, housing, and



other social supports, all of which can make an important impact on health. We are especially interested in MA plans paying for supportive services such as home-delivered meals, home modifications, and stand-by personal care for urgent situations, for persons with properly certified diagnoses of functional impairments. We encourage CMS to allow the beneficiary's living situation to be among the objective findings that could condition supplemental benefits. For example, frail persons living alone could be eligible for home-delivered meals whereas similarly frail persons living with family could be ineligible. We endorse the regulatory clarification that a plan can implement these flexible benefits in a county segment without implementing it throughout their service area. In this way, the plan and others can gain experience. We also strongly encourage CMS to monitor the use and usefulness of these supplemental services from the start. These are new arrangements and we need to learn from the pioneers quickly. However, there are currently no metrics in place to provide an objective measure of outcomes from broadening such offerings. We, therefore, recommend that CMS develop such measures and apply them on the segments of plans that undertake this work.

Passive Enrollment Flexibilities

We endorse the endeavor to move beneficiaries from one highly integrated plan to another when the first has become dysfunctional or unavailable. CMS asks for advice on measuring quality of the destination plan with regard to behavioral health and long-term services and supports. We suggest that CMS evaluate the destination plan's behavioral health services by having no more than a few days of waiting lists and appropriate expertise readily available. We suggest that CMS evaluate the destination plan's long-term services and supports by assessing elements such as the following proportions: Persons using nursing facilities long-term who are in nursing homes with one or two stars as a proportion of all beneficiaries in nursing homes long-term; Proportion of persons who died in the year who had a stage III or IV pressure ulcer documented in OASIS or MDS in their last year; and Proportion of persons with conventionally disabling diagnoses (e.g., neuromuscular degenerative diseases, dementia, stroke) who were in the Emergency Room or Observation Stay more than twice in the year. Once CMS has a way to identify functional disability (e.g., under the IMPACT act), tying performance to the population that has 2 or more ADL dependencies would be a good step forward.

MA/Part D Quality rating system

We support the proposed change to the previous requirement that all future measures be National Quality Foundation (NQF) validated. This opens this door to new measures that may be



less expensive and lengthy to develop and confirm, which is of particular interest to the advanced illness field, as we have lacked the resources and evidence base to develop measures and provide for stewardship of them on the previous NQF-only track.

Regardless of whether new measures are validated by the NQF or not, however, we repeat what we have said in past, which is that we need both new measures for the advanced illness population and for this population to be *excluded* from preventive and Health Outcomes Survey measures that can often be counterproductive. We also need more measures focused on outcomes and the member's experience of care and, ideally, ones that track whether the care delivered was aligned with that member's goals and values. Better metrics are in place for SNPs, but very few elders living with disabilities and advanced illnesses are enrolled in SNPs. For the rest, the MA or Part D plan is penalized for quite appropriate non-use of cancer screenings, preventive medications, and hypertension control – and there are no metrics for such elements as generating or aligning services with a negotiated care plan, or for supporting caregivers.

In addition to measuring performance of entities that receive Medicare payments, CMS should begin to learn to measure the performance of overall systems that involve multiple providers. For example, CMS should begin to learn how well do beneficiaries do in the hospital – homecare – nursing facility care – hospice networks that serve a defined geographic community.

Thank you for the opportunity to comment on the draft of this Strategic Plan. We believe with the suggestions above it could improve and incentivize better care for all those living with advanced illness.

If you have any questions, please contact Joanne Lynn, Director, Elder Care and Advanced Illness, Altarum, at 202-776-5109 or Joanne.Lynn@Altarum.org.

Sincerely,

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Director, Elder Care and Advanced Illness