



March 5, 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-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 and 2019 draft Call  
Letter**

Dear Ms. Verma,

The National Hospice and Palliative Care Organization (NHPCO) is pleased to offer comments on the Advance Notice of Methodological Changes for Calendar Year (CY) 2019 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2019 draft Call Letter, published on December 27, 2017. NHPCO is the largest membership organization representing the entire spectrum of hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 57,000 hospice professionals in the United States, caring for the vast majority of the nation's hospice patients. NHPCO is committed to improving end-of-life care and expanding access to hospice and palliative care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

NHPCO's comments on the 2019 draft Call Letter reflect our commitment to the needs of beneficiaries with advanced serious illness, as well as beneficiaries who have enrolled in hospice. Beneficiaries with serious illness deserves important consideration as we look at services for this patient population in Medicare Advantage plans and/or accessing Part D prescription drug coverage.

There has been significant discussion about this population among healthcare providers and researchers for some time. The challenge is to prospectively identify the advanced seriously ill population and connect these individuals to appropriate services in a timely manner. Amy S. Kelley MD, MSHS Associate Professor Brookdale Department of Geriatrics & Palliative Medicine, Icahn School of Medicine at Mount Sinai, New York, New York.<sup>1</sup> She was one of the first researchers to recognize the denominator problem caused by a lack of a standard definition to identify the seriously ill. After creating a working definition,

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<sup>1</sup> Amy Kelley Bio: [https://www.researchgate.net/profile/Amy\\_Kelley](https://www.researchgate.net/profile/Amy_Kelley)

she facilitated research to validate the effectiveness of the definition. Amy S. Kelley, MD, MSHS, provides a contextual definition of serious illness in a Letter to the Editor in the September 2014 issue of the Journal of Palliative Medicine:

“Serious illness” is a condition that carries a high risk of mortality, negatively impacts quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress.

Further research by Dr. Kelley and her colleagues was published by Health Services Research in 2017, identifying characteristics of a patient population with serious advanced illness and in need of palliative care. The referenced study looks at subjects’ outcomes one year after they first met each of the study criteria:

- (A) One or more severe medical conditions (Condition) and/or receiving assistance with activities of daily living (Functional Limitation);
- (B) Condition and/or Functional Limitation **and** hospital admission in the last 12 months and/or residing in a nursing home (Utilization) and
- (C) Condition **and** Functional Limitation **and** Utilization. Definitions are increasingly restrictive but not mutually exclusive.<sup>2</sup>

NHPCO would be pleased to assist in identifying subject matter experts in palliative care could be very helpful to the CMS/NCQA discussions around ways to identify this patient population and appropriately address prescribing and care issues.

## **Section I – Medicare Parts C and D: Enhancements to the 2019 Star Ratings and Future Measurement Concepts**

### **New Measures for 2019 Star Ratings**

**Statin Use in Persons with Diabetes (SUPD) (Part D) and Medication Adherence (ADH) for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D).**

**NHPCO Comments:** NHPCO supports the adjustment to exclude hospice patients from the new 2019 Star Ratings measures for statin use in persons with diabetes and in medication adherence for hypertension, diabetes and cholesterol.

### **Potential Changes to Existing Measures**

- 1. Telehealth and Remote Access Technologies (Part C).** *CMS solicited feedback on the appropriateness of including telehealth and/or remote access technology encounters, as allowed under the current statutory definition of Medicare-covered telehealth services and/or as provided by the MAO as an MA supplemental benefit, as eligible encounters in various Part C quality measures. CMS would welcome feedback to share with NCQA on feasibility of and*

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<sup>2</sup> HSR: Health Services Research 52:1, Part I, pgs. 113-131 (February 2017)

*strategies for addressing telehealth services especially regarding the following measures that are reported by Medicare contracts:*

- *Use of Spirometry Testing in the Assessment and Diagnosis of COPD*
- *Adults' Access to Preventive/Ambulatory Health Services*
- *Controlling High Blood Pressure*
- *Comprehensive Diabetes Care*

**NHPCO Comments:**

Telehealth has the potential to facilitate good care for palliative care patients facing serious illness and could be successfully used in this patient population. For many patients with serious or chronic health conditions, frequent monitoring is necessary to manage care and avoid adverse consequences and hospitalizations, but the burden of travelling to visit a health care provider can be significant and limit care. Use of telehealth technologies and services can address these challenges, and NHPCO fully supports their increased use and expansion.

- 2. Cross-Cutting Exclusions for Advanced Illness (Part C).** *NCQA is evaluating the clinical appropriateness and feasibility of excluding individuals with advanced illness from selected HEDIS measures. While HEDIS measures are designed to compare the quality of care provided to general populations or disease-specific care provided to individuals with a chronic condition, these measures may not be clinically appropriate for certain individuals with advanced illness and may overlook the quality issues that are specific to these patients. NCQA is therefore assessing the need for having exclusions for selected HEDIS measures for patients with advanced illness where providing certain treatments and services may not be appropriate. NCQA is exploring which specific illnesses and healthcare utilization may warrant an exclusion, and to which measures the exclusion should be applied. If approved, updates to HEDIS measures for any additional exclusions would be incorporated in HEDIS 2019.*

**NHPCO Comments:** Exclusion of individuals with advanced illness from some HEDIS measures is appropriate and needed for the patient population involved, just as hospice patients should be excluded from certain measures. The measures developed and the identification of inappropriate treatments and services must be done carefully and appropriately to ensure quality care, but the focus should be on the quality issues most relevant to these patients. NHPCO has experience in measure development and offers consultation and expertise in identifying HEDIS measures and identifying patient populations with advanced illness where a measure needs to be adjusted or may not be appropriate.

**Health Related Supplemental Benefits**

**NHPCO Comment:** Consistent with recently enacted legislation,<sup>3</sup> we strongly encourage CMS to implement the new interpretation for a service or item to be “primarily health related” to recognize the need to “compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization.” The new interpretation is a vital step toward addressing the diverse needs of Medicare beneficiaries, at any stage of life, and supports patient centered goals of care. We note that hospices have had a broad and long-lasting experience providing services that are not primarily health related to Medicare beneficiaries, and we offer our comments with that context in mind. We strongly encourage CMS to meet the intent of the expanded definition by covering nutritional needs<sup>4</sup>, caregiver support<sup>5</sup>, and addressing social determinants of health<sup>6</sup> as part of services that would “ameliorate the functional/psychological impact of injuries or health conditions” and be considered “medically appropriate”.

However, it is not clear whether the broader interpretation will yield the expected results due to the constraints CMS articulated. Specifically, the primary purpose of an item or service will continue to be “determined by national typical usages of most people using the item or service and by community patterns of care.” Furthermore, CMS restricts the expanded interpretation whereby it would only be considered in specific circumstances that “must be medically appropriate and ordered by a licensed provider as part of a care plan if not directly provided by one.” We are concerned that necessary services that meet the intent of the expanded definition would not be items or services that a licensed provider could order (such as Meals on Wheels); but would be captured in the development and update of a comprehensive plan of care. CMS should revise this aspect of the criteria to state the item or service “must meet the definition of primarily health related, be ordered by a licensed provider, or identified as part of a care plan”. We offer our assistance and collaboration in any way that CMS would find helpful.

### **Potential New Measures for 2020 and Beyond**

- 1. Transitions of Care (Part C)** *CMS appreciates feedback received about a new HEDIS Transitions of Care measure with four indicators:*
  - a. Notification of Inpatient Admission:** *Documentation of primary care practitioner notification of inpatient admission on the day of admission or the following day.*
  - b. Receipt of Discharge Information:** *Documentation of primary care practitioner receipt of specific discharge information on the day of discharge or the following day.*

<sup>3</sup> Medicare Extenders package: <https://www.congress.gov/bill/115th-congress/house-bill/1892/text?q=%7B%22search%22%3A%5B%22honoring+hometown+heroes%22%5D%7D&r=3>

<sup>4</sup> <http://journals.sagepub.com/doi/pdf/10.1177/0260106014537146>

<sup>5</sup> [http://nationalacademies.org/hmd/reports/2017/integrating-the-patient-and-caregiver-voice-into-serious-illness-care-proceedings.aspx?\\_ga=2.191254702.507628716.1520000609-527750616.1519134146](http://nationalacademies.org/hmd/reports/2017/integrating-the-patient-and-caregiver-voice-into-serious-illness-care-proceedings.aspx?_ga=2.191254702.507628716.1520000609-527750616.1519134146)

<sup>6</sup> <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

- c. **Patient Engagement After Inpatient Discharge:** *Documentation of patient engagement (e.g., office visits, visits to the home, or telehealth) provided by primary care practitioner within 30 days after discharge.*
- d. **Medication Reconciliation Post-Discharge (which is currently a HEDIS measure):** *Documentation of medication reconciliation within 30 days of discharge.*

**NHPCO Comments:** NHPCO notes that the intent of these indicators is to “improve the quality of care transitions from an inpatient setting to home.” As NCQA considers measures for transitions of care, we would encourage consideration of measures that include care coordination across providers following an inpatient discharge. True and effective coordination of care means timely communication and documentation among all service providers who are involved with the patient once they leave the inpatient setting.

We also encourage NCQA to consider timelier follow up for patient engagement and medication reconciliation for the advanced illness population. Research has shown that a subset of the seriously ill population is likely to be re-hospitalized within 7 days due to medication or symptom management issues. A recent study of heart failure patients found that “the daily risk of readmission was highest on day 3 after discharge.”<sup>7</sup>

## 2. Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C).

**NHPCO Comments:** NHPCO notes that the first timeframe referenced for a post-ED visit is not until day 7 post-ED. We are concerned that 7 days is too long for the first follow up for this patient population, as many patients may return to the ED before day 7. We recommend consideration of a 1, 7, 14... day post ED visit follow-up to address emergent issues that may not be resolved in the ED.

## 3. Care Coordination Measures (Part C). *Effective care coordination, including care transition, contributes to improved health outcomes. CMS is working to expand efforts to better evaluate a plan’s success at effective care coordination. We have identified potential new care coordination measures and are currently testing them for possible future implementation.*

**NHPCO Comments:** NHPCO would encourage CMS and others to be inclusive in discussions of effective care coordination – both within the MA plan and in working with community resources to which the patient is referred. In our experience, both components of care coordination are important.

### Opioid Overuse Policy

NHPCO has been actively involved in discussions on opioid prescribing policies for some time, as patients with advanced illness and at the end of life are often using opioids in combination with other drugs to

<sup>7</sup> Ziaieian B, Fonarow GC. The Prevention of Hospital Readmissions in Heart Failure. *Progress in cardiovascular diseases*. 2016;58(4):379-385. doi:10.1016/j.pcad.2015.09.004.)

manage pain and other distressing symptoms. Current opioid policy provides some exclusions for beneficiaries enrolled in hospice and with cancer. However, there is a large patient population with advanced illness receiving advanced illness management or palliative care and taking opioids and other medications to effectively manage symptoms. We are concerned that access to needed medications for this group of beneficiaries will be limited and will result in avoidable suffering. NHPCO would be pleased to bring subject matter experts together to work with CMS on identifying this patient population and developing appropriate opioid prescribing policy.

NHPCO provides comments on specific areas of opioid policy addressed in the Draft Call Letter below:

### **Changes to Existing Display Measures**

1. **Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D).** *PQA's opioid measures examine multi-provider and/or high dosage opioid use among individuals 18 years and older without cancer and not in hospice care. The PQA's Measure Update Panel and Quality Metrics Expert Panel approved nonsubstantial changes to the measures. First, each rate will have a separate title and the term "morphine equivalent dose" will be changed to "morphine milligram equivalents."*

- **Measure 1:** Use of Opioids at High Dosage in Persons without Cancer (OHD): The proportion (XX out of 1,000) of individuals from the denominator receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer.
- **Measure 2:** Use of Opioids from Multiple Providers in Persons without Cancer (OMP): The proportion (XX out of 1,000) of individuals from the denominator receiving prescriptions for opioids from four (4) or more prescribers AND four (4) or more pharmacies.
- **Measure 3:** Use of Opioids at High Dosage and from Multiple Providers in Persons without Cancer (OHDMP): The proportion (XX out of 1,000) of individuals from the denominator receiving prescriptions for opioids with a daily dosage greater than 120 mg morphine milligram equivalents (MME) for 90 consecutive days or longer, AND who received opioid prescriptions from four (4) or more prescribers AND four (4) or more pharmacies.

**NHPCO Comments:** We are pleased that hospice patients and those with cancer are excluded from these measures. However, we are very concerned about the patients with a serious advanced illness who are seen by palliative care providers – they are neither hospice patients nor have a diagnosis of cancer. They may be on long-term low or high dose opioids for chronic pain or other symptoms. Requiring them to have scripts filled on a weekly basis would be a significant hardship for both the patient and the provider. Putting a cap on the oral morphine equivalents in some situations would be contrary to the principles of palliative care practice, would limit the ability of providers to effectively manage symptoms in palliative care patients, and would cause significant

suffering. We encourage CMS and NCQA to look carefully at this patient population to assure that they have access to medications that treat their pain and other symptoms.

2. **Concurrent Use of Opioids and Benzodiazepines:** *This measure assesses the percentage of individuals 18 years and older with concurrent use of opioids and benzodiazepines. We tested the measure specifications using 2016 PDE data. We adjusted the measure for member-years and evaluated the number of contracts with greater than 30 member-years in the denominator. A total of 680 Part D contracts met the eligibility requirements for the Concurrent Use of Opioids and Benzodiazepine measure. The rate associated with the top 5% of PDP contracts was 42.9% while MA-PD contracts had a higher rate of 51.4%.*

**NHPCO Comments:** NHPCO is pleased to see that beneficiaries with cancer or who are in hospice are excluded from this measure. However, for patients with advanced serious illness, appropriate medication management may include both opioids and benzodiazepines. We recommend that CMS and NCQA use caution in the continuing implementation of this measure and take into account the group of patients with advanced serious illness and their needs.

### 3. **Assessment of Care for People with Multiple High-Risk Chronic Conditions (Part C)**

*NCQA is considering a new measure concept that would adapt the current Care for Older Adults measure by expanding the number of indicators and broadening the populations covered by the set of measures. Care for Older Adults currently has four indicators and is reported by MA Special Needs Plans (SNPs) only. The new measure, Assessment of Care for People with Multiple High-Risk Chronic Conditions, would apply to all Medicare plans and would target the population of people with two or more high-risk chronic conditions.*

**NHPCO Comments:** NHPCO supports the components currently included in the measure: physical function assessment, cognitive function assessment, pain assessment, fall risk assessment, goals of care discussion, and advance care planning. In addition to the components that may be included in this measure, NHPCO would encourage CMS and NCQA to assess other symptoms in addition to pain, including but not limited to shortness of breath, nausea and anxiety or distress. There is also growing evidence that social determinants of health play an important role in health and we would recommend that they be considered as well.

### **Feedback on Additional Measurement Concepts**

*CMS and measure developers are exploring additional measurement concepts for future work, such as functional status, and use of non-pharmacological or non-opioid pain management interventions, which will require use of non-claims data. CMS is interested in stakeholder feedback about how these “upstream” concepts can inform measurement of quality of care and how measurement of these concepts might help CMS assess MA contracts’ role in and capacity to affect the quality of care. We are also interested in stakeholder feedback on how these concepts can be measured without adding undue burden on plans or providers. However, given the importance of addressing the opioid epidemic, we will consider adding measurement or reporting burden if less burdensome options are not available.*

**NHPCO Comments:** NHPCO appreciates the opportunity to provide feedback on additional measurement concepts. Functional status can be a better indicator of need and predictor of utilization than the number of secondary diagnoses. Family caregiver capability to provide care should also be considered. A functionally impaired patient with a single diagnosis with a functionally impaired spousal caregiver will likely have

higher utilization than the same patient with a capable caregiver and a good social support system.

However, these should not be measures per se. Improving function is not typically an appropriate goal for this patient population and should not be a quality measure. Instead, patient functional status and caregiver capability should be part of the assessment. A process measure could be developed related to completion of these assessments or functional status and caregiver capability could be used for risk adjustment. In either instance, the data on both should be collected and used to inform future measures.

Thank you for the opportunity to comment. NHPCO stands ready and willing to help in any way with the comments we have made and look forward to ongoing dialogue. For further discussion, please contact Judi Lund Person, Vice President, Regulatory and Compliance at 703-837-1500 or at [jlundperson@nhpco.org](mailto:jlundperson@nhpco.org).

Sincerely,

A handwritten signature in cursive script, appearing to read 'Edo Banach'.

Edo Banach, JD  
President and CEO