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Centers for Medicare and Medicaid Services

Request for comments on CMS-4182-P “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”

Submitted By:

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Re: Request for comments on CMS-4182-P

Dear Sir or Madam:

Teradata Government Systems LLC (Teradata), a wholly owned subsidiary of Teradata Corporation, is pleased to submit our response to the proposed rule "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" request for comments.

Teradata has been helping the Centers for Medicare and Medicaid Services (CMS) gain insights into a vast scope of CMS's data for over 10 years as part of the Integrated Data Repository (IDR). We integrated over 63 billion claim lines, dating back to 2006, across 65 disparate data sources/CMS programs into the IDR and have used it to conduct queries and analysis for a wide variety of functions and groups across CMS. We have begun to align state data in the IDR along with the existing CMS data.

Thank you for this opportunity. If you have any questions, please do not hesitate to contact me directly at (703) 244-1994 or Cat.Evans@Teradata.com.

Respectfully submitted,

Catharine Evans

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Healthcare Industry Consultant

Request for comments on CMS-4182-P

On behalf of the Teradata Corporation, we would like to thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment on the proposed rule, and specifically for this opportunity to provide input on section II.A.1.c.(2), the proposed implementation of the Comprehensive Addiction and Recovery Act of 2016 (CARA), sections 704(g)(3) and 1860D-4(c). These sections of CARA require CMS to establish a framework under which Part D plan sponsors may establish a drug management program for beneficiaries at-risk for prescription drug abuse which may limit those beneficiaries' access to coverage of controlled substances that CMS determines are "frequently abused drugs" to a selected prescriber or network pharmacy. Such programs are commonly referred to as "lock-in programs."

We believe that a lock-in policy could have tremendous benefits for patients and for the Medicare program. Forty-six state Medicaid agencies have lock-in programs with the potential to improve care coordination between providers, reduce nonmedical use behaviors, and limit costs stemming from nonmedical use and diversion (Roberts and Skinner. "Assessing the present state and potential of Medicaid controlled substance lock-in programs." J Manag Care Spec Pharm. 2014 May;20(5):439-46). We concur with CMS's estimate that the proposed Medicare lock-in program could prevent or reduce the human toll of opioid abuse and over use and generate a net savings in 2019 of \$13 million to the Trust Fund because of reduced scripts (CMS-4182-P). CMS's estimate of savings are consistent with recent research that found that lock-in programs have reduced spending on opioid prescriptions and decreased the number of prescriptions and pharmacies used by at-risk individuals in state Medicaid programs (Skinner et al. "Reducing Opioid Misuse: Evaluation of a Medicaid Controlled Substance Lock-In Program." J Pain. 2016 Nov; 17(11):1150-1155).

However, Skinner et al also caution that "care should be taken to ensure that programs such as [lock-ins] do not constrain patients' legitimate needs for analgesic medications."

On page 51 of the rule, you state: "We are particularly interested in receiving comments on whether CMS should adjust the clinical guidelines so that more or fewer potential at-risk beneficiaries are identified, and if more are identified, whether the additional number would result in a manageable program size for plan sponsors (or too few beneficiaries to be meaningful)."

We believe that the right answer is neither more nor fewer at-risk beneficiaries, but instead **increasing the confidence that the highest risk beneficiaries have been accurately identified.** CMS already uses a set of rules to identify "at-risk beneficiaries" and inform Part D plan sponsors of at-risk beneficiaries in their plans through the Overutilization Monitoring System (OMS). These rules are designed to err on the side of caution and label a relatively small number of beneficiaries as being at-risk for good reason: "Case management is very resource intensive for sponsors and PBMs, we have limited the scope of the current policy in terms of

the number of beneficiaries identified by OMS, and when expanding that number, we have made changes incrementally through annual Parts C&D Call Letter process.”

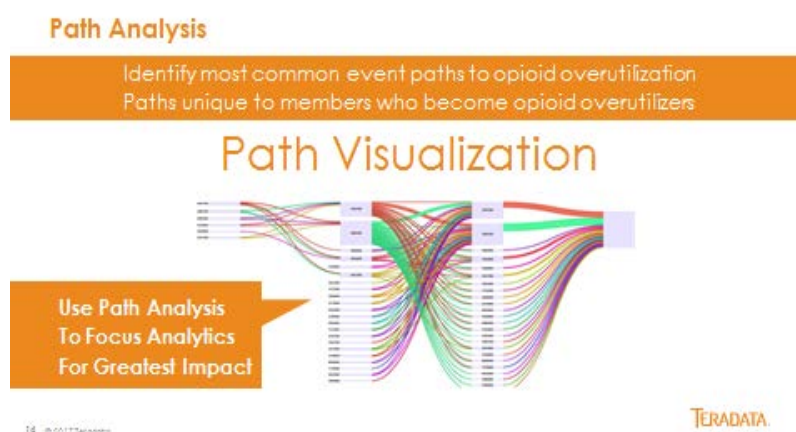
The proposed lock-in would be an additional administrative burden for the Part D plan sponsors and—by design—is restrictive and potentially burdensome for beneficiaries. This additional burden on plan sponsors and beneficiaries argues even more strongly for **greater accuracy in the process of identifying at-risk beneficiaries to be locked-in**. Given the potential burden on patients, it becomes even more important to correctly identify at-risk beneficiaries and not to constrain patients’ legitimate needs and service patterns.

Thus, we re-iterate our suggestion from our letter on transforming Medicare Part D (submitted April 24, 2017) to apply an analytic technique called **path analysis** to the problem of identifying beneficiaries for the lock-in program. CMS has already spent 10 years investing in a clean, consolidated data warehouse called the Integrated Data Repository

(IDR). Unlike similar data stores in CMS, the IDR’s data is integrated as it is ingested into the system – allowing CMS users to do advanced analytics on any combination of data at any time. Pre-Integration allows users to perform cross program (Part A, B, D, MA, etc.) analytics without constantly struggling with the data matching.

Using advanced analytics on the full set of data contained in the IDR, including clinical claims information, CMS can make the existing OMS more precise and accurate. Specifically, path analysis could be applied to the individuals who already meet the OMS criteria for high-risk in terms of dosage and number of healthcare providers and would benefit from a lock-in prior to acquiring prescriptions at multiple pharmacies.

Performing data mining on integrated, cross program data can reveal paths to addictions so that interventions can target the right care at the right time to patients. Path analysis is state of the art for many of our healthcare customers. CMS should consider a behavioral analytic approach using a variety of tools to evaluate a patient’s journey to overutilization. It may be far easier to restrict an at-risk beneficiary to a single pharmacy of their choice at the onset of opioid therapy instead of waiting for the beneficiary to develop a pattern of services at multiple pharmacies and—only after the pattern is developed—then have the plan sponsors intervene and restrict the number of pharmacies available to that beneficiary. In other words, path analysis could be used to review beneficiaries who are already “at-risk” in terms of dosage and



number of providers, predict the beneficiaries who are also “at-risk” of multiple pharmacy use, and lock them in before they develop a pattern of multiple pharmacy use.

Also, instead of being restricted to Part D claims to develop an understanding of the patient, this advanced, predictive analytic would leverage the 360-degree view of the patient within the IDR and inspect the entire series of medical events that signal the need for an intervention and/or education. The IDR combines Part D claims with inpatient, outpatient, and other medical data in a time-series that could provide a rich illustration of the path to addiction through a series of actions and outcomes—not just dosage and number of providers.

The path of a patient is the series of events that lead to poor outcomes, such as an injury, followed by an appropriate pain medication prescription, followed by a trigger, ending in an avoidable trip to the emergency room and uncoordinated prescribing. Integrating data that includes health care and health-related events in time sequence can support analytics to discover these paths and predict over utilizers who do not yet meet all of the current OMS criteria. Conversely, this analysis could rule-out very low risk individuals who do meet the current OMS criteria but also share characteristics of patients who do not develop opioid overutilization.

In addition to the *intended* consequences of a lock-in program, evidence also demonstrates that a lock-in can cause substantial shifts in plan enrollment: for a Medicare lock-in to be effective, Part D plan sponsors must be able to share beneficiaries’ lock-in status to avoid beneficiaries circumventing the lock-in by switching plans. In a study of the implementation of a state-level Medicaid managed care lock-in, researchers found that over half of locked-in individuals dropped their original plan; 29% in the first 6 months after the lock-in and 11% semiannually after 24 months (Dreyer, Michalski, Williams. “Patient Outcomes in a Medicaid Managed Care Lock-in Program.” J Manag Care Spec Pharm. 2015 Nov; 21(11):1006-12).

A plan-sponsor-facing dashboard on lock-in status could provide near-real-time information to plan sponsors to prevent “plan shopping” by beneficiaries. The IDR’s extremely frequent refresh rate could provide data for such a dashboard.

We hope to explore opportunities to work with you and your team to fight the epidemic of opioid abuse. Other customers of ours have used the path analysis we’ve shared in this letter to unlock their data and improve business solutions. Teradata has tools and expertise that can unlock more of the power of your IDR and allow your data to improve your critical mission of improving the health of all Americans.