



January 16, 2018

Ms. Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services,  
Attention: CMS-4182-P  
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Via electronic submission: <http://www.regulations.gov>

**Re: CMS-4182-P – Proposed Revisions to  
The Medicare Advantage Program (Part C)**

Dear Administrator Verma:

Thank you for the opportunity to submit comments on the proposed revisions to the Medicare Advantage Program (Part C).

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons with serious illness have access to quality palliative care, regardless of diagnosis, treatment setting, or state of the disease. Palliative care focuses on providing patients with relief from the pain, symptoms and stress of a serious illness, and can be provided along with curative treatment.

Studies show that without palliative care, patients with serious illness receive health care that is characterized by inadequately treated symptoms, poor communication with health care providers, and enormous strain on family members or other caregivers.<sup>i,ii</sup> By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve both quality of care<sup>iii,iv,v</sup> and quality of life<sup>vi,vii,viii</sup> during and after treatment.<sup>ix</sup> Furthermore, palliative care results in fewer crises, reducing emergency department and hospital utilization, and resulting in overall cost savings<sup>x,xi</sup>.

CAPC appreciates CMS's thoughtful approach when developing revisions to the Medicare Advantage (MA) Program. We offer the following comments and recommendations for consideration as you finalize the rule.

### **Flexibility in Uniformity Requirements**

CAPC applauds CMS's revised interpretation that enables plans to provide access to services based on health status or disease state, particularly targeting supplemental benefits for their most medically vulnerable enrollees. In our continued discussions with MA plans, CAPC has heard that the previous interpretation of the uniformity requirement was a barrier to improving the care of those with serious illness. Yet we know that beneficiaries with serious illness have additional needs that their healthier counterparts lack, and, as noted, addressing those needs has been proven to not only improve their quality of life, but also ultimately, reduce emergency department and hospital utilization. A recent summary of successful health plan approaches in caring for this population can be found in the recent publication from CAPC, [Serious Illness Strategies](#).

Additionally, we agree with CMS' proposal that plans must use medical criteria that are objective and measurable, to ensure equity and non-discrimination. However, we are concerned that a key variable of proactively identifying the seriously-ill population – functional impairment – is not yet objectively and measurably available to MA plans. Therefore, as CMS continues to support flexibility in meeting the needs of the plans' complex enrollees, we encourage you to launch a parallel effort to assess and collect functional status, similar to what is required under the IMPACT act.

In issuing guidance to plans concerning benefits for their most medically-vulnerable enrollees, CAPC recommends that CMS highlight the following:

- **Encourage plans to target supplemental benefits and cost-sharing reductions to beneficiaries with dementia.** Mean out-of-pocket costs for the last five years of life are two to three times higher for people with dementia when compared to those facing cancer, heart disease, or all other conditions. More striking, researchers have found that people with dementia spend 33 percent of their wealth on out-of-pocket health expenses, compared to 11 percent of those in all the other disease categories. As expected, the disparity grows stronger for the African American population, with a median 84 percent of their resources spent on out-of-pocket costs.<sup>xii</sup>
- **Clarify that plans can modify cost-sharing and benefits to improve access to palliative care.** We have heard from a number of MA organizations that their efforts to offer and encourage palliative care services and supports are stymied by enrollees' financial concerns. We are especially troubled by this additional barrier to patient-centered care for the seriously ill because palliative care is still often misunderstood by the general population; as such, enrollees may undervalue access to such care when their own financial resources are at stake. Therefore, we encourage CMS to consider cost-sharing adjustments for the following services, for a defined population of seriously ill enrollees:
  - Consultations with a palliative care team or a palliative care specialist;
  - Home visits made by a physician or advanced practice nurse for the purpose of symptom management; and
  - Provider visits for chronic care management (99490), advanced care planning (99497 and 99498); and complex chronic care management services (99487 and 99489).

## Revisions to the Quality Rating System

CAPC appreciates CMS' codification of the quality rating system in the federal register. We offer the following comments for consideration:

- **Increase the weighting for the patient experience domain.** We strongly support CMS' proposal to increase the weight of the patient experience/complaints and access measures. First, it is absolutely essential that patients have sufficient information to support decision-making, and that their own values and goals are understood and respected; health plans and their providers must be incentivized to devote the time and attention to these important conversations. Moreover, patient experience is highly correlated with outcomes such as reduced re-admissions<sup>xiii</sup> and mortality<sup>xiv</sup>, suggesting that patient experience might be a more effective measure to evaluate overall quality of care.

- **Exclude the seriously ill population for preventive and HOS measures, as feasible.** While we agree that MA plans should advance preventive care and maintain or improve physical health for the majority of their enrollees, there will always be a subset of enrollees facing serious illness and continued decline. We encourage CMS to work with measure stewards such as NQCA and explore other options that can exclude the seriously ill population from such measures. If requested, CAPC can provide additional information on potential approaches to identifying the seriously ill population for exclusion. Exclusion of the seriously ill population from these measures will also protect against discriminatory enrollment, and will not unfairly evaluate plans that support this population in making diagnostic and treatment decisions based on patient preferences.

## Implementing the Comprehensive Addiction and Recover Act (CARA) provisions

CAPC shares CMS' concern about opioid abuse, and we recognize the need to address the issue. We offer the following comments on the provisions included in this proposed rule:

- **Exclude enrollees that have elected hospice care, that are residents of long-term care facilities, and that have a cancer diagnosis.** We strongly support the exemption of these beneficiary populations from the CARA provisions.
- **Additionally exclude beneficiaries who are receiving palliative care.** We also appreciate that CMS considered also excluding those receiving palliative care and end-of-life services, and acknowledge that these populations are currently difficult to administratively identify through CMS data. However, we would urge CMS to develop ways to do so, as palliative care is often brought in particularly because of intractable pain, and facing potential barriers in these extremely high-need patients is, of course, concerning, and may unintentionally cause great harm.

## Additional Comments on Medicare Advantage Regulation

- **Explore quality requirements for MA vendors and subcontractors.** Increasingly, MA plans are contracting with other organizations to assume responsibility for the subset of seriously ill beneficiaries. While there are certain advantages to these arrangements, we are not aware of any systematic mechanisms to ensure that vendors follow clinical guidelines or comply with quality standards. This is particularly concerning as vendors are often brought on to control spending, which puts seriously ill beneficiaries at great risk for under-treatment. Furthermore, the risk is exacerbated by the fact these beneficiaries are often the least likely to self-direct their care.

Therefore, we recommend that CMS add a new requirement specifying that if MA plans contract with third-party organizations to focus on their high-cost beneficiaries (aka “seriously ill,” “advanced illness,” or “end-of-life” specialty programs), they must contract with vendors that either have certification/accreditation from a respected quality organization, or can demonstrate that they meet clinical guidelines from the National Consensus Project for Quality Palliative Care<sup>xv</sup>. Because we realize that this recommendation will require additional investigation and exploration prior to enactment, we further recommend that CMS establish a working group to define such contracting requirements. CAPC would be willing to participate in any next steps on this.

- **Network adequacy reviews should evaluate network availability of palliative care services.** We have been told by participating plans that as many as 10% of a MA plan's enrolled population are in need of palliative care, yet we also know that only a small fraction receive it. While there are many reasons for this gap, a major one is that MA plans do not currently need to delineate the availability of palliative care professionals and services to their members. With CMS' heightened interest in network adequacy, this is a prime opportunity to address this omission, and to require that palliative care clinicians be separately listed in the provider directory, and be included in network adequacy evaluations. We further recommend that MA plans specifically note in their directories which of their network hospitals hold Advanced Certification in Palliative Care from the Joint Commission, and which hospitals participate in the National Palliative Care Registry to report the composition and capacity of their palliative care teams.

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Thank you for the opportunity to submit these comments. Please do not hesitate to contact myself or Allison Silvers, Vice President for Payment & Policy at [Allison.Silvers@mssm.edu](mailto:Allison.Silvers@mssm.edu) if we can provide any further assistance.

Sincerely,

*Diane E. Meier*

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<sup>i</sup> Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association* 7 January 2004; 291(1):88-93.

<sup>ii</sup> Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly* September 2011; 89(3):343-380.

<sup>iii</sup> Bakitas MA, Tosteson TD, Li Z, et al. Early versus delayed initiation of concurrent palliative oncology care: patient outcomes in the ENABLE III randomized controlled trial. *J Clin Oncol*. 2015;33(13):1438-45.

<sup>iv</sup> Smith G, Bernacki R, Block SD. The role of palliative care in population management and accountable care organizations. *J Palliat Med*. 2015;18(6):486-494.

<sup>v</sup> Riolfi M, Buja A, Zanardo C, Marangon CF, Manno P, Baldo V. Effectiveness of palliative home-care services in reducing hospital admissions and determinants of hospitalization for terminally ill patients followed up by a palliative home-care team: a retrospective cohort study. *Palliat Med*. 2014;28(5):403-411.

<sup>vi</sup> Davis MP, Temel JS, Balboni T, Glare P. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. *Ann Palliat Med*. 2015;4(3):99-121.

<sup>vii</sup> Rabow M, Kvale E, Barbour L, Cassel JB, Cohen S, Jackson V, Luhrs C, Nguyen V, Rinaldi S, Stevens D, Spragens L, Weissman D. Moving upstream: a review of the evidence of the impact of outpatient palliative care. *J Palliat Med*. 2013 Dec;16(12):1540-9.

<sup>viii</sup> Kavalieratos, D, J Corbelli, and D Zhang. "Association Between Palliative Care and Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis." *JAMA*, (2016): 316(20).

<sup>ix</sup> Delgado-Guay MO, Parsons HA, Li Z, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 15 January, 2009, *Cancer*; 115(2):437-45

<sup>x</sup> Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff*. 2011;30(3):454-463.

<sup>xi</sup> Lustbader D, Mudra M, Romano C, Lukoski E, Chang A, Mittelberger J, Scherr T, Cooper D. The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization. *J Palliat Med*. 2016 Aug 30 [https://www.ncbi.nlm.nih.gov/pubmed/27574868]

<sup>xii</sup> Kelley AS, et. al, The burden of healthcare costs for patients with dementia in the last five years of life, *Ann Intern Med*. 2015;163:729-736. doi:10.7326/M15-0381

<sup>xiii</sup> Carter J, Ward C, et al. "The Association Between Patient Experience Factors and Likelihood of 30-Day Readmission: A Prospective Cohort Study" *BMJ Qual Saf* 2017 December 8

<sup>xiv</sup> Glickman SW, Boulding W, et al. "Patient Satisfaction and Its Relationship With Clinical Quality and Inpatient Mortality in Acute Myocardial Infarction" *Circulation* 2010 March 16

<sup>xv</sup> https://www.nationalcoalitionhpc.org/ncp/