National Partnership for Hospice Innovation
1299 Pennsylvania Ave., Suite 1175
Washington DC, 20004

March 1, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-2018-0154
7500 Security Boulevard,
Baltimore, MD 21244-1850

Re: Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Call Letter: Part 2

Dear Administrator Verma:

The National Partnership for Hospice Innovation (NPHI) greatly appreciates the opportunity to provide comments on *Part II of the Advance Notice of Methodological Changes for Calendar Year (CY) 2020 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2020 Call Letter* (the "call letter") (CMS-2018-0154). NPHI is a collaborative of the nation's most innovative, community-based, not-for-profit, hospice and palliative care providers that serve as a critical safety net in communities across the United States. In coming together, we work to identify, enhance, and spread the best practices in which our members are engaged. NPHI members have decades of experience in providing the highest-quality hospice and palliative care to those facing the final stages of their lives. This commitment is fundamental to our mission and distinguishes us as leaders whose innovative programs reflect the original intent of the Medicare Hospice benefit.

NPHI applauds CMS' commitment to the goal of promoting innovation and flexibility in the Medicare Advantage (MA) program, while ensuring that the proposed programmatic updates safeguard and enhance patient and family wellbeing. With CMS set to test the delivery of Medicare Hospice Benefit (MHB) services through the MA program via the Value-Based Insurance Design (VBID) demonstration beginning in 2021, it is more critical than ever that non-profit, community-based hospice provider perspectives on proposed MA changes are acknowledged by CMS. To that end, we are pleased to be able to offer the following comments on specific provisions in the Advance Notice and Call Letter:

***Advance Notice: Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs* (pgs. 35-36)**

As noted in our separate comment letter on Part 1 of the Advance Notice, NPHI supports CMS's proposal to revise the CMS-HCC risk-adjustment model to add two dementia-related HCCs (51 and 52) to the Payment Condition Count (PCC) model. Neurological conditions, including Alzheimer's disease and

dementia, comprise almost one-fourth of all diagnoses among Medicare hospice patients,[1] so it will be very important for these two dementia-related HCCs to be fully phased in to the MA risk-adjustment model when the hospice benefit is included in MA covered benefits, which could start as soon as 2021 under the recently-announced expansions to the MA VBID demonstration. Assuming this proposed change to the risk-adjustment model is implemented, we agree that the frailty adjustment for PACE and FIDE SNPs also should be adjusted to reflect the movement of these dementia-related risk factors from the model's residual into the model itself.

In addition, we request that CMS begin considering how the CMS-HCC risk-adjustment model will need to change when a hospice benefit carve-in is implemented in the MA VBID demonstration. For example, CMS may need to increase the frailty adjustment for all MA plans because the relative severity of illness of plans' risk pools could increase as plans attract and retain more members with serious illness and near the end of life. CMS could explore to what extent the enrollment and service use changes expected to result from the carve-in will be reflected in components of the model such as HCC condition counts and the residual. This analysis should drive the decision of whether to revise the frailty adjuster to reflect all the impacts, both direct and indirect, of the hospice benefit carve-in.

Draft CY 2020 Call Letter: Enhancements to the 2020 Star Ratings and Future Measure Concepts

Measure Updates for 2020 Star Ratings

Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Diabetes Medications, and Medication Adherence for Cholesterol (Statins) (Part D) **(pg. 109)**

NPHI agrees with the proposal to exclude patients enrolled in hospice from the medication adherence measure for hypertension, diabetes, and cholesterol-lowering medications.

New 2020 Display Measures

Transitions of Care (Part C) (pg. 127)

NPHI supports the addition of the specified Transitions of Care measure to the new 2020 MA Display Measures, and we understand why hospice patients would be excluded from this measure as it is currently specified. However, we urge CMS to expeditiously work to include a measure that captures the rate of appropriate referrals and transitions to hospice for seriously ill MA plan members. Implementation of this measure should not depend on whether the hospice benefit is "carved in" to MA plan coverage, because variation in the rates of hospice referrals can be a useful indicator of MA plan enrollees' access to hospice services whether the benefit is covered under traditional Medicare or MA.

Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions (Part C) (pg. 128)

This measure should exclude patients enrolled in hospice, because follow-up care for hospice patients after an ED visit is the responsibility of the hospice in which they are enrolled. As CMS considers future

[1] Medicare Payment Advisory Commission, A Data Book: Health care spending and the Medicare program, Chart 11-10 (June 2018).

measures to capture quality of care when the hospice benefit has been carved in (as early as 2021 under the MA VBID demonstration), it should consider a measure of ED use by hospice patients. High-quality hospice care involves diligently managing each patient's pain and other palliative care needs such that unplanned visits to an ED should be very rare and infrequent. High rates of ED visits by hospice patients is an indicator of low-quality hospice care.

Change to Existing 2020 Display Measures (pg. 130-131)

Use of Opioids at High Dosage and from Multiple Providers (OHDMP) and Antipsychotic Use in Persons with Dementia (APD) (Part D) (pg. 130)

The first of these two measures should exclude patients enrolled in hospice because of its potential to inhibit hospice patients' access to appropriately prescribed opioids for end-of-life pain management.

Potential Changes to Existing Star Ratings and Display Measures (pgs. 132-137)

Plan All-Cause Readmissions (Part C) (pg. 132)

This measure should exclude patients enrolled in hospice, because follow-up care for hospice patients after an ED visit should be given by the hospice in which they are enrolled. As CMS considers future measures to capture quality of care when the hospice benefit has been carved in (as early as 2021 under the MA VBID demonstration), it should consider a measure of ED use by hospice patients. High-quality hospice care involves diligently managing each patient's pain and other palliative care needs such that unplanned visits to an ED should be very rare and infrequent. High rates of ED visits by hospice patients is an indicator of low-quality hospice care.

Medication Reconciliation (Part C) (pg. 132)

See comments under "Transitions of Care" measure above.

Concurrent Use of Opioids and Benzodiazepines (COB) (Part D) (pgs. 135-136)

This measure should exclude patients enrolled in hospice or palliative care programs because of its potential to inhibit hospice patients' access to appropriately prescribed opioids and benzodiazepines for end-of-life pain and anxiety management.

Use of Opioids from Multiple Providers and/or at High Dosage in Persons without Cancer (Part D) (pgs. 135-136)

This measure should exclude patients enrolled in hospice or palliative care programs because of its potential to inhibit patients' access to appropriately prescribed opioids for end-of-life pain management.

Potential New Measure Concepts

Cross-Cutting Topic – Exclusions for Advanced Illness (Part C) (pg. 138)

NPHI understands why it may be appropriate to exclude persons with advanced illness from certain HEDIS measures when it is not clinically appropriate to include them. We are concerned, however, that there are few MA quality measures that specifically address the quality of care for patients with advanced illness, and we ask CMS to work with stakeholders as soon as possible to explore new measure concepts that specifically address the unique care needs and challenges of patients with serious illness. These types of measures could include focused additions to the MA CAHPS patient experience survey, adaptation of current D-SNP measures, and patient-reported outcome (PRO) measures specifically designed for individuals with serious illness.

Patient-Reported Outcome Measures (Part C) (pgs. 139-140)

This measure should exclude patients enrolled in hospice because of the inapplicability of measures of functional improvement for hospice patients. CMS currently requires hospices under traditional (fee-for-service) Medicare to administer the Hospice CAHPS® survey to measure each hospice's patient experiences, and CMS could consider adapting the results of this survey from each MA plan's hospice provider network to create a composite rating of the patient experience of the plan's members enrolled in hospice.

Pain Management (Part C) (pg. 140)

This measure should exclude patients enrolled in hospice because of its potential to inhibit hospice patients' access to appropriately prescribed opioids for end-of-life pain management.

***Non-Opioid Pain Management Supplemental Benefits* (pg. 159)**

NPHI supports CMS encouraging MA organizations to consider pursuing supplemental benefit designs that include "medically-approved non-opioid pain management and complementary and integrative treatments." Complementary pain and symptom management therapies have been used in hospice settings for years, and have been shown to improve patients' self-reported capacity to cope with and manage pain.[2] Expanding access to non-opioid pain management treatments through MA supplemental benefits can ensure patients receiving hospice and/or palliative care services and their providers are able to choose from a broader, more comprehensive suite of interventions that address all facets of an individual's pain.

NPHI believes that combining opioid and non-opioid pain management treatments for certain hospice and palliative care patients can have a synergistic effect, such that the appropriate combination of both kinds of therapies can result in more positive pain management outcomes than either could effectuate on their own. To that end, we urge CMS to ensure that its encouragement that MA organizations consider non-opioid pain management treatments as supplemental benefits does not inadvertently result in an increase in an MA plan's reluctance to cover and/or authorize the appropriate use of opioid pain management treatments for hospice and palliative care patients. Given this patient population's high and persistent

[2] Zeng, Y. et al. (2018) Complementary and Alternative Medicine in Hospice and Palliative Care: A Systematic Review. *Journal of Pain and Symptom Management*, *56*(5), 781 – 794. https://doi.org/10.1016/j.jpainsymman.2018.07.016

pain and symptom burden, it is critical that they retain timely access to all categories of pain management, opioid and non-opioid alike.

A General Point on Access to Supplemental Benefits for Hospice Patients Enrolled in MA

On the subject of supplemental benefits, NPHI would like to express its concern that MA plan members who elect to receive and transition to hospice care still have access to any supplemental benefits offered by their MA plan. This should be the case under the current policy with the hospice benefit carved out of MA plan coverage, and it will become even more critical when hospice is carved into MA, starting with the MA VBID demonstration in 2021.

Special Supplemental Benefits for the Chronically Ill (SSBCI) **(pgs. 161-164)**

NPHI supports and applauds CMS' decision to expand flexibility in the MA supplemental benefit program with the goal to "better tailor benefit offerings for the chronically ill population, address gaps in care, and improve specific health outcomes." Non-profit, community-based hospice and palliative care providers are well-positioned to deliver a number of newly allowable supplemental benefits to MA beneficiaries under the increased flexibility, including home-based palliative care, in-home support services, caregiver supports, and non-opioid pain management treatments.

Flexibility to define a "chronic condition" (pg. 162)

While we agree that the list of chronic conditions in section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual that CMS is using to satisfy the statutory definition of "chronic condition" for CY 2020 SSBCI eligibility is an appropriate starting point, we support CMS allowing MA plans the future flexibility to determine what constitutes a chronic condition that meets the statutory standard (i.e. "is life-threatening or significantly limits overall health or function of the enrollee"). Increasing this flexibility should allow plans to innovate SSBCI that could target the seriously ill population whose conditions are not on the list at section 20.1.2 of Chapter 16b of the Medicare Managed Care Manual. We caution, however, that in the event CMS grants MA plans this greater flexibility to define chronic conditions, there should be sufficient oversight of the plans' definitions to ensure they are not overly restrictive and thus result in limiting access to SSBCI for beneficiaries who would otherwise be eligible for them under the current statutory definition.

Requirement that SSCBI "have a reasonable expectation of improving or maintaining the health or overall function of the enrollee" (pg. 162)

NPHI is concerned about the potential interpretation of the language that requires a SSBCI "*have a reasonable expectation of improving or maintaining the health or overall function of the enrollee."* This requirement could present problems for supplemental benefits that are meant to target the seriously ill if a strict reading of improvement or maintenance is enforced. NPHI recommends that CMS consider an interpretation that looks at the reasonable expectation of improvement or maintenance in relation to the beneficiary's reasonable expectation of improvement or maintenance without access to the SSBCI. This interpretation seems in line with the statutory intent, as a "reasonable expectation of improvement or maintenance" links this reasonable expectation to the SSBCI intervention. For example, if a person with a serious illness that will experience decline would experience that change in health or functional

status more quickly if he or she were unable to access non-emergency medical transportation (NEMT), that should qualify as a reasonable expectation that an SSBCI that covers NEMT will improve or maintain the health or overall function even if the timing of that improvement or maintenance is not infinite.

Furthermore, for someone with a serious illness that is not curable and will ultimately cause decline – an SSBCI with a reasonable expectation of improvement or maintenance of the beneficiary's quality of life for as long as possible, which is a primary goal of supportive care interventions, should be appropriate. For a person with a serious illness, the maintenance of their health or functioning might be measured in a different way than for others – for example, maintaining a person's ability to do a favorite hobby or spend time with family – but an SSBCI could potentially further those goals as well. We want to be sure that this class of beneficiaries is not limited from accessing these potential benefits as a result of how this statutory phrase is interpreted.

Prohibition on SSBCI that entail capital or structural improvements to a beneficiary's home that could potentially increase property value (pgs. 162-163)

NPHI applauds CMS for allowing certain home modifications to qualify as SSBCI. Home modifications such as the addition of bathroom grab bars and shower stools can help reduce the risk of falls and keep seriously ill beneficiaries safe and in their preferred home setting. We understand CMS' concerns around allowing MA plans to provide SSBCI that "include capital or structural improvements to the home of the enrollee that could potentially increase property value". However, there are numerous instances in which home modification interventions that might incidentally result in capital or structural improvements that increase property value (i.e. installing permanent wheelchair ramps; widening hallways; improving lighting; etc.) are medically appropriate for seriously ill patients with functional limitations in the sense that they have been shown to improve health, wellbeing, activity of daily living/instrumental activity of daily living (ADL/IADL) maintenance, and mortality.[3]

We recommend more clarity around the requirements for home modifications. Sometimes adding a permeant structure may be safer and more appropriate for the beneficiary's need and NPHI is concerned that plans will be fearful about approving the modifications that best fit beneficiary needs out of fear that it could "increase the value of the property." Clarification is also needed because as currently defined, the definition by which CMS is defining "value" is subjective – a permanent wheelchair ramp may increase the value for a seriously ill beneficiary who needs it, but not to a young family who may buy that house in the future. NPHI believes that home modifications are critically important to keeping those with serious illness at home and would like to see this opportunity utilized as appropriately as possible.

Requirement that MA plans coordinate benefits with available community and social services (pg. 163)

NPHI supports the requirement that MA plans "coordinate benefits with community and social services generally available in the area served by the MA plan", and appreciates the explicit guidance that plans can contract with community-based organizations (CBOs) to provide and/or determine eligibility for

[3] Cho, H. Y., MacLachlan, M., Clarke, M., & Mannan, H. (2016). Accessible Home Environments for People with Functional Limitations: A Systematic Review. *International journal of environmental research and public health*, *13*(8), 826. doi:10.3390/ijerph13080826

SSBCI. Seriously ill patients and their families have extensive non-medical social support needs that can best be delivered by the network of CBOs in their local community. These organizations, including many non-profit community-based hospice providers, often have a history of local trust and expertise in social and community care interventions that an MA plan may not possess. Partnering with high-quality CBOs to deliver certain supplemental benefits is an efficient way for plans to tap into existing capacity for delivering this kind of care, and can result in improved health outcomes for beneficiaries and their families and reduced costs for the Medicare program through a reduction in avoidable acute care utilization.[4]

Waiving the uniformity requirements with respect to SSCBI (pg. 163)

NPHI supports waiving the uniformity requirements with respect to SSCBI. This action will allow plans to target and tailor benefits to meet individual beneficiary needs, a move that aligns with CMS' goal to create a more person-centered and flexible MA program. Individuals receiving hospice and palliative services have some of the most complex care needs of any patient population. Allowing for targeted supplemental benefit interventions that address the uniquely complicated clinical and social circumstances of these patients will help ensure they receive the most appropriate and high-quality care.

We support CMS' guidance to plans that they "develop objective criteria (e.g., health risk assessments) and maintain detailed documentation for determining when one chronically ill enrollee is eligible for a particular item or service and another is not." To the extent feasible, these criteria and documentation should be shared with any contracted provider or CBO that is delivering supplemental benefit services to plan beneficiaries. Doing so will help ensure that these entities are proactively aware of plan coverage policies and can work collaboratively with the plan to maintain appropriate and timely service delivery to enrollees.

Medicare Part D Changes

Naloxone Co-Prescribing and Formulary Tier Placement (pg. 174)

NPHI supports CMS' encouragement that MA plans co-prescribe naloxone with opioid prescriptions to beneficiaries who are at an increased risk for opioid overdose, contingent on ensuring that the plan authorizations for these co-prescriptions do not unintentionally limit seriously ill hospice and palliative care patients' access to appropriate opioid medication for pain and symptom management. We also agree that targeted education of prescribers, enrollees, and their families on co-prescribing of naloxone is critical to the policy's success and to prevent inappropriate use or diversion. The education is also critical so that beneficiaries and their families know when it would be appropriate to administer naloxone to a seriously ill patient. We recommend requiring that MA plans develop processes and materials to facilitate such education for prescribers and enrollees.

[4] Brewster, A., Kunkel, S., Straker, J., & Curry, L. (2018). Cross-Sectoral Partnerships By Area Agencies On Aging: Associations With Health Care Use And Spending. *Health Affairs, 37*(1). https://doi.org/10.1377/hlthaff.2017.1346

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Additionally, we support CMS encouraging MA plans to place naloxone products on their generic formulary tiers as a way to limit high out-of-pocket costs for these drugs that represent a financial barrier to their timely access.

Medicare Part D Opioid Overutilization Policy (pgs. 186-188)

NPHI appreciates and supports CMS' exclusion of beneficiaries in hospice care and those receiving palliative or end-of-life care from the Medicare Part D opioid policies. These patient populations have complex and intense pain and symptom management needs that justify their exemption from polices that would limit timely and appropriate access to certain opioid medications.

Opioid Potentiator Drugs (pgs. 190-191)

NPHI appreciates CMS' concerns around the risks of concurrent opioid and other central nervous system-active drugs (i.e. benzodiazepines, gabapentin, pregabalin). However, we would point out that for some hospice patients and those receiving palliative care, this concurrent use is appropriate to manage their uniquely complex pain and symptom burden. As such, we would request that those receiving palliative care be exempted from MA plan drug management program (DMP) case management, lest the soft and/or hard safety edits it triggers restrict timely and appropriate access to all medications that help alleviate these patients' intense pain and symptoms.

Part D Mail Order Auto-Ship Modifications (pgs. 199-201)

NPHI requests that CMS provide additional details on the procedures and protocols it intends to pursue to address the confusion around auto-shipped drug orders and financial responsibility when a beneficiary elects hospice coverage. Because patients who are electing hospice coverage often forget to manually cease their auto-ship Part D drug orders before they are formally enrolled in hospice, they may continue to receive unwanted or unneeded Part D drugs. This has resulted in situations where the beneficiary's hospice and Part D plan are unsure of who is responsible for payment for these auto-shipped "extra" orders. NPHI requests that CMS promulgate guidance on the appropriate roles of the hospice, Part D plan, and beneficiaries in such situations.

We thank you for the opportunity to provide input on these proposed changes to the MA program, and we look forward to continuing to work with CMS to ensure that non-profit, community-based hospice and palliative care providers can contribute to MA innovation that will improve the lives of beneficiaries and reduce costs for the healthcare system. If you have any questions regarding this letter, please contact Davis Baird at dbaird@hospiceinnovations.org.

Sincerely,

Tom Koutsoumpas
President and CEO
National Partnership for Hospice Innovation


NPHI
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