



November 17, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: CMS-3321-NC: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Thank you for the opportunity to comment on changes to the physician payment system. The Pew Charitable Trusts is an independent, non-profit research and public policy organization that seeks to advance policies that help people receive high-quality health care as they near the end of their lives. The development of the new Merit-based Incentive Payment System (MIPS) by the Centers for Medicare & Medicaid Services (CMS) presents a key opportunity to promote improved end-of-life and palliative care.

The need for palliative care—the comprehensive care and management of the physical, psychological, emotional, and spiritual needs of patients with chronic, debilitating, or life-threatening illness and their families—is growing rapidly. One-quarter of adults in the U.S. have multiple chronic conditions and would benefit from palliative care to help manage their conditions.¹ Unfortunately, our health system does not currently have an effective and consistent strategy to provide supportive care to this population.

Access to palliative care can increase patient satisfaction, improve clinical outcomes, and reduce costs of care for patients enrolled in palliative care services.² Advance care planning can also significantly improve outcomes of care, including increased compliance with patient preferences, fewer hospitalizations, and less intensive treatments.^{3,4} Both the Centers for Disease Control and

¹ Brian Ward and Jeannine Schiller, “Prevalence of Multiple Chronic Conditions Among US Adults: Estimates From the National Health Interview Survey, 2010,” *Preventing Chronic Disease Public Health Research, Practice, and Policy* 10, no. Special Topic (April 25, 2013), http://www.cdc.gov/pcd/issues/2013/pdf/12_0203.pdf.

² Gade G, Venohr I, Conner D, McGrady K, Beane J, Richardson R, Williams M, Liberson M, Blum M, Della Penna R. Impact of an inpatient palliative care team: a randomized control trial. *J Palliat Med* 2008; 11:180-90.

³ Joan M. Teno, Andrea Gruneir, Zachary, Schwartz, Aman Nanda, Terrie Wetle. “Association between advance directives and quality of end-of-life care: a national study.” *Journal of American Geriatrics Society*. Feb 2007;55(2):189-194.

⁴ Karen M Detering, Andrew D Hancock, Michael C Reade, William Silvester. “The impact of advance care planning on end of life care in elderly patients: randomized controlled trial.” *BMJ*. 2010;340:c1345; Bernard J. Hammes, Brenda L. Rooney. “Death and end-of-life planning in one midwestern community.” *Archives of Internal Medicine*. Feb 23 1998;158(4):383-390.

Prevention (CDC)⁵ and the Institute of Medicine (IOM) have advocated for increased use of advance care planning.⁶

There are a number of challenges to ensuring all patients can obtain quality palliative and end-of-life care including better assessing the quality of services, improving access to this care regardless of diagnosis, geography, or care setting, and ensuring patients' wishes can be transmitted and easily accessed across care settings. Pew believes CMS has the opportunity to address these challenges through the MIPS program.

Significant Need for Palliative and End-of-Life Care Quality Measures

Quality measurement is essential to assess the care patients receive as they near the end of their lives. Unlike other areas of care, such as surgery and infection prevention, Medicare lacks consistent and comparable performance indicators across settings to assess whether patients are given the opportunity to plan for the end of life and whether their documented instructions are followed. The dearth of quality metrics results in a lack of transparency and accountability for palliative care programs, large health systems, and even accountable care organizations.⁷

Measuring and reporting outcomes on the quality of end-of-life and palliative care can change the way health systems and payers care for patients. For example, when Arizona required Medicaid long-term care contractors to report on implementation of advanced directives in 2007, the share of beneficiaries with advanced directives in place rose from 42 percent to 65 percent over three years.⁸

Develop More Quality Measures

Although progress has been made in the use of palliative and end-of-life quality measures, especially in hospice care, these tools remain underused in a variety of care settings. For example, almost 90 percent of large hospitals in the U.S. have palliative care programs,⁹ but there are relatively few measures addressing the quality of palliative care delivered by those hospitals and their staff. Quality measures for symptom management are largely limited to pain control; measures regarding biopsychosocial care, such as depression or the psychological effects of pain, are almost entirely absent. Research estimates suggest that more than 60 percent of cancer patients experience psychological distress and that half of hospice patients or more suffer from some form of neuropsychiatric illness including depression, anxiety, and delirium during

⁵ Centers for Disease Control and Prevention's Healthy Aging Program, "Give Peace of Mind: Advance Care Planning" (March 3, 2014), available at <http://www.cdc.gov/aging/advancecareplanning/>.

⁶ Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, (Washington, DC: National Academies Press, 2014).

⁷ Committee on Approaching Death, "Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life" (Washington, D.C.: Institute of Medicine, 2014).

⁸ Arizona Health Care Cost Containment System and Arizona Long Term Care System (ALTCS), "Advance Directives Performance Improvement Project," Final Report (Phoenix, AZ, December 2011), https://www.azahcccs.gov/reporting/Downloads/PerformanceImprovementProjects/FinalAdvDir_FullRpt2011_11.04.11.pdf.

⁹ Tamara Dumanovsky et al., "The Growth of Palliative Care in U.S. Hospitals: A Status Report," *Journal of Palliative Medicine*, September 29, 2015, doi:10.1089/jpm.2015.0351.

their course of enrollment.¹⁰ Quality metrics should take into account how providers address these complex needs.

Fortunately, there have been promising signs of progress in the development of new measures. CMS indicated to the National Quality Forum (NQF) Measure Applications Partnership (MAP) Clinician Workgroup that it is interested in measures for specialty providers, such as palliative care providers. The NQF Clinician Workgroup independently identified palliative and end-of-life care as a gap area in the Physician Quality Reporting System (PQRS), and Pew was encouraged to see NQF's recent announcement that it will be reviewing palliative and end-of-life care quality measures in 2016. Developing new measures for palliative care would help to meet the quality reporting needs of physicians practicing within the specialty.

Pew encourages CMS and the Agency for Healthcare Research and Quality (AHRQ) to develop and test new person- and family-centered quality measures that are applicable across sites of care and specific to people with serious illnesses near the end of life. This could be accomplished by focusing on measures that address concordance of care with patient preferences regardless of disease, type of provider, or care-setting.

At the same time, Pew encourages CMS and AHRQ to develop a better definition of beneficiaries who would benefit from palliative care and should be captured in these quality measures. Without an accurate assessment of the total population in need of palliative care services, it is impossible to truly drive quality improvements.

Expand the Use of Existing Measures

Physician quality reporting presents a key opportunity to expand the use of quality measures for palliative and end-of-life care. Unfortunately, CMS's FY2016 proposed changes to the PQRS contain only a single measure on palliative and end-of-life care: the percentage of patients ages 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) and who report that their pain was brought to a comfortable level within 48 hours.

Many measures from the hospice item set could be incorporated into PQRS. While these measures are not currently as holistic as palliative and end-of-life care principles typically are, they would greatly expand what is available in PQRS. For that reason, Pew recommends that CMS look at the feasibility of integrating measures from the current hospice item set into the MIPS program for physicians to assess a larger spectrum of the physical aspects of patient care including:

- **NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen**
Percentage of vulnerable adults (including hospice patients) treated with an opioid that are offered/prescribed a bowel regimen or documentation of why this was not needed.

¹⁰ "Integrating the Biopsychosocial Model Into Quality Measures in Palliative Care: A Case for Improving the Hospice Item Set - Pdf," accessed November 3, 2015, [http://www.jpsmj.com/article/S0885-3924\(14\)00259-0/pdf](http://www.jpsmj.com/article/S0885-3924(14)00259-0/pdf).

- **NQF #1634 Pain Screening**
Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
- **NQF #1637 Pain Assessment**
This quality measure is defined as the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
- **NQF #1639 Dyspnea Screening**
Percentage of hospice or palliative care patients who were screened for dyspnea during the hospice admission evaluation / palliative care initial encounter.

In addition to the existing hospice item set, there is currently a PQRS measure that addresses advance care planning documentation that should be considered for public reporting within MIPS. PQRS #047/NQF #0346 measures the percentage of an eligible professional's patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record, or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. This measure was recently adopted for home health agencies as well and will be required for public reporting starting in 2016. Without a reported quality measure that patients and families can access through the Physician Compare website, patients are unable to identify the physicians completing and documenting these conversations. For that reason, Pew recommends that CMS add PQRS 047/NQF #0346 measure to the Physician Compare website.

Appropriate Attribution of Quality

Many palliative care physicians provide care outside of a private or group practice. Pew supports providing eligible professionals the option of electing to have their performance on quality measures tied to the performance of a facility, such as an affiliated hospice, home health agency, or hospital. This could provide another opportunity for palliative care specialists to be assessed using measures unique to their specialty. However, this should remain an option for eligible professionals.

Palliative and End-of-Life Care Alternative Payment Models Are Needed

Access to palliative care services is uneven across the United States. One-third of U.S. hospitals do not have a palliative care program. Additionally, Medicare payment rules make it difficult for people who are ineligible for hospice to access community-based palliative care.¹¹ Since Medicare regulations only allow prescribing providers to bill for services in an outpatient setting, it is therefore difficult for community-based organizations and small practices to provide the full interdisciplinary team that is a key component of palliative care.¹²

¹¹ Dumanovsky et al., "The Growth of Palliative Care in U.S. Hospitals."

¹² Amy S. Kelley and Diane E. Meier, "The Current and Potential Role of Palliative Care for the Medicare Population," *Generations*, June 7, 2015, <http://www.asaging.org/blog/current-and-potential-role-palliative-care-medicare-population>.

Accordingly, CMS needs to develop models of care that can broaden access to high-quality palliative care. Potential models would focus on opportunities for community-based providers and small practices to provide palliative care to individuals ineligible for hospice. Including palliative care as an element in existing alternative payment models like Patient-Centered Medical Homes, Accountable Care Organizations, and bundled payment agreements may be one way to accomplish this. Additionally, CMS needs to develop models that expand payment to include the full interdisciplinary care team. As CMS is considering models of care that would be appropriate for physician-focused payment models, we encourage the agency to include models that offer a robust palliative care component.

Advance Care Planning Information Must Be Transmitted Across Settings

Pew strongly believes that the ability to consistently capture and transmit advance care plans across settings is a core health IT function necessary for managing patient populations, coordinating care, and engaging patients. Care near the end-of-life is exceedingly complex and may require more coordination between settings and professionals than other types of care.¹³ Health IT technology is currently limited by setting and provider—making it difficult to coordinate care and leading to unwanted and unnecessary interventions at the end-of-life. Research has found that even where EHRs have increased the documentation of advance directives, there has been “an increase in inaccurate advance directive documentation from labeling errors made in transfer of information to the EHR and systems of advance care planning.”¹⁴

The final rules issued by CMS and the Office of the National Coordinator for Health Information Technology (ONC) in October are the first step to establishing standards in EHRs for providers to capture a patient’s full advance care plan. However, we encourage CMS as it develops MIPS, to ensure that eligible practitioners participating in alternative payment models as well as their patients have access to advance care plans and can communicate them across settings and providers. The IOM’s report *Dying in America* provides several examples of EHRs and technology supporting advance care planning.

Conclusion

Pew appreciates the agency’s progress on end-of-life issues. The establishment of payment codes for advanced care planning demonstrates the agency’s commitment to improving end-of-life care. Incorporating models of palliative and end-of-life care into the new physician-focused payment system is a logical next step. Additionally, we strongly urge CMS to prioritize the development of new quality measures and consider the inclusion of the current hospice quality measures in the MIPS for eligible professionals. Finally, Pew strongly encourages CMS to ensure that MIPS support the transmission of advance care plans across care settings, as they are a critical element of the shared-decision making process and essential to ensure the a patient’s care is aligned with his or her wishes.

¹³ Committee on Approaching Death, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life” (Washington, D.C.: Institute of Medicine, 2014).

¹⁴ Bose-Brill, S., and T. R. Pressler. 2012. Commentary: Opportunities for innovation and improvement in advance care planning using a tethered patient portal in the electronic health record. *Journal of Primary Care & Community Health* 3(4):285-288.

If you have any questions, or need further assistance, please do not hesitate to contact me at 202-522-2127 or lgoldberg@pewtrusts.org.

Sincerely,

A handwritten signature in black ink on a light gray rectangular background. The signature reads "Lee Goldberg" in a cursive, flowing script.

Lee Goldberg
Director, Improving End-of-Life Care Project
The Pew Charitable Trusts