

March 1, 2016

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

Submitted electronically via MACRA-MDP@hsag.com.

RE: Draft CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System and Alternative Payment Models

Thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) draft Quality Measure Development Plan, which will outline the role that quality measures can play in the new Merit-based Incentive Payment System (MIPS) and in the move to Alternative Payment Models (APMs). The development of this plan is a key opportunity to improve the quality of end-of-life and palliative care and increase access to this care. For this to happen, CMS should prioritize—throughout the Measure Development Plan—the implementation of new palliative and end-of-life care quality measures. CMS should also apply existing patient-centered quality measures to other care settings.

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.

Improving End-of-Life and Palliative Care Quality Measures Are a Priority

Unfortunately, the current health care system lacks consistent and comparable performance indicators of quality for end-of-life care. This is particularly important for Medicare, which finances the care for 80 percent of decedents annually. The data that we do have give mixed signals on the quality of care received by this population. A study comparing the responses of bereaved families from 2011 through 2013 found that more providers discussed a patient's religious and spiritual concerns than in earlier years.¹ However, a comparison of billing data for 2000 and 2009 also shows increased use of intensive care units at the end of life, more late referrals to hospice care, and an increased rate of rehospitalization during the last 90-days of life.

End-of-Life Quality Measures and Models are a Nationally Recognized Need

Two recent consensus reports from the Institute of Medicine (IOM) highlight the need for improved quality measurement and reporting for end-of-life and palliative care. In 2015, the IOM released *Vital Signs: Core Metrics for Health and Health Care Progress*, which identified a set of core measures for health and health care; these were intended to apply at varying levels

¹ Joan Teno, Vicki Freedman, Judith Kasper, Pedro Gozalo and Vincent Mor, "Is Care for the Dying Improving in the United States?", 2015, *Journal of Palliative Medicine* 18, no. 8. DOI: 10.1089/jpm.2015.0039.

from individual providers to whole states. The IOM also identified end-of-life measures as a key element within the Care Match with Patient Goals core domain. The report states:

“In addition to the best current measure of patient-clinician communications, the Committee identified two related priority measures; use of shared decision making and end-of-life care... End-of-life care represents a critical area in need of significant development in terms of both care and its measurement, and one in which patient and family views and perspectives play a critical role.”²

This concern was echoed in the IOM’s important report, *Dying in America*, which highlighted the need for improved quality metrics for palliative and end-of-life care. The Committee made the following recommendation:

“... [T]he federal government should require public reporting on quality measures, outcomes, and costs regarding care near the end of life (e.g., in the last year of life) for programs it funds or administers (e.g., Medicare, Medicaid, the U.S. Department of Veterans Affairs). The federal government should encourage all other payment and health care delivery systems to do the same.”³

There have been signs of progress recently in some care settings in assessing patient preferences and goals. The *Improving Medicare Post-Acute Care Transformation Act of 2014* statute requires CMS to develop cross-cutting measures for the post-acute settings, such as nursing homes and home health agencies, which compare quality in those settings. A key feature of the legislation was its focus on patient-centeredness in order to capture patient preferences and goals.

There has also been some progress on the development of measures for individual physicians as well. Last fall, CMS told 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 NQF MAP’s 2016 Final Recommendations to CMS there was even a new measure recommended on cancer patient hospice referrals. In 2016, NQF will be working to identify and endorse new performance measures that address palliative and end-of-life care as well as conducting a maintenance review of 16 previously-endorsed measures. This work presents a further opportunity to improve the measures available to assess the care provided by clinicians.

Opportunity for New Measures Under the Medicare Access and CHIP Reauthorization Act
The Physician Quality Reporting System (PQRS) is one of the main tools CMS uses to assess the quality of care provided by physicians and other clinicians. The *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA) mandates that CMS improve the PQRS system by developing better metrics to more accurately assess care. However, the lack of meaningful end-of-life and palliative care measures in the PQRS makes quality improvement extremely difficult for physicians in palliative care as well as physicians who are not specialists but care for patients

² *Vital Signs: Core Metrics for Health and Health Care Progress* (Washington, D.C.: National Academies Press, 2015), <http://www.nap.edu/catalog/19402>.

³ Committee on Approaching Death, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life.”

at the end of life. With the passage of MACRA and the development of the MIPS program, Medicare has an opportunity to expand the use of measures for palliative and end-of-life care.

To assess palliative and end-of-life care today, Medicare relies on limited outcome measures to assess physical symptoms such as pain near the end of life and process measures that are primarily focused on documentation of care plans. There are many other aspects of care that also need increased quality reporting, both for physical symptoms such as pain and dyspnea, as well as for the holistic treatment of the individual. For example, biopsychosocial care, such as depression or the psychological effects of pain, has no quality indicators but is extremely important for those facing advanced and life threatening illness.⁴

In addition to the need for basic holistic measures that address physical and biopsychosocial care, there is a profound need for a standardized indicator of whether or not a patient's goals, values, and preferences were respected and ultimately achieved. Pew strongly encourages CMS to explicitly prioritize the funding of a new palliative and end-of-life care measure or measure set around the concordance of care received with patient preferences.

Using MACRA resources, CMS could, over the next five years, fund the development of new measures for concordance and make this aspect of care more patient-centered. CMS could also fund new measures for other palliative and end-of-life care domains to help meet the quality reporting needs of physicians practicing within the specialty.

End-of-Life and Palliative Care Measures are Essential to Alternative Payment Models

MACRA encourages the development of integrated health systems and alternative payment models such as Accountable Care Organizations (ACOs). This represents a key opportunity to improve access to palliative care services in the United States. Although one-quarter of adults in the U.S. have multiple chronic conditions and would benefit from palliative care to help manage their conditions⁵, 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.⁶ Medicare regulations state that the only individuals who can bill for services in an outpatient setting are prescribing providers; this leaves registered nurses, certain types of social workers and physical therapists unable to bill for home-based palliative care. This creates barriers for community-based organizations and small practices to provide the full interdisciplinary team that is a key component of palliative care.⁷

Accordingly, CMS should 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

⁴ "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.jpmsjournal.com/article/S0885-3924\(14\)00259-0/pdf](http://www.jpmsjournal.com/article/S0885-3924(14)00259-0/pdf).

⁵ 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.

⁶ 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.

⁷ 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>.

Medical Homes, ACOs, and bundled payment agreements may be one way to accomplish this. Other potential models may expand payment to include the full interdisciplinary care team.

The development of quality measures is essential to the success of integrated health. As the IOM noted, the dearth of quality metrics can result in a lack of transparency and accountability for palliative care programs.⁸ There are currently no quality indicators for ACOs that attest to the quality of end-of-life care. With CMS's ambitious goal of having nearly 50 percent of all payments linked to alternative payment models by 2018, CMS must be prepared to invest in developing and implementing quality metrics to assess the palliative and end-of-life care provided by ACOs.

Quality Domain Priorities Under MIPS

MACRA specifically defines five core domains for the purposes of creating the Measure Development Plan and prioritizing new quality measures for physician quality reporting. Three of these domains are well-aligned with the goals of quality palliative and end-of-life care. Pew provides the following comments on these core measure domains.

Clinical Care

CMS has indicated an interest in developing clinical measures based on evidence and practice guideline from professional clinical societies. Pew strongly urges CMS to consider the National Consensus Project for Quality Palliative Care's *Clinical Practice Guidelines for Quality Palliative Care 3rd edition 2013* as a guide to development of gap clinical measures. This document is developed and periodically revised through a consensus process among representatives of the major hospice and palliative care organizations that includes multiple disciplines.

The Clinical Practice Guidelines for Quality Palliative Care is the recognized standard for palliative care standards and was used by NQF in 2006 to develop their report, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*, which focused on eight domains of National Consensus Project's guidelines.⁹ The work was also used during the *Measuring What Matters* project to define measurement domains and eventually a core set of measures that represent what matters most to patients and families.¹⁰

Pew also strongly recommends that CMS develop and test new patient reported outcome measures (PROM) that are applicable across sites of care and specific to people with serious illnesses near the end of life. Unlike experience-of-care surveys that are given to patients or their family members several months after a patient has received care (discussed further below), PROMs asks patients directly about symptoms and the effects of treatment at the time of service. For care at the end of life, understanding patients' symptoms and needs is extremely important to ensure they receive the care they need.

⁸ 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).

⁹ National Quality Forum, *A National Framework and Preferred Practices for Palliative and Hospice Care Quality*. (Washington, D.C.: National Quality Forum, 2006).

¹⁰ Sydney Morss Dy et al., "Measuring What Matters: Top-Ranked Quality Indicators for Hospice and Palliative Care From the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association," *Journal of Pain and Symptom Management* 49, no. 4 (April 2015): 773–81, doi:10.1016/j.jpainsymman.2015.01.012.

Care Coordination

The CMS draft Measure Development Plan provided examples of care coordination activities, including timely exchange of clinical information to patients and other providers. Pew strongly believes that the ability to consistently capture and transmit advance care plans (ACP) across settings is needed to manage patient populations, coordinate care, and engage patients. Care near the end of life is exceedingly complex and may require more coordination between settings and professionals than other types of care.¹¹ A study in the *Journal of the American Medical Association* found that people face an average of 3.1 transitions between different care sites in their final three months of life.¹² Additional studies have found that as very sick patients were transferred between several care settings, the likelihood that ACP information was available in new settings was “no greater than chance.”¹³ The accessibility of these key documents is critical to care for the sickest populations.

Pew commends CMS for taking a number of important steps last year to promote the use of advance care planning. The agency finalized a decision to reimburse eligible providers for holding advance care planning conversations.¹⁴ Additionally, new federal rules for electronic health records (EHRs) ensure that patients’ ACPs can now be captured and transmitted electronically.¹⁵ Finally, new quality measures for home health agencies require asking and documenting whether beneficiaries have an ACP.¹⁶

Continuing the agency’s progress on end-of-life issues in this critical area, Pew strongly encourages CMS to incorporate measures to ensure that if there is any advanced care document that does exist, it is accessible to all clinicians. Much like the measure examples provided in the Care Coordination domain of the draft Measurement Development Plan (NQF #2732),¹⁷ a measure could be developed for physicians who are reimbursed for end-of-life counseling to see if the resulting document or if discussion notes are uploaded into a patient’s EHR. This would link the payment code with documentation of a plan. Ensuring clinicians are appropriately capturing this information in a transferable EHR will improve care for those near the end of their lives.

Patient and Caregiver Experience

Ensuring patient- and family-centered care at the end of an individual’s life means integrating a patient’s preferences into his or her care. In eleven percent of deaths, bereaved families said decisions were made that their loved one would not have wanted; this percentage increases for those who died in ICUs.¹⁸ However, these patient and caregiver experiences are often not captured. One problem is that the clinician and group experience of care survey excludes the

¹¹ 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).

¹² Joan M. Teno et al., “Change in End-of-Life Care for Medicare Beneficiaries: Site of Death, Place of Care, and Health Care Transitions in 2000, 2005, and 2009,” *JAMA* 309, no. 5 (2013): 470–77.

¹³ Victoria Y. Yung et al., “Documentation of Advance Care Planning for Community-Dwelling Elders,” *Journal of Palliative Medicine* 13, no. 7 (July 2010): 861–67, doi:10.1089/jpm.2009.0341.

¹⁴ Beginning in January 2016, eligible providers will be able to bill under CPT codes 99497 and 99498 for advance care planning conversations.

¹⁵ The Office of the National Coordinator of Health Information Technology mandated a “patient generated health field” as part of Meaningful Use Stage 3.

¹⁶ Home health agencies are required to use NQF #0326 measure as part of the Home Health Value-Based Purchasing Model and ask beneficiaries 65 years and older if they have an advance care plan.

¹⁷ NQF #2732: International Normalized Ratio (INR) Monitoring for Individuals on Warfarin after Hospital Discharge

¹⁸ Joan Teno, Vicki Freedman, Judith Kasper, Pedro Gozalo and Vincent Mor, “Is Care for the Dying Improving in the United States”, 2015, *Journal of Palliative Medicine* 18, no. 8. DOI: 10.1089/jpm.2015.0039.

perspectives of patients (and their families) who have died.¹⁹ Excluding these populations leaves systems without information about the quality of care of those who died and limits the ability to improve care.²⁰ Pew strongly encourages CMS to adapt questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey to assess palliative care professionals and professionals who dealt with patients facing the end of life in other settings than hospice.

Applicability of Measures Across Health Care Settings

Pew commends CMS for working to adopt and align existing measures originally developed for other settings for use by clinicians and other levels of care like health plans. Creating continuity in measurement across settings and levels of care will make evaluating health care performance more equitable. While palliative and end-of-life care may lack clinician-level metrics, significant work has been conducted in the Hospice Quality Reporting Program to assess care. Many measures from the hospice item set could be incorporated into PQRS. While these measures are not currently as holistic in scope as the National Consensus Project's palliative care clinical practice guidelines are, the addition of this item set would greatly expand what is available in PQRS. Pew recommends that CMS look at the feasibility of integrating certain measures from the current hospice item set into the PQRS program for physicians to assess a broader spectrum of the patient's palliative and end-of-life 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.
- **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.

Conclusion

Improved quality measures for clinicians will help ensure all beneficiaries have access to consistent, coordinated, palliative and end-of-life care. Pew strongly urges CMS to prioritize the development of new quality measures in the areas of palliative and end-of-life care for the current PQRS as well as APMs. To address the mandate from Congress on quality domains, CMS should consider developing clinical care measures using the National Consensus Project palliative care domains as well as develop new PROM; implementing care coordination measures that address the documentation of ACPs in EHRs; and using the current CAHPS hospice survey to address patient and caregiver experience across settings and clinicians. Finally,

¹⁹ "CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child," *NQF: Quality Positioning System™*, accessed February 8, 2016, <http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=902&print=0&entityTypeID=1>.

²⁰ Teno, Joan M., and Pedro L. Gozalo. 2014. "Quality and Costs of End-of-Life Care." *JAMA: Journal of the American Medical Association*, November 12. 1868-1869. *Academic Search Complete*, EBSCOhost (accessed February 19, 2016).

Pew strongly urges CMS to consider the inclusion of the current hospice quality measures in PQRs for eligible professionals.

Thank you for considering Pew's comments. Should you have any questions or if we can be of assistance, please contact Lee Goldberg at lgoldberg@pewtrusts.org or 202-552-2127.

Sincerely,

A handwritten signature in black ink that reads "Lee Goldberg". The signature is written in a cursive style and is placed on a light gray rectangular background.

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