

August 21, 2017



Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence, Ave., S.W.
Washington, D.C. 20201

**Re: CMS-5522-P – Medicare Program; CY 2018 Updates to the Quality Payment Program;
Proposed Rule**
82 Fed. Reg. 30010 (June 30, 2017)

Dear Administrator Verma:

We are writing collectively as members of the Patient Quality of Life Coalition, a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, with the overarching goal of providing patients with serious illness greater access to palliative care services. Members represent patients, health professionals, and health care systems.

It focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis)¹ and can be provided along with curative treatment. The goal is to improve quality of life for both the patient and the family.

Studies show that without palliative care, patients with serious illness and their families receive poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other caregivers.^{2,3} By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve both quality of care and quality of life during and after treatment.^{4,5} In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.⁶ The American Heart Association / American Stroke Association have stated that palliative care can be a helpful complement

¹ Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. *J Clinical Oncol* 2012; 30: 880-887.

² Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7; 291(1):88-93.

³ Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly*. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

⁴ Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) *Cancer* 437-45 (2009).

⁵ Casarett D, et al., Do palliative consultations improve patient outcomes? 56 *J Am Geriatric Soc'y* 593, 597-98 (2008).

⁶ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363:733-742.

to current care practices and can improve quality of life for stroke patients, caregivers, and providers.⁷ Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.⁸

Yet despite the demonstrated benefits of palliative care, there remain millions of Americans who do not access such services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.⁹

The Coalition appreciates the opportunity to provide comments on the proposed updates to the Quality Payment Program (QPP). We offer the following recommendations with respect to specific policy proposals:

MIPS Quality Category

Table E: Measures with Substantive Changes Proposed for MIPS Reporting in 2018

Title: E.3. Dementia: Cognitive Assessment

Current Measure Description: Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.

Proposed Substantive Change: The measure currently allows for medical exceptions, including diagnosis of severe dementia, palliative care, or other medical reasons, from numerator compliance.

Rationale: The technical expert panel convened by our measure development contractor recommended removing these exceptions as cognitive assessment is especially important for planning the care of patients who are very sick or have advanced-stage dementia. The denominator identifies patients with dementia. Prior to this change, patients with severe dementia, palliative care, and medical reasons were removed from the denominator. While the denominator seeks patients with dementia, the number of patients with severe dementia is likely non-trivial and could impact performance rates. It is recognized that patients with perceived severe dementia still need an objective assessment of their cognition to appropriately care for them.

The Coalition supports the removal of the palliative care exclusion from this denominator. As discussed in the introduction, palliative care should ideally be made available to patients upon diagnosis of

⁷ Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association

<http://circ.ahajournals.org/content/early/2016/08/08/CIR.000000000000438> Aug 16.

⁸ Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. www.innovations.ahrq.gov/content.aspx?id=3370.

⁹ IOM (Institute of Medicine). 2014. Dying in America: Improving quality and honoring individual preferences near the end of life. Washington, DC: The National Academies Press.

dementia. Palliative care can help support both patients and their families in the early stages of the illness by helping patients articulate what they consider to be an acceptable quality of life (given the reality of the diagnosis), establish goals of care, and appoint a health care proxy prior to cognitive decline. As the illness progresses, periodic cognitive assessments help clinicians, patients, and families determine the patients' current capacity to make medical decisions.

The measure as currently designed would prevent clinicians who are treating dementia patients receiving palliative care services from submitting data on this measure, which would essentially prevent them from receiving "credit" for providing good care. While it is our hope that an inability to submit data on this quality measure would not prevent treating clinicians from conducting a cognitive assessment when it is clinically indicated, the current denominator exclusion creates a minor disincentive to do so. Therefore, we agree with CMS' proposal to remove medical exclusions – particularly palliative care – from this denominator.

MIPS Improvement Activities Category

Table F: Proposed New Improvement Activities for the Quality Payment Program Year 2 and Future Years

Activity ID: IA_PM_XX

Subcategory: Population Management

Activity Title: Provide Clinical-Community Linkages

Activity Description: Engaging community health workers to provide a comprehensive link to community resources through family-based services focusing on success in health, education, and self-sufficiency. This activity supports individual MIPS eligible clinicians or groups that coordinate with primary care and other clinicians, engage and support patients, use of health information technology, and employ quality measurement and improvement processes. An example of this community based program is the NCQA Patient-Centered Connected Care (PCCC) Recognition Program or other such programs that meet these criteria.

The Coalition strongly supports the addition of this new Improvement Activity. We believe that inclusion of this new Improvement Activity will help to promote the use of palliative care services, which are designed to address the needs of a patient in a holistic manner, including connecting the patient and caregivers with community-based resources as appropriate.

Activity ID: IA_PM_XX

Subcategory: Population Management

Activity Title: Advance Care Planning

Activity Description: Implementation of practices/processes to develop advance care planning that includes: documenting the advance care plan or living will within the medical record, educating clinicians about advance care planning motivating them to address advance

care planning needs of their patients, and how these needs can translate into quality improvement, educating clinicians on approaches and barriers to talking to patients about end-of-life and palliative care needs and ways to manage its documentation, as well as informing clinicians of the healthcare polity of advance care planning.

The Coalition supports the addition of the new Improvement Activity as a standalone activity. Advance care planning (ACP) allows providers and their patients (and their families and/or caregivers) to discuss and make known the patients' treatment goals and preferences. The advance care planning process can begin at any stage or state of health, and should center on frequent conversations with family members and care providers.¹⁰

While we are pleased that Medicare now reimburses for advance care planning services, we recognize that more needs to be done to encourage advance care planning discussions between providers and patients. Research suggests that only one in three U.S. adults has completed any type of advance directive,¹¹ and many do not recall participating in discussions about their goals of care. When done properly, ACP can improve quality of life for patients,^{12,13} improve patient and family satisfaction,¹² and reduce in-hospital death.¹⁴ Establishing advance care planning as its own improvement activity will help promote implementation of practices and processes that will ensure more clinicians have goals of care conversations with patients and families.

Activity ID: IA_PSPA_XX

Subcategory: Patient Safety and Practice Assessment

Activity Title: CDC Training on CDC's Guideline for Prescribing Opioids for Chronic Pain

Activity Description: Completion of all the modules of the Centers for Disease Control and Prevention (CDC) course "Applying CDC's Guideline for Prescribing Opioids" that reviews the 2016 "Guideline for Prescribing Opioids for Chronic Pain." Note: This activity may be selected once every 4 years, to avoid duplicative information given that some of the modules may change on a year by year basis but over 4 years there would be a reasonable expectation for the set of modules to have undergone substantive change, for the improvement activities performance category score.

¹⁰ Institute of Medicine. (2014). *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: National Academies Press.

¹¹ Yadav KN, Gabler NB, Cooney E, Kent S, Kim J, Courtright KR, et al. (2017). *Approximately one in three US adults completes any type of advance directive for end-of-life care*. Health Aff. 36(7):1244-1251.

¹² Detering KM, et al. (2010). *The impact of advance care planning on end of life care in elderly patients: randomised controlled trial*. BMJ. 340: p. c1345.

¹³ Wright, A.A., et al. (2008). *Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment*. JAMA. 300(14):1665-1673.

¹⁴ Bischoff, K.E., et al. (2013). *Advance care planning and the quality of end-of-life care in older adults*. J Am Geriatr Soc. 61(2):209-214.

The Coalition has concerns about the inclusion of this Improvement Activity. While we support CMS' intent by adding this activity, we are concerned with the use of the CDC Guideline for Prescribing Opioids for Chronic Pain as the framework for these efforts. With the increase in opioid abuse, the Coalition agrees that all clinicians should be trained on key aspects of opioid prescribing (e.g., conducting a comprehensive pain assessment, matching the drug class to the pain, assessing risk for opioid substance use disorder, etc.). We are mindful of the serious and growing public health crisis caused by the inappropriate use of opioid analgesics nationwide, and support evidence-based efforts to reduce harms and adverse events associated with such misuse.

At the same time, we want to make sure public policies intended to reduce inappropriate use of opioids do not simultaneously create access barriers to pain management for patients for whom opioids are medically indicated, and who are benefiting from such treatment. We have previously expressed concern with how the CDC Guideline was developed, and these concerns included the fact that several recommendations were not wholly supported by the evidence, nor were they appropriately balanced to accommodate the legitimate needs of all patients who experience severe physical pain due to illness or injury.¹⁵

While people receiving palliative care are technically excluded from the Guideline, many clinicians do not understand what palliative care is and/or who should receive these services. As the national conversation on opioid misuse has led to increasingly restrictive policies around prescribing, clinicians are growing more reluctant to prescribe opioids to seriously ill patients. Therefore, while we agree with the overall intent of this activity, we ask that CMS work with the CDC to ensure a clearer presentation in its training materials regarding: what palliative care is; the population that should receive these services; and the recognition that amidst opioid reduction efforts, undertreatment of pain also remains a significant issue. The Coalition would be happy to provide information and resources to support these efforts.

MIPS Final Score Methodology

CMS is proposing to provide bonus points to Eligible Clinicians and Groups who care for complex patients. The Coalition supports adding such a short-term bonus to the MIPS calculation, as it acknowledges the additional work and responsibility of caring for complex patients (such as those who receive palliative care).

Conclusion

¹⁵ Patient Quality of Life Coalition. Letter to Tom Frieden (Centers for Disease Control) and Debra Houry (National Center for Injury Prevention and Control) re: Draft Guidelines for Prescribing Opioids for Chronic Pain, 2016 [CDC-2015-0112-0001]. Submitted January 13, 2016.

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed updates to the Quality Payment Program. If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition, at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

Alzheimer's Association

American Academy of Hospice and Palliative Medicine

American Association of Colleges of Nursing

American Cancer Society Cancer Action Network

American Society of Clinical Oncology

Catholic Health Association of the United States

Center to Advance Palliative Care

Coalition for Compassionate Care of California

Motion Picture & Television Fund

National Palliative Care Research Center

National Patient Advocate Foundation

Oncology Nursing Society

Pediatric Palliative Care Coalition

Physician Assistants in Hospice and Palliative Medicine

ResolutionCare Network

Supportive Care Coalition