



June 9, 2017

Ms. Seema Verma, Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Ave. SW Washington, DC 20201

Dear Administrator Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on the proposed rule: *Medicare Program; Hospital Inpatient Prospective Payment Systems (IPPS) for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System (LTCH PPS) and Proposed Policy Changes and Fiscal Year 2018 Rates; Quality Reporting Requirements for Specific Providers*; particularly with respect to the policies that would affect providers treating those with advanced illness.

## **Background**

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, providers, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some patients and their families may lead to transition to hospice. It is with this population in mind that we comment on the following aspects of the *IPPS and LTCH PPS proposed rule*.

## **Overall comment**

C-TAC supports the new measures in this proposed rule as they will improve the care of those with advanced illness. However, there is a pressing need to establish additional quality measures that support evidence-based care for individuals with advanced illness. Additional measures should address the full range of care that these patients need in terms of symptom management, social and spiritual support, care coordination, and identification of their goals and preferences and whether those goals are met. With the rapid aging of our population, C-TAC would be interested in



discussing opportunities to streamline the process to accelerate measure implementation and is currently working with other organizations in the field to explore alternate measure options.<sup>1</sup>

## **Specific Comment Areas**

### End-of-Life (EOL) Measures in the PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

The proposed measures are:

- Proportion of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (NQF #0210);
- Proportion of Patients Who Died from Cancer Admitted to the ICU in the Last 30 Days of Life (NQF #0213);
- Proportion of Patients Who Died from Cancer Not Admitted to Hospice (NQF #0215); and
- Proportion of Patients Who Died from Cancer Admitted to Hospice for Less Than Three Days (NQF #0216).

C-TAC supports the adoption of these measures. The first two measures address treatment that is usually no longer appropriate for the advanced illness population and which often leads to unnecessary, futile, and possibly unwanted, care. The latter two measures highlight that referrals to hospice come unfortunately too late to be of full benefit to patients with cancer and families.

We do recommend, however, that CMS consider expanding measures to include additional illnesses and provider types. ICU care and late referral to hospice are issues for all advanced illnesses, including heart failure, kidney failure, dementia, etc. and so measures should be developed and validated for other illnesses as well. In addition, the above EOL measures (though they would represent meaningful progress) will only apply to the small number of hospitals in the PCHQR program. For that reason, C-TAC recommends that CMS consider expanding them for use in additional care settings. The proposed rule specifically references that these measures could potentially be implemented in the hospital quality reporting program (QRP) program after additional consideration by MAP and we strongly support work towards that goal.

### Advance Care Planning Measure in the Long-Term Care Hospital (LTCH) Quality Reporting Program

The proposed rule also asks for comments on a measure being considered for possible inclusion in future years for the LTCH QRP that documents whether a patient has an Advance Care Plan. C-TAC

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<sup>1</sup> <http://healthaffairs.org/blog/2017/05/25/building-additional-serious-illness-measures-into-medicare-programs/>



supports the adoption of such a measure as it will promote the important process of advance care planning. We recommend that CMS consider using the National Quality Forum (NQF) Advance Care Plan measure #0326<sup>2</sup> for this purpose. This measure is already used in a number of Medicare programs<sup>3</sup> and has undergone NQF's evaluation process.

The proposed rule also asks for comment on what would qualify as an advance care plan for this measure and we agree that this needs to be clarified as several different types of documents or conversations could be considered Advance Care Plans. They range from advance directives, living wills, and state POLST/MOLST forms to a note in the chart confirming that a conversation with a hospitalized patient about their treatment plan has occurred and summarizing that plan. From a hospital standpoint, the latter care plan may be the most appropriate as someone's wishes regarding resuscitation from an advance directive are generally less relevant than ones for specific hospital procedures and treatment. Clarifying what components of an Advance Care Plan need to be included will provide much-needed direction to clinicians who have often been unable or reluctant to have such conversations. If patients are unwilling to engage in advance care planning, then that should be noted in the chart and not counted against the hospital in the QPR.

## **Conclusion**

Thank you for the opportunity to comment on this proposed rule. We believe it could improve and incentivize better care for Medicare beneficiaries with advanced illness including appropriate and timely referral to hospice.

If you have any questions, please contact Marian Grant, Policy Consultant at C-TAC, at 443-742-8872 or [mgrant@thectac.org](mailto:mgrant@thectac.org).

Sincerely,

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<sup>2</sup> <http://www.qualityforum.org/QPS/0326>

<sup>3</sup> Home Health Value Based Purchasing, Medicare Physician Quality Reporting System (PQRS), Physician Feedback/Quality and Resource Use Reports (QRUR), and Physician Value-Based Payment Modifier (VBM).

