



September 24, 2021

COALITION MEMBERS

American Academy of Hospice
and Palliative Medicine
(AAHPM)

Association of
Professional Chaplains
(APC)

The Catholic Health Association
of the United States
(CHA)

Center to Advance
Palliative Care
(CAPC)

HealthCare
Chaplaincy Network™
(HCCN)

Hospice and Palliative
Nurses Association
(HPNA)

National Association for Home
Care & Hospice
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National Hospice and
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(NHPCO)

National Palliative
Care Research Center
(NPCRC)

Palliative Care Quality
Collaborative
(PCQC)

Physician Assistants in Hospice
and Palliative Medicine
(PAHPM)

Social Work Hospice &
Palliative Care Network
(SWHPN)

Society of Pain & Palliative
Care Pharmacists
(SPPCP)

Amy Bassano
Deputy Director
Center for Medicare and Medicaid Innovation

Sent via email

RE: National [Coalition](#) for Hospice and Palliative Care Recommendations for Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness

Dear Deputy Director Bassano,

The National Coalition for Hospice and Palliative Care appreciated the opportunity to meet with you and your team at the Center for Medicare and Medicaid Innovation (CMMI) on March 10, 2021, to discuss the delay in implementation of the Serious Illness Population option within the Primary Care First (PCF) model. During that meeting, you expressed an interest in hearing our latest recommendations on how to identify people with serious illness and measure and improve the quality of their care. To that end, we formed an interdisciplinary and cross-organizational workgroup to develop recommendations for a standard set of high priority quality measures for people with serious illness; we intend for these recommendations to apply under any payment model that includes patients with serious illness. Throughout this work, we were guided by one bottom line principle: ***For people with serious illness, the quality of care should not depend on the payment model.*** We are pleased to share our findings and recommendations with you here and would welcome a meeting to discuss them with you and your team in more depth.

We appreciate the strategic vision for CMMI that the CMS Leadership Team outlined in its recent article for *Health Affairs Blog*, particularly the call for making equity a centerpiece for every model, focusing on more integrated and scalable models, and encouraging a broader array of quality investments. We are committed to advancing equitable access to palliative care, which takes a person-centered approach and provides the social, spiritual and cultural supports that are key to reducing disparities. We agree that achieving the goal of more equitable and integrated models will require an investment in quality. Our Coalition believes that our proposal to develop cross-cutting quality measures centered on what matters most to people with serious illness aligns perfectly with this new strategy and vision for CMMI.

General Findings and Recommendations

- Structural and process quality measures, though the only tools currently available for some important quality concepts, have limited usefulness in driving quality improvement and accountability. Nonetheless, certain required structures and processes for serious illness care should be specified in all relevant models as provider participation requirements, as further detailed below. Attestation and audit are appropriate methods for ensuring participating providers' fidelity to these requirements.
 - **Structural requirements** for models providing care to people with serious illness should include the following:
 - i) Care is provided by an interdisciplinary team that includes a clinician licensed or certified to provide psychosocial-spiritual care (social worker, psychologist, counselor or chaplain) and at least one clinician with demonstrated palliative care expertise (for example, palliative care certification within their discipline).
 - ii) The clinical care team is available by phone, has access to health records, and can make visits when necessary on a 24/7 basis.
 - **Process requirements** for models providing care to people with serious illness should include the following:
 - i) A comprehensive assessment is completed shortly after admission; the assessment addresses the patient's treatment goals and preferences, identifies their physical, emotional, social, spiritual, cultural and practical needs, and guides the development of an individualized plan of care.
 - ii) Patients are assessed; the plan of care is updated; and care is coordinated following discharge from the hospital or any major care transition.
- Although cost measures and program integrity measures play an important role in determining overall value, they should not be used as proxy indicators for the quality of care provided and are not addressed further in this document.
- To be truly cross-cutting, currently available quality measures must be adapted to employ a broad denominator identifying the population with serious illness, tested across a full range of care settings and service delivery models, and adjusted to assess performance at the level of individual clinicians, group practices and populations.
- While we recognize the importance of scientific rigor and the value of review and endorsement by the National Quality Forum and Measures Applications Partnership, we also see an urgent need to accelerate the development of the next generation of quality measures. We support the testing of new and unendorsed measures within CMMI model demonstrations, provided the testing methodology is rigorous and incentives are not linked to such indicators until they have been demonstrated to be valid and effective. We appreciate that CMMI has taken this approach with the development and testing of the

Days at Home quality measure and propose making a similar investment in expanding, revising and testing the measures we recommend below.

- In considering our recommendations, ***we prioritized the following guiding principles:***
 - Focusing on what matters most to patients and families
 - Addressing healthcare inequities and social determinants of health
 - Supporting a thriving workforce
 - Building on the best and broadest measures available today or in development
 - Minimizing data collection burden on participating providers
- As detailed in the table below, our recommended four measures address the following high-priority measure concepts for improving care of people with serious illness:
 - Patient-reported experience of serious illness care
 - Prevention and treatment of symptoms
 - Timely and appropriate use of hospice care
 - Avoidance of potentially preventable hospital stays
- Please note that we have limited these recommendations to quality measures and concepts. We would welcome a separate discussion on other elements of accountability for quality, such as measure exclusions, risk adjustment, item weighting, scoring methodology, comparison groups, benchmarking and linkage to incentives.

Recommended Set of Cross-cutting Quality Measures to Include in All Payment Models Involving Care for People with Serious Illness

Concept	Measure	Type	Stage of Development	Adaptation Needed
Patient-reported Experience of Serious Illness Care	Feeling Heard and Understood https://www.nationalcoalitionhpc.org/qualitymeasures/	Patient-reported experience of care	Submitted to CMS for consideration for the Measures Under Consideration (MUC) List and to the National Quality Forum (NQF) for endorsement	Alter denominator to identify a broad serious illness population, expand care and model settings, and expand to include relevant clinicians outside specialty palliative care

<p>Prevention and Treatment of Symptoms</p>	<p>Getting the Help Wanted for Pain https://www.nationalcoalitionhpc.org/qualitymeasures/</p>	<p>Patient-reported experience of care</p>	<p>Submitted for MUC List consideration and NQF endorsement</p>	<p>Alter denominator to identify a broad serious illness population, expand care and model settings, and expand to include relevant clinicians outside specialty palliative care</p>
<p>Timely and Appropriate Use of Hospice Care</p>	<p>Paired: Percentage of Patients Who Died and Received Hospice Care https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5735 and Hospice Median Length of Stay (MLOS) for Patients Who Died and Received Hospice Care https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=5736</p>	<p>Utilization outcome</p>	<p>NQF endorsed 0215 and 0216</p>	<p>Expand to a broad population with serious illness besides cancer, change from who didn't to who did receive hospice care, and replace the hospice stay <3 days with the hospice MLOS</p>
<p>Avoidance of Potentially Preventable Hospital Stays</p>	<p>All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions https://cmit.cms.gov/CMIT_public/ViewMeasure?MeasureId=2816</p>	<p>Utilization outcome</p>	<p>NQF endorsed 2888</p>	<p>Focus the denominator on the broad serious illness population within any model or care setting</p>

Recommended Method for Identifying the Serious Illness Population

CMMI has a tremendous opportunity to highlight the unique needs of people living with serious illness across *any* model or population, by defining a “denominator” sub-population and monitoring performance on the quality concepts noted above. To assess the sub-population with serious illness across broader models and populations, the Coalition proposes the

following method to identify Medicare and Medicaid beneficiaries in claims and encounter data.

Specifically, based on the most recent peer-reviewed evidence¹, we recommend using a **two-factor combination** to define the denominator: a qualifying diagnosis(es), together with a claims-based indicator of unmet need. The recommended diagnoses and indicators are:

Population for Evaluation	
<p>First, a qualifying diagnosis(es): at least one of these</p> <p>(The full list of relevant ICD-10 codes modeled in Kelley et al., 2021, is available upon request)</p>	<ul style="list-style-type: none"> → Advanced cancer (locally advanced or metastatic) → End stage or stage 5 renal disease → Advanced dementia → Advanced lung disease with home oxygen or hospitalized for the condition → Advanced heart failure with home or oxygen or hospitalized for the condition → Advanced liver disease → Diabetes with severe complications → Advanced Parkinson’s disease → Amyotrophic Lateral Sclerosis, Huntington’s, progressive supranuclear palsy or other neurodegenerative diseases → Hip fracture, over age 70 → Stroke requiring hospital admission → Human Immunodeficiency Virus (HIV) with complications of Acquired Immunodeficiency Syndrome (AIDS)
<p>--AND--</p>	
<p>At least one of these indicators of unmet need, impaired function, and/or high symptom burden</p>	<ul style="list-style-type: none"> → One or more emergency department visits within past six months → One or more hospital admissions within the past six months → Home health episode with date of admission not following a hospital discharge (e.g., community referral) → Sequential home health episodes → Durable medical equipment claims consistent with impaired function or high symptom burden (as used in the proposed Serious Illness Population option of the PCF model) → Documented difficulty with activities of daily living captured in ICD-10 codes, or documented in post-acute discharge data → Documented social needs (e.g., unsafe housing, food insecurity) captured in ICD-10 codes, or documented in a social needs screen such as in the Accountable Health Communities program

¹ Kelley AS, Ferreira KB, Bollens-Lund E, Mather H, Hanson LC, Ritchie CS. Identifying Older Adults With Serious Illness: Transitioning From ICD-9 to ICD-10. *J Pain Symptom Manage*. 2019 Jun;57(6):1137-1142. doi: 10.1016/j.jpainsymman.2019.03.006. Epub 2019 Mar 12. PMID: 30876955.

We are mindful that systemic biases in diagnostic testing, assessment of social needs, and recording may lead to an under-representation of Black, Indigenous, and People of Color (BIPOC) in the two-factor denominator.² We encourage CMMI to test for this bias with current Medicare claims, and if disparities are noted, to consider expanded criteria for BIPOC beneficiaries, perhaps including an age indicator or age plus dual eligibility to minimize inequities in quality monitoring.

In conclusion, we have identified persistent quality measurement gaps and recommend that CMS increase its support for quality measure development and stewardship in general and particularly that CMS invest in the testing of a cross-cutting broad denominator to identify the serious illness population and measure key quality concepts across all relevant care settings and payment models.

We appreciate and request the opportunity to bring together the small group from our Coalition to discuss these recommendations with you and your team soon. Our Coalition looks forward to working with you and your staff to improve the care for Medicare beneficiaries with serious illness. Amy Melnick, Executive Director, amym@nationalcoalitionhpc.org, will work with your staff to coordinate a convenient time to continue our dialogue. Thank you for your consideration and review of our Coalition's recommendations.

Coalition Signatories

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Hospice Palliative Nurses Association

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Social Work Hospice and Palliative Care Network

Society for Pain and Palliative Care Pharmacists

² Obermeyer, Z., Powers, B., Vogeli, C., & Mullainathan, S. (2019). Dissecting racial bias in an algorithm used to manage the health of populations. *Science*, 366(6464), 447–453. <https://doi.org/10.1126/science.aax2342>