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2025 Pre-Rulemaking Measure Review Preliminary Assessment

MUC ID	Title
MUC2025-020	Advance Care Planning (ACP)
Measure Steward & Developer	**Proposed CMS Programs**
Centers for Medicare & Medicaid Services (CMS)	Links to programs are embedded below: Ambulatory Surgical Center Quality Reporting Program End-Stage Renal Disease Quality Incentive Program Home Health Quality Reporting Program Hospital Inpatient Quality Reporting Program Hospital Outpatient Quality Reporting Program Hospital Value-Based Purchasing Program Inpatient Psychiatric Facility Quality Reporting Program Inpatient Rehabilitation Facility Quality Reporting Program Long-Term Care Hospital Quality Reporting Program Medicare Promoting Interoperability Program Merit-based Incentive Payment System Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program Rural Emergency Hospital Quality Reporting Program Skilled Nursing Facility Quality Reporting Program Skilled Nursing Facility Value-Based Purchasing Program

Measure Overview
Rationale: This measure aims to advance person-centered care by ensuring that hospitals provide patients and their caregivers the opportunity to discuss their goals of care and/or capture patients' existing ACP decisions. ACP is widely recognized as important to patient care by patients, surrogates, and clinicians, and is associated with improvements in numerous outcomes for patients' and their caregivers' experiences and satisfaction with end-of-life (EOL) care.[1,2,3] The 1990 Patient Self Determination Act mandates healthcare facilities to inform patients of their medical decision-making rights and document their ACP decisions in medical records.[4] Yet engagement in ACP remains low

[1] McMahan RD, Tellez I, Sudore RL. Deconstructing the Complexities of Advance Care Planning Outcomes: What Do We Know and Where Do We Go? A Scoping Review. J Am Geriatr Soc. 2021;69(1):234-244. doi:10.1111/jgs.16801
[2] Malhotra C, Huynh VA, Shafiq M, Batcagan-Abueg APM. Advance care planning and caregiver outcomes: intervention efficacy - systematic review. BMJ Support Palliat Care. 2024 Jan 8;13(e3):e537-e546. doi: 10.1136/spcare-2021-003488. PMID: 35788465.
[3] Song MK, Manatunga A, Plantinga L, Metzger M, Kshirsagar AV, Lea J, Abdel-Rahman EM, Jhamb M, Wu E, Englert J, Ward SE. Effectiveness of an Advance Care Planning Intervention in Adults Receiving Dialysis and Their Families: A Cluster Randomized Clinical Trial. JAMA Netw Open. 2024 Jan 2;7(1):e2351511. doi: 10.1001/jamanetworkopen.2023.51511. PMID: 38289604; PMCID: PMC10828909.
[4] Patient Self Determination Act of 1990.; 1990. https://www.congress.gov/bill/101st-congress/house-bill/4449

Measure Overview
across United States populations.[5,6]
CMS-provided program rationale: CMS is considering adding this measure to the Hospital Inpatient Quality Reporting Program, the PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), and the Promoting Interoperability Program to promote better person-centered care through wider adoption of advanced care planning documentation. This also promotes CMS initiatives around improving the ability to age with dignity. This measure complements the Documentation of Goals of Care Discussions Among Cancer Patients (PCH-42) currently in the PCHQR Program by expanding these important discussions to a broader scope of care situations, a much larger patient population, and promoting interoperable electronic record keeping. Documentation through structured data fields in the EHR also promotes continuity of care within the context of a patient's goals if they transition between different facilities or change providers. CMS is also considering adding this measure to the Merit-based Incentive Payment System (MIPS). This measure would provide a more robust alternative to the current MIPS clinical quality measure (CQM) and Medicare Part B claims advance care planning measure by expanding the denominator population, allowing different types of advance care plans for numerator compliance, and ensuring a decision is documented as a result of the advance care planning discussion assessed. This measure allows the MIPS eligible clinician choice of the most appropriate advance care plan document based on setting and scope of care. As an eCQM, this measure would also help to reduce reporting burden for MIPS eligible clinicians and would be broadly applicable across multiple clinician specialty types, including hospitalists, which represent a gap area for measurement in MIPS.
Description: Percentage of patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document or documentation of an advance care planning discussion resulting in a documented decision in the electronic health record (EHR by the time of hospital discharge for at least one hospital encounter during the measurement period.
Measure background: New measure never reviewed by the Measure Applications Partnership (MAP) Workgroup or PRMR; never used in a Medicare program.
Numerator: Patients aged 18 years and older at the start of the measurement period with one or more inpatient encounters during the measurement period who have an advance care planning document and/or documentation of an advance care planning discussion resulting in a documented decision in the EHR by the time of hospital discharge during at least one inpatient encounter during the measurement period. The numerator may be satisfied by any one of the following: 1. ACP document, as evidenced by: a. Health Care Agent (Health Care Proxy or Medical Power of Attorney for Health Care) b. Advance Directive (or Living will) c. Portable medical orders, such as: i. Medical Order for Scope of Treatment (MOST) ii. Medical Order for Life Sustaining Treatment (MOLST) iii. Physician Order for Life Sustaining Treatment (POLST) iv. Do not Resuscitate (DNR) Order form or diagnosis code

[5] Yadav KN, Gabler NB, Cooney E, Kent S, Kim J, Herbst N, Mante A, Halpern SD, Courtright KR. Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care. Health Aff (Millwood). 2017 Jul 1;36(7):1244-1251. doi: 10.1377/hlthaff.2017.0175. PMID: 28679811

[6] Gelfman LP, Barnes DE, Goldstein N, Volow AM, Shi Y, Li B, Sudore RL. Quality and Satisfaction With Advance Care Planning Conversations Among English- and Spanish-Speaking Older Adults. J Palliat Med. 2023 Oct;26(10):1380-1385. doi: 10.1089/jpm.2022.0565. Epub 2023 Jun 19. PMID: 37335910; PMCID: PMC10551762.

Measure Overview	
OR 2. Documentation that an ACP discussion resulting in a documented decision occurred during the measurement period. **Exclusions:** N/A	
Denominator: Patients aged 18 years and older as of the start of the measurement period, who are discharged from an inpatient hospitalization during the measurement period. **Exclusions:** N/A **Exceptions:** N/A	
Substantive changes from prior version (if applicable): N/A	
Measure type: Process	**Measure is a composite:** No **Measure is digital and/or an eCQM:** Yes **Measure is a paired or group measure:** No
Level of analysis: Facility	**Data source(s):** Digital-Electronic Health Record (EHR) Data
Care setting(s): Hospital inpatient acute care facility	**Risk adjustment or stratification:** No
CBE endorsement status: Not Endorsed	**CBE endorsement history:** Never Submitted
Is measure currently used in CMS programs? No	**Measure addresses statutorily required area?** No

Evaluation

Meaningfulness

Importance	
Type of evidence:	Peer-Reviewed Original Research [MUC Entry/Review Information Tool (MERIT) Submission Form]
Importance: This measure aims to advance person-centered care by ensuring that hospitals provide patients and their caregivers the opportunity to discuss their goals of care and/or capture patients' existing ACP decisions. Literature submitted by the developer shows that despite decades since the Patient Self-Determination Act mandated support for advance directives, engagement in ACP remains low. National data show that only one-third of adults have completed any type of advance directive, and even among seriously ill or high-risk patients, documentation and billing for ACP discussions are infrequent. Studies consistently highlight the need for standardized, system-wide processes to improve ACP documentation and ensure continuity of care across settings. Performance data show wide variation in the proportion of patients who complete ACP, with measure scores ranging from 13.3-84.3%. Three of four members of the technical expert panel (TEP) representing patients and caregivers agreed or strongly agreed that the measure is meaningful and/or produces information that is valuable to patients and caregivers in making their care decisions; one remained neutral because they felt that ACP discussions are important even if they do not result in care decisions.	
Rating: Met	

Conformance
Measure alignment with conceptual intent: The goal of this measure is to advance person-centered care by determining whether hospitals provide patients and their caregivers the opportunity to discuss their goals of care and/or capture patients' existing ACP decisions. The numerator includes several forms of possible evidence for ACP, including a named health care agent, an advance directive (or living will), portable medical orders, or a Do Not Resuscitate (DNR) Order form or diagnosis code. The denominator includes all patients aged 18 years and older. This is consistent with key program goals for the programs for which this measure is proposed, such as the Hospital Inpatient Quality Reporting Program goal of improving patient experiences of care as well as the PCHQR Program goal to equip consumers with quality-of-care information to make informed decisions about health care options among others.
Rating: Met

Feasibility	
eCQM feasibility testing/analysis conducted:	Yes [Feasibility Scorecard]

Feasibility: Feasibility testing showed minimal burden on reporting entities. Data elements are routinely collected in electronic health records.

The feasibility scorecard addresses the following domains:

- Data availability: Data element exists in a structured format in this EHR.
- Data accuracy: Information is from authoritative source and/or is highly likely to be correct.
- Data standards: Data element is coded in a nationally accepted terminology standard or can be mapped to that terminology standard.
- Workflow: The data element is routinely collected during clinical care and requires no, or limited, additional data entry from a clinician or other provider, and no EHR interface changes.

Several data elements required additional review due to missing values across different EHR systems. The Healthcare Agent & Power of Attorney Documentation was missing workflow data in EHR #1 (Epic), while Advance Care Planning Documentation had missing workflow entries in EHR #1 (Epic) and EHR #3 (Epic), and EHR #4 (Cerner). The Do Not Resuscitate (ICD-10) element lacked workflow data in EHR #3, and the Goals, Preferences, and Priorities for Medical Treatment element had the most gaps, with missing entries across all four EHRs in categories including data availability, data accuracy, and workflow. These gaps highlight areas where data capture and standardization may need strengthening to support comprehensive care planning.

To address these gaps, the developer notes in their feasibility plan that they recommend retaining all four data elements in the measure specifications. For Healthcare Agent & Power of Attorney Documentation and Advance Care Planning Documentation, structured fields exist in standard EHRs, and uptake is growing across measured entities; facilities are encouraged to work with vendors to align data capture with standardized terminology. The Do Not Resuscitate (ICD-10) code is widely supported and valid, though not yet consistently documented across all entities. For Goals, Preferences, and Priorities for Medical Treatment, while not yet a standalone structured field in most EHRs, its clinical relevance warrants inclusion in the measure, allowing entities that do capture it to report the data and informing future stakeholder-driven improvements.

Considerations for the committee: Committee members are encouraged to draw on their professional experience to evaluate whether the developer's proposed feasibility plan adequately addresses concerns about data elements.

Rating: Met

Validity	
Validity testing method(s):	Face Validity, Agreement between eCQM and manual reviewer [ACP Face Validity Measure Testing Attachment]
Testing level(s)	Patient-level encounter testing
Was this measure tested in the same target population as the CMS program?	Yes
Validity: Ten experts and patients/caregivers on the TEP voted on the measure's face validity. One member abstained from voting. A total of 70% of voting members agreed or strongly agreed the measure could differentiate good from poor quality care. Those who disagreed asserted that assessing the presence of ACP documentation could not determine if quality care was provided. Patient-level validity testing was conducted by comparing agreement between the eCQM and a manual reviewer. The measure developer reviewed 266 charts. Data element testing revealed a high level of agreement (92-100%) for all data elements but one. Improved agreement can be achieved by hospitals with more accurate labeling of advance directives in the EHR.	
Threats to validity: Submission materials did not discuss potential threats to validity. Based on the submission form, the measure is not recommended to be risk adjusted or stratified. **Considerations for the committee:** Committee members may consider their professional experience with validity testing to assess whether additional testing or examination of potential threats to validity should be explored in future iterations.	
Rating: Met	

Reliability	
Reliability testing method(s):	Signal-to-Noise (e.g., Beta-Binomial, Mixed Logistic Regression) [MERIT Submission Form]
Testing level:	Facility
Reliability discussion: Reliability was calculated across 179,476 persons from 18 facilities, and the developer reports a minimum facility-level signal-to-noise reliability of 0.9976, indicating that 100% of the entities have a reliability above the threshold of 0.6. With additional reliability testing across 43 facilities, the measure developer reports a minimum facility-level signal-to-noise reliability of 0.9939, likewise indicating that 100% of the entities have a reliability above the 0.6 threshold.	
Additional reliability analyses: Based on the minimum, maximum, median, and mean performance scores, Battelle performed a statistical	

Reliability
simulation to create the decile table shown in Table 1. The measure developer provided mean reliability by deciles in Table 2.
Rating: Met

Reliability Tables

Tables 1 and 2 show deciles by performance score and reliability based on the submission material information provided for the performance score and calculated reliability for the 179,476 persons across 18 entities. Battelle created Table 1. For this measure, a higher score indicates better quality of care. The measure developer created Table 2. These tables provide reviewers with a standardized format to assess reliability.

Table 1. MUC2025-020 Performance Score Deciles

Lowest Performers → **Highest Performers**

-	Overall	Min	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10	Max
Mean Score	38.5	13.3	18	23	24	26	27	29	38	50	65	84	84.3
Number of Entities	18	1	2	2	1	2	2	2	2	1	2	2	1

Table 2. MUC2025-020 Mean Reliability (by Reliability Decile)

-	Overall	Decile 1	Decile 2	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8	Decile 9	Decile 10
Mean Score (SD)	0.9987 (0.0012)	0.9958 (0.0012)	0.9972 (0.0002)	0.9984 (0.0002)	0.9988 (0.0001)	0.9991 (0.0001)	0.9992 (<0.0001)	0.9993 (<0.0001)	0.9994 (<0.0001)	0.9996 (0.0001)	0.9997 (0.0001)
Number of Facilities	43	4	4	5	4	4	5	4	5	4	4

Usability	
Usability considered in application:	Yes, the developer briefly discussed the usability of the measure but did not directly assess usability within the selected CMS programs in the submission.
Usability discussion: Empirical data submitted by the measure developer indicate there is considerable variability in measure performance across facilities. While the developer did not directly discuss usability of the measure within their selected CMS programs in their application, they did note that this measure improves upon the existing advance care plan measures by widening the eligible cohort to include patients aged 18 years and older and by including additional modes of advance care planning documentation in the measure numerator. Limitations noted for current measures within the program include that existing measures use billing codes only and are limited to patients aged 65 and older. The developer did not identify the potential for unintended consequences.	
Rating: Met	

Appropriateness of Scale

Appropriateness of Scale	

Similar or related measures in program(s):	• Advance Care Plan
	  ○ 00037-01-C-MIPS
	  ○ 00037-04-C-MODEL/BPCIA
	  ○ 00037-05-C-MODEL/MDTCOC
	  ○ 00037-06-C-MODEL/PCF
	• HEDIS Measurement Year 2024 Advance Care Planning

Measure balance, burden, and value across target populations/measured entities: This measure improves upon the existing advance care plan measures by widening the eligible cohort to include patients aged 18 years and older and by including additional modes of advance care planning documentation in the measure numerator. Existing measures use billing codes only and are limited to patients aged 65 and older. This measure allows CMS to monitor performance of advance care planning activities at the hospital level using additional EHR data for an expanded cohort of patients 18 and older. The proposed measure aligns with the currently in-use measure variations in other programs. **Considerations for the committee:** Based on clinical and professional experience, the committee should consider how different patient populations or measured entities might benefit or experience burden from use of the measure.	

Time-to-Value Realization

Time-to-Value Realization	
Plan for near & long term impacts after implementation:	None Specified

Measure implementation impacts over time: The developer did not discuss near and long-term impacts of implementing the measure. However, they note that awareness of ACP is low and billing codes for ACP are underutilized. Studies suggest that health care organizations should establish systematic processes to mandate clear, standardized documentation of ACP discussions and decisions within EHRs, ensuring accessibility for all clinicians so that ACP discussions and decisions can be updated iteratively based on prior discussions. However, how long this measure will take to improve awareness and/or utilization of ACP is unclear.

Considerations for the committee:

- What are the potential near- and long-term impacts of this measure on measured entities and patient populations?
- Will benefits and burdens associated with this measure be realized within an appropriate implementation time frame?
- How will this measure mature through revisions in the future if added to these programs' measure sets?

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