Penn Medicine
Lancaster General Health

January 5, 2026

Centers for Medicare & Medicaid Services

Dear Sir or Madam,

Thank you for the opportunity to comment on CMS's proposed clinical quality metric that emphasizes completion of advance directive documents. I support CMS's intent to strengthen advance care planning (ACP) across care settings, but am concerned that the proposed measure conflates documentation with conversation quality and could create perverse incentives that undermine patient-centered care.

Emphasizing the presence of a completed Advance Directive document does not assess whether a high-quality goals-of-care conversation actually occurred, nor whether the documented preferences are accurate, understood, or actionable in the clinical context. Furthermore, a documentation-centric measure risks driving workflows toward rapid form completion rather than meaningful, iterative conversations, especially at transitions or discharge, where time pressure is acute.

High quality Advance Care Planning depends on whether patients (and surrogates) understand prognosis, trade-offs, and likely outcomes; whether preferences are elicited in language they understand; and whether those preferences are translated into actionable orders (e.g., care plans or medical orders) when appropriate. A count of forms (or EHR flags) cannot validate these elements. Poor-quality or checkbox ACP can yield documented preferences that are outdated, misinformed, or inapplicable to current clinical realities—leading to care that is misaligned with patient goals.

I urge CMS to pivot from a documentation-only process metric toward a conversation-centered quality measure set that is feasible, equitable, and clinically meaningful. This requires the ability to capture conversations that ensure the patient (or surrogate) has discussed the expected trajectory and uncertainties and that the healthcare provider has elicited what matters most (e.g., function, longevity, symptom relief) and acceptable trade-offs.

I request CMS consider requiring documentation of key conversation elements (illness understanding, values, preferences translation, surrogate confirmation) rather than a completed advance directive form alone, and avoid measure specifications that anchor completion of a specific legal form, particularly when patients may not be prepared to make those decisions in real time. I request consideration for the conversation-centered measures to be tested in SNFs and other settings identified in the Measures Under Consideration (MUC) process to validate feasibility and avoid unintended consequences before broad adoption.

If CMS wants Advance Care Planning to truly improve patient experience and outcomes, the metric must reward high-quality, values-based conversations—then reflect those conversations in accessible, actionable documentation. Counting forms is easy; getting goals-of-care right is harder. The measure should incentivize the harder, more human work that patients need.

Sincerely,

Bethann M. Scarborough, MD, CPE
Medical Director of Palliative Care Servies
Patient Quality and Safety Officer