



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

BOARD OF DIRECTORS

EXECUTIVE COMMITTEE

Vicki Jackson, MD MPH FAAHPM
PRESIDENT

Arif Kamal,
MD MBA MHS FASCO FAAHPM
PRESIDENT-ELECT

Elise Carey, MD FACP FAAHPM
TREASURER

Kimberly Curseen, MD FAAHPM
SECRETARY

Holly Yang,
MD MSHPEd HMDC FACP FAAHPM
PAST PRESIDENT

Joseph D. Rotella,
MD MBA HMDC FAAHPM
**CHIEF MEDICAL OFFICER,
EX-OFFICIO BOARD MEMBER**

DIRECTORS AT LARGE

Michael Barnett,
MD MS FAAP FAAHPM

Rachelle Bernacki, MD MS FAAHPM

Gary Buckholz, MD HMDC FAAHPM

Sandra Gomez, MD FAAHPM

Christopher A. Jones,
MD MBA HMDC FAAHPM

Dio Kavalieratos, PhD FAAHPM

Stacie Levine, MD FAAHPM

Mary Lynn McPherson,
PharmD PhD BCPS FAAHPM

Laura J. Morrison, MD FACP FAAHPM

Lindsay Ragsdale, MD FAAP FAAHPM

Alvin L. Reaves, III, MD FACP FAAHPM

Phillip Rodgers, MD FAAHPM

Bethany Cox Snider,
MD HMDC FAAHPM

Alison Wiesenthal, MD FACP FAAHPM

CHIEF EXECUTIVE OFFICER

Wendy-Jo Toyama, MBA FASAE CAE

Submitted electronically via regulations.gov

May 21, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Request for Information on Medicare Advantage
Data [CMS-4207-NC]

Dear Administrator Brooks-LaSure:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare and Medicaid Services (CMS) for the opportunity to comment in response to the Request for Information (RFI) on Medicare Advantage (MA) Data. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below.

- CMS should take steps to improve the completeness and reliability of encounter data, including to require standardized reporting on the use of supplemental benefits, in order to better understand service utilization patterns among MA patients with serious illness.
- CMS should address known limitations in the collection and reporting of quality data to allow for the assessment of quality of care furnished to patients with serious illness.
- CMS should require MA plans to collect and report on our recommended cross-cutting quality measures that assess quality of care for patients with serious illness.
- CMS should prioritize and incentivize transparent collection and reporting of social risk data via z codes.
- CMS should release detailed data on plan and beneficiary experience under the MA Value-Based Insurance Design (VBID) Model Hospice Component expeditiously upon its completion.
- CMS should require health plans to centrally report standardized data on prior authorization metrics based on specific categories of items and services, rather than at the aggregate level.

Utilization and Quality Data on Patients with Serious Illness in Medicare Advantage

Patients with serious illness – including those at the end of life – are among the most vulnerable and high-need patients in the Medicare program. Understanding their experiences of care, including through both utilization data and quality data, is critical for assessing plans’ ability to effectively manage their care, as well as for identifying opportunities for improvement. Likewise, reliable data allows beneficiaries to make informed decisions when selecting plans each year. Unfortunately, there are limitations in the currently available data that hinder adequate assessment. To begin, research suggests that the quality of MA encounter data is uncertain and regularly incomplete.¹ While the Medicare Payment Advisory Commission (MedPAC) acknowledges that the encounter data are incrementally improving, many factors contribute to ongoing poor data quality.² Furthermore, encounter data do not include information about utilization of supplemental benefits, many of which may be important in supporting patients with serious illness. ***AAHPM believes that CMS should take steps to improve the completeness and reliability of encounter data, including to require standardized reporting on the use of supplemental benefits, in order to better understand service utilization patterns among MA patients with serious illness.***

Challenges with data on quality performance also limit stakeholders’ ability to understand the care experience for patients with serious illness and whether or not they are receiving high-quality care. As Ankuda et al³ highlight, data under the quality bonus program (QBP) are reported at the MA contract level, which may encompass a variety of plans and benefit designs and span large disparate geographic areas; patients with serious illness are under-sampled in MA Consumer Assessment of Healthcare

¹ Jung J, Carlin C, Feldman R, Tran L. Implementation of resource use measures in Medicare advantage. *Health Serv Res* 2022;57: 957-62.

² Medicare Payment Advisory Commission. Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources. March 7, 2024. Accessed from https://www.medpac.gov/wp-content/uploads/2023/10/MA-encounter-data_FINAL.pdf on March 11, 2024.

³ Ankuda CK, Aldridge MD, Braun RT, Coe NB, Grabowski DC, Meyers DJ, Ryan A, Stevenson D, and Teno JM. Addressing serious illness care in Medicare Advantage. *NEJM* 2023;388(19): 1729-1732.

Jung J, Carlin C, Feldman R, Tran L. Implementation of resource use measures in Medicare advantage. *Health Serv Res* 2022;57: 957-62.

Providers and Systems (CAHPS) surveys; and many QBP measures are less relevant to patients with serious illness. These limitations ultimately hinder researchers' and other stakeholders' ability to assess the quality of care furnished to patients with serious illness, especially at a plan-by-plan level. **AAHPM recommends that CMS address these limitations to allow for the assessment of quality of care furnished to patients with serious illness across the MA program but also by individual plans.** For example, CMS could:

- Identify and implement more granular reporting of MA quality data. For example, reporting could be conducted at a local market-area level, consistent with previous MedPAC recommendations.
- Require MA plans to increasing sampling of patients with serious illness in CAHPS and other non-claims-based sources of quality data.
- Stratify data collected on existing measures based on serious illness status.
- Require MA plans to collect and report data on new measures that capture more meaningful aspects of care for patients with serious illness.

With respect to specific quality measures, AAHPM joined with partners through the National Coalition for Hospice and Palliative Care to develop [recommendations](#) for a standard set of high priority quality measures that would apply under any payment model – including Medicare Advantage – that includes patients with serious illness. These include measures that focus on:

- Patient-reported experience of serious illness care
- Prevention and treatment of symptoms
- Timely and appropriate use of hospice care, and
- Avoidance of potentially preventable hospital stays.

We believe these recommended cross-cutting quality measures are centered on what matters most to patients with serious illness and should therefore be collected and reported by MA plans. Understanding MA plans' performance on these measures will help to better understand the extent to which MA patients with serious illness are receiving high-quality care and will enable targeting of poor performing plans for intervention.

Finally, AAHPM recognizes that utilization and outcomes may vary based on a number of factors, including race, gender identity, sexual orientation, age, religion, ethnicity, socioeconomic status, or disability, and that data on social determinants of health can help to manage patients that have challenging social needs. While z codes are available to report data on social risk, we note that many providers see little incentive to report these codes and find that reporting of social risk fails to translate into any action to address patients' needs. ***We therefore encourage CMS to prioritize the transparent collection and reporting of social risk data via z codes across both the MA and fee-for-service programs, including through provider education, support for providers to implement data collection processes, incentives for reporting of z codes for either patients or clinical teams, and incorporation into MA risk adjustment.***

Data from MA Value-Based Insurance Design (VBID) Model Hospice Component

Consistent with our call for better utilization and quality data for MA patients with serious illness, ***we urge CMS to release detailed data on plan and beneficiary experience under the MA VBID Model Hospice Component expeditiously upon its completion.*** With CMS' announcement in March that it would be terminating the Hospice Component of the VBID model at the end of 2024,⁴ CMS discontinued the only CMS Innovation Center model explicitly providing palliative care and concurrent hospice/treatment. We believe that these data can provide valuable lessons that can help inform future efforts to better manage patients with serious illness near the end of life.

Data that should be released should include, but not be limited to, information on:

- Beneficiary enrollment into hospice
- Beneficiary disenrollment from hospice
- Beneficiary use of concurrent care services and supplemental services
- Plans' use of prior authorization for concurrent care services, including approval and denial rates and timelines for determinations
- Hospice quality performance, including – as available – performance on metrics tracked under the Hospice Quality Reporting Program
- Patient and caregiver satisfaction with the carved-in hospice experience
- Plans' contracted hospice networks, and
- Use of contracted versus non-contracted hospice providers.

Utilization Management Data

AAHPM appreciates that CMS has taken significant steps to improve MA prior authorization processes. As we have noted previously, our members report significant burden associated with submitting and following-up on prior authorization requests. A single prior authorization request can take an hour or more of physician or clinical staff time to process, diverting attention and resources away from patient care. Furthermore, prior authorization requirements delay patient access to medically necessary and appropriate care in the best-case scenarios, while denying access altogether in the worst. Either outcome can lead to significant patient harm. **And while we** recognize that prior authorization may be an important tool in cases where providers are routinely furnishing care that is inconsistent with available evidence, we believe that there are too many cases where prior authorization does not support the delivery of high-quality, evidence-based care but rather is used as a blunt tool to curb utilization across the board.

⁴ Centers for Medicare and Medicaid Services. The future of the hospice benefit component of the Value-Based Insurance Design (VBID) Model. March 4, 2024. Accessed from <https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-announcement> on March 11, 2024.

CMS' finalized requirement for plans to publicly report prior authorization metrics aggregated for all items and services – including the percentage of standard prior authorization requests that were approved, denied, and approved after appeal; the percentage of requests for which the timeframe for review was extended and the request was approved; the percentage of expedited prior authorization requests that were approved and denied; and the average and median time that elapsed between a request and a determination for standard and expedited requests – would help to hold plans accountable for implementing reasonable prior authorization policies. However, consistent with our previous recommendation, ***we believe that such data should be reported based on specific categories of items and services, rather than just aggregate data.*** Such information would help stakeholders better understand plans' prior authorization practices and increase the efficiency around the submission of prior authorization requests. Standardization of reporting across plans – as well as reporting centrally to CMS rather than simply posting on individual websites – would also facilitate stakeholders' ability to compare and contrast plans on their prior authorization metrics and to identify trends in the use of prior authorization across plans and regions. Additionally, reporting of total numbers of requests – in addition to the required percentages – would help stakeholders understand the magnitude of burden plans impose through their prior authorization processes.

* * * * *

Thank you for the opportunity to provide feedback in response to this RFI. Please direct questions or requests for additional information to Wendy Chill, Director of Health Policy and Government Relations, at wchill@aaahpm.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Vicki Jackson". The signature is fluid and cursive, with a large loop at the end.

Vicki Jackson, MD, MPH, FAAHPM
President