

# Congress of the United States

Washington, DC 20510

September 22, 2021

The Honorable Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare and Medicaid Services  
200 Independence Avenue, SW  
Washington, DC 20210

Dear Administrator Brooks-LaSure:

By 2030 more people in the United States will be older than age 65 than younger than age five.<sup>1</sup> Our health care system is unprepared for the complexity of caring for a diverse population of older adults—a problem that the COVID-19 pandemic has magnified. Beneficial at any stage of a serious illness, palliative care is an interdisciplinary model of care designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families, and caregivers.

As strong supporters of innovative approaches to improving access to more equitable health care for all Americans, we encourage you to implement a community-based palliative care (CBPC) program for patients and families facing serious illness. Specifically, we believe it is time to carry out a CBPC demonstration under the authority of the CMS Centers for Medicare and Medicaid Services Innovation (CMMI), either as a new model or to build upon the Medicare Care Choices Model (MCCM).

The MCCM tested the effect of allowing eligible beneficiaries the option to receive supporting services from participating hospices while continuing to receive treatment for their terminal condition through fee-for-service Medicare. Continuing to understand how ongoing receipt of curative treatment affect delivery of supportive services will help meet the needs of individuals who prefer not to elect traditional Medicare hospice benefit and forgo care.

Hospice and palliative care providers deliver CBPC through an interdisciplinary team wherever a patient calls home, including in assisted living facilities and nursing homes. Providing care at home allows some of our most vulnerable populations to remain safe from communicable disease, comfortable, and surrounded by loved ones; it can also alleviate the burden on our nation's hospitals and other inpatient settings. The goal is to improve the quality of life and beneficiary and family satisfaction with care at the end of life, inform new payment approaches for the Medicare program, and reduce Medicare expenditure.

Most importantly, differences in Medicare hospice use persist across racial and ethnic groups. Black, Brown, and Asian Americans access these services at much lower rates than their White counterparts, making up approximately 15% of all Medicare beneficiaries receiving hospice services in 2018.<sup>2</sup> While the reasons for these differences are not fully understood, they include

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<sup>1</sup> <https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html>

<sup>2</sup> <https://www.nhpc.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf>

cultural or religious beliefs, preferences for end-of-life care, disparities<sup>3</sup> in access to care or information about hospice, mistrust of the medical system and other social determinants of health.<sup>4</sup>

Currently, hospice is limited to patients with less than six months to live and requires both the patient to forego any curative treatments traditionally covered under Medicare. The MCCM model has tested whether allowing for some flexibility in the types of services available to hospice enrollees improves quality of life and satisfaction with the benefit, while reducing costs. *Expanding* MCCM to allow for pre-hospice community-based palliative care or launching a new model focused on CBPC may help examine some of the reasons why the rate of uptake of hospice and other end-of-life services among certain populations, including people of color, is low and care delivery is more fragmented. By testing a model that removes some key barriers to care for seriously ill individuals, the CMMI can take a step toward better understanding how we may reduce disparities in the utilization of this type of care.<sup>5</sup>

Evidence shows that CBPC would lead to improved quality and cost outcomes for beneficiaries experiencing serious illness. A 2017 study in the *Journal of Palliative Medicine* found that the impact of a CBPC program implemented within an Accountable Care Organization (ACO) “was associated with significant cost savings, fewer hospitalizations, and increased hospice use in the final months of life.”<sup>6</sup> Additionally, a community-based palliative care demonstration enables access to a specially trained interdisciplinary clinical team that can provide symptom management while the patient continues to pursue disease-modifying treatment. Symptom management is crucial for seriously ill patients with comorbidities who are battling conditions such as COVID-19.

We propose testing coverage of CBPC by launching a new CMMI model or implementing a second phase II of the MCCM.<sup>7</sup> Either approach would provide a path to testing a new option for eligible Medicare beneficiaries to receive CBPC services from selected providers while continuing to receive services provided by other Medicare providers, including care for their terminal condition. For the intervention to be most beneficial it should be implemented in the last one to two years of life. According to a NORC analysis, CBPC could improve the quality of life for seriously ill individuals and reduce overall health care spending by covering more conditions and beneficiaries and by increasing the monthly payments to qualifying entities from \$400 to \$600 per-member per-month.<sup>8</sup>

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<sup>3</sup> <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2769692>

<sup>4</sup> [http://www.medpac.gov/docs/default-source/reports/mar21\\_medpac\\_report\\_ch11\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch11_sec.pdf?sfvrsn=0)

<sup>5</sup> Ensuring Equitable Access to Needed Care for the Seriously Ill through the Medicare Care Choices Model (MCCM) by Lori Bishop, Annie Acs, Dianne Munevar, and Ryan Murphy. See <https://csupalliativecare.org/ensuring-equitable-access-to-needed-care-for-the-seriously-ill-through-the-medicare-care-choices-model-mccm/>.

<sup>6</sup> Dana Lustbader, Mitchell Mudra, Carole Romano, Ed Lukoski, Andy Chang, James Mittelberger, Terry Scherr, and David Cooper. The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization. *Journal of Palliative Medicine*. Jan 2017.23-28. <http://doi.org/10.1089/jpm.2016.0265>

<sup>7</sup> Ensuring Equitable Access to Needed Care for the Seriously Ill through the Medicare Care Choices Model (MCCM) by Lori Bishop, Annie Acs, Dianne Munevar, and Ryan Murphy. See <https://csupalliativecare.org/ensuring-equitable-access-to-needed-care-for-the-seriously-ill-through-the-medicare-care-choices-model-mccm/>.

<sup>8</sup> NORC at the University of Chicago is an independent social research organization. See [www.norc.org](http://www.norc.org)

We appreciate your consideration of this important request and look forward to working with you on this issue. Should you have any questions regarding this request, please contact Alison Hernandez ([alison.hernandez@mail.house.gov](mailto:alison.hernandez@mail.house.gov)) in my office.

Sincerely,



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Steven Horsford  
Member of Congress



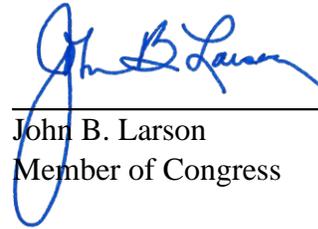
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