



January 7, 2022

Dr. Elizabeth Fowler  
Director  
Center for Medicare and Medicaid Innovation  
U.S. Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244  
[CMMIstrategy@cms.hhs.gov](mailto:CMMIstrategy@cms.hhs.gov)

55 West 125th Street  
13th Floor  
New York, NY 10027  
TEL 212-201-2670  
FAX 212-426-1369  
[capc.org](http://capc.org)

Re: **Improving Equity during Serious Illness  
Additional Comments**

Dear Dr. Fowler:

We are writing in follow-up to the December 10 paper sent by the Coalition to Transform Advanced Care (C-TAC), providing recommendations to ensure equitable access to a high quality of life during serious illness. As you may know, the population living with serious illness is sizable – between 5 to 12 percent of the US adult population and roughly half a million children<sup>i</sup> –and these individuals account for the preponderance of hospitalizations, emergency room visits, and post-acute service utilization.

Yet despite being disproportionate users of the US health care system, people with serious illness often have poor experiences and avoidable crises, particularly for Black Americans living with serious illness. For example:

- More than half of the emergency department visits for solid tumor patients are potentially preventable.<sup>ii</sup>
- Symptoms are often un- or under-treated<sup>iii</sup>, with significant under-treatment for Black patients, likely due to disparities in assessment<sup>iv</sup> and the provider perceptions.<sup>v</sup>
- A survey of Medicare beneficiaries living with serious illness revealed 61 percent experienced at least one problem receiving care, with more than 20 percent reporting conflicting recommendations from clinicians, and more than half not having their preferences taken into account.<sup>vi</sup>

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons living with serious illness have access to quality palliative care, regardless of diagnosis, treatment setting, state of the disease, or individual circumstances. We carry out this mission both by working to promote access to specialty palliative care teams and by working to improve the knowledge and skills of all clinicians who serve seriously ill patients and their families.

CAPC appreciates the new strategic direction of the Center for Medicare and Medicaid Innovation (CMMI), focusing on equity, innovation, affordability, and partnership. In particular, CAPC applauds the acknowledgement that palliative care must be tested across models, the greater use of waivers and flexibilities, and greater reliance on patient-reported outcomes. To

build on the useful information from our colleagues at C-TAC detailing how inclusion of palliative care advances these objectives, we want to highlight a few specific recommendations that should be prioritized to advance CMMI's goals for beneficiaries with serious illness.

### **Requiring Screening for, and Access to, Specialty Palliative Care in Relevant Models**

Because of the proven positive impact of specialty palliative care on both quality and cost,<sup>vii</sup> [palliative care access should be required in relevant accountable care models \(aligns with Innovation Center strategic objective #3\)](#). Currently, a small proportion of providers in CMMI models recognize the value of palliative care and work to improve access for selected patients, but this process is voluntary and greatly underutilized. For example, one study found only 24 percent of Medicare Shared Savings Program participants included palliative care or hospice physicians in their network,<sup>viii</sup> and CAPC's interactions with many ACOs confirms this relative lack of palliative care integration.

We understand that CMMI might still be considering a distinct payment model to support teams that provide primary and palliative care for beneficiaries living with serious illness. We support such a distinct payment model to ensure that accountable providers can financially support equitable access to palliative care, and thus eliminate one of the greatest barriers.<sup>ix</sup>

Yet in addition, because specialty palliative care has been shown to produce quality and spending improvements among patients with cancer,<sup>x</sup> heart failure,<sup>xi</sup> and other advanced illnesses, [any model that serves these beneficiaries should require processes that proactively identify patients with unmet palliative care needs and referral for specialty palliative care consultation \(aligns with Innovation Center strategic objective #3\)](#). For example, RTI found a significant quality and cost performance difference between Oncology Care Model practices who incorporate early palliative care and those that do not,<sup>xii</sup> while earlier studies have shown that early palliative care may even improve longevity.<sup>xiii</sup> CMMI should heed these findings in the next iteration of accountable oncology care to include the best practice of palliative care consultation upon diagnosis.

One opportunity to require access to palliative care is to [incorporate a standardized screening tool based on both diagnosis and an indication of unmet need \(aligns with Innovation Center strategic objectives #1, #2, and #3\)](#). Almost all CMMI models involve care management infrastructure, and care managers can be successfully trained in both screening and competent communication<sup>xiv</sup>. As a starting point, CMMI might consider the [screening recommendations CAPC has developed](#) in consultation with private payers and ACOs. Note that standardized screening is also essential to advancing equity. Studies have shown that access to palliative care is one-third lower for Black patients when compared to white patients,<sup>xv</sup> while disparities in both patient-provider communications and pain/symptom management continue to persist.

Lastly, we commend CMMI on its inclusion of flexibilities in hospice care under current models. In particular, CAPC is learning that the 'terrible choice' required to access Medicare hospice benefits

has a disproportionate impact on Black beneficiaries, unfairly reducing access to end-of-life supports and bereavement services. Therefore, we encourage CMMI to [continue to allow concurrent hospice and curative benefits for those participating in accountable models \(aligns with Innovation Center strategic objectives #2 and #3, and potentially #4\)](#).

### **Incentivizing High Quality Communication and Symptom Management**

CMMI models can be instrumental in reducing disparities in the quality of patient-provider communication, as well as inequitable pain and symptom management. First, all Medicare and Medicaid value-based payment arrangements should incorporate quality measures that reward providers for high-quality communication and sufficient management of pain, all from the perspective of the beneficiary. As noted above, systemic disparities in communication and symptom management exist, but can be overcome with attention and training. Therefore, [we recommend that all models include two specific patient reported quality measures \(to align with Innovation Center strategic objectives #1 and #2\)](#):

- A composite measure of how well patients feel heard and understood by their care team
- A measure of getting the help wanted for pain by the care team

More [information on these measures](#) is available through the National Coalition for Hospice and Palliative Care.

While quality measures are an important opportunity to incentivize patient-centered care, additional structural requirements or incentives must also be in place to truly transform the care delivery system. Providers caring for people with serious illness, such as those in models specific to high-need older adults or beneficiaries with certain conditions such as heart failure or cancer, should [demonstrate completion of training or competency in communication and pain/symptom management skills \(aligns with Innovation Center strategic objectives #1 and #4\)](#). This can be accomplished by requiring proof of training in order to participate in the model, or through structural measures and incentives. Please refer to CAPC's [recommended competencies by discipline](#) for consideration.

### **Other Recommendations to Advance Equity and Value during Serious Illness**

The recommendations above – incorporating access to specialty palliative care into relevant models and incentivizing skilled communication and symptom management – can have a significant impact on both economic value and equitable quality of care for Medicare and Medicaid beneficiaries, and can be easily implemented with the tools at CMMI's disposal. In addition, we would like to offer additional recommendations that can make meaningful structural changes to the US delivery system which will benefit all those facing serious illness and reduce racial disparities among them. We encourage CMMI staff to continue to think creatively as to how best to accomplish these changes, and would welcome the opportunity to provide assistance and additional information. These recommendations are:

- [Add incentives as well as grants for specialty palliative care services in public hospitals and other resource-limited acute care hospitals \(aligns with Innovation Center strategic objectives #1 and](#)

**#3).** As noted above, Black patients with serious illness have reduced access to specialty palliative care teams, and this is largely due to differences in the type of hospitals used. In fact, equalizing access to hospital-based palliative care may be the most effective mechanism to improve equity during serious illness. [Some private payers](#) have used financial incentives to advance access to inpatient palliative care for their members, and we encourage CMMI to explore what might be included in accountable care models.

- **Incorporate peer navigators/community health workers in relevant models (*aligns with Innovation Center strategic objectives #3 and #5*).** CAPC has recently investigated interventions which have been shown to improve quality of life for Black patients during serious illness<sup>xvi</sup>, and the use of peer navigators holds a great deal of promise. Studies have shown that peers can improve understanding of the illness and its trajectory, provide emotional support to family caregivers, hold conversations to clarify values and goals of care, and serve as an effective advocate for much-needed pain and symptom management. CMMI models, particularly those serving low-income and marginalized populations, can require or encourage peer navigators and more definitively test this promising addition to care delivery during serious illness.

\* \* \* \* \*

Thank you for the opportunity to submit these comments. Please do not hesitate to contact me, Allison Silvers, Chief Health Care Transformation Officer ([Allison.Silvers@mssm.edu](mailto:Allison.Silvers@mssm.edu)) or Stacie Sinclair, Associate Director of Policy and Care Transformation ([Stacie.Sinclair@mssm.edu](mailto:Stacie.Sinclair@mssm.edu)) if we can provide any further assistance.

Sincerely,



Brynn Bowman  
Chief Executive Officer  
Center to Advance Palliative Care  
[Brynn.Bowman@mssm.edu](mailto:Brynn.Bowman@mssm.edu)

cc: Jon Broyles, CEO, Coalition to Transform Advanced Care

References:

---

- i <https://www.commonwealthfund.org/publications/issue-briefs/2016/aug/high-need-high-cost-patients-who-are-they-and-how-do-they-use>; <https://pubmed.ncbi.nlm.nih.gov/15351754/>
- ii <https://pubmed.ncbi.nlm.nih.gov/29452549/>
- iii <https://pubmed.ncbi.nlm.nih.gov/27112310/>
- iv <https://pubmed.ncbi.nlm.nih.gov/30632104/>
- v <https://pubmed.ncbi.nlm.nih.gov/17534011/>
- vi <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/94/2018/10/CMWF-NYT-HSPH-Seriously-Ill-Poll-Report.pdf>
- vii <https://www.capc.org/documents/download/245/>
- viii <https://pubmed.ncbi.nlm.nih.gov/29058518/>
- ix <https://www.healthaffairs.org.eresources.mssm.edu/doi/10.1377/forefront.20191230.51481/full/>
- x <https://pubmed.ncbi.nlm.nih.gov/28603881/>; <https://pubmed.ncbi.nlm.nih.gov/33423523/>
- xi <https://pubmed.ncbi.nlm.nih.gov/28982506/>
- xii <https://meetings.asco.org/abstracts-presentations/154668>
- xiii <https://pubmed.ncbi.nlm.nih.gov/20818875/>
- xiv <https://pubmed.ncbi.nlm.nih.gov/29630470/>
- xv <https://pubmed.ncbi.nlm.nih.gov/32372699/>
- xvi <https://pubmed.ncbi.nlm.nih.gov/30389494/>