



April 28, 2020

The Honorable Mitch McConnell

Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Nancy Pelosi

Speaker
U.S. House of Representatives
Washington, DC 20151

FROM: National Hospice Stakeholders

National Hospice and Palliative Care Organization
National Association for Home Care & Hospice
LeadingAge
Visiting Nurse Associations of America/ElevatingHOME

RE: COVID-19 Requests

The organizations listed above want to thank you for your leadership in this time of extraordinary challenge for our country. The providers that we represent are all focused solely on doing what is best for our patients, their families, and our program staff and volunteers during this unprecedented time. Since over 95 percent of our services are delivered in patients’ homes and other places of residence, it is vital to maintain access to high-quality hospice and palliative care during this emergency. It is in this spirit that we offer the following specific recommendations for legislative and regulatory flexibilities.

Introduction

The National Hospice and Palliative Care Organization (NHPCO), the National Association for Home Care & Hospice (NAHC), LeadingAge, and the Visiting Nurse Associations of America/ElevatingHOME are committed to ensuring that all Americans have access to affordable, high quality hospice care. America’s hospice providers deeply appreciate Congress’s swift and effective efforts to combat the COVID-19 crisis. In addition to continuing to provide services to our patients, who are among the most vulnerable of populations, hospice providers stand ready to continue to offer expert advice on how to support patients and families in the community during this public health crisis and we look forward to continued collaboration with Congress to ensure quality serious-illness and end-of-life care for all Americans, and a robust Medicare Hospice Benefit for years to come.

Priorities for Hospice Providers in 4th COVID-19 Legislative Package

1. Support for Bereavement and Trauma Informed Care

Grief and Counseling Support: The hospice community remains the local community grief support experts around the country and often will be the source for grief and psychosocial support in the community for a range of situations involving loss and grief. Hospice and palliative care providers are uniquely positioned through their expertise with the grieving and healing process to provide care to communities coping with trauma. By statute, hospices are required to provide grief and bereavement counseling services to family members for 13 months after the death of a loved one. Hospices routinely provide this service to families and patients they have served, but they are also called upon to provide bereavement care in communities that have faced a difficult event, such as a terrorist attack, natural or manmade disaster. Hospice providers have the ability to provide support services for those who are suffering due to prolonged isolation during the crisis, to those families who may suddenly lose a family member or have to make a difficult decision about a family member's care due to COVID-19 and to healthcare professionals in nursing homes, hospitals and other healthcare settings who have experienced extensive losses while caring for patients.

Hospices stand ready to support those individuals and families coping with COVID-19. If Congress agrees that the need is there, hospices would be honored to serve in this capacity by scaling their grief counseling programs to meet the needs in communities around the country for those suffering losses, both physically and mentally.

Recommendation:

We recommend funding grants for community support to provide bereavement and delayed grief reaction services for both individuals and in group settings. We would recommend that the parameters for participation be limited to programs with a history of providing grief counseling and/or trauma informed care to their communities as well as requiring that programs have licensed staff delivering the services.

2. Availability of in-home respite care and flexibility for inpatient respite during the emergency.

Hospice providers are working to adapt their care to the conditions of the crisis. One phenomenon is that patients are being kept in hospice inpatient beds longer due to an inability to safely discharge or transfer patients. Often the patient no longer qualifies for the Medicare Hospice General Inpatient level of care, but must remain in a facility, using the inpatient respite care benefit. We ask that the inpatient respite benefit be expanded so that it can be utilized for more than 5 days during the public health emergency when the hospice judges and documents that it cannot safely transfer or discharge the patient. Reasons for this could be, but are not limited to, a caregiver having COVID-19, being fearful of exposure to COVID-19 from the patient, or not having a nursing home bed to discharge to.

Under certain circumstances respite care is needed but placement in a facility for inpatient respite care is not feasible. This issue is exacerbated by the pandemic but is not unique to the circumstances caused by the crisis. Therefore, we propose that hospices be permitted, on a permanent basis, to provide respite care in a patient's place of residence when circumstances prohibit its provision in a facility setting, or when it is the preference of the patient and family, and that this care be paid at the inpatient respite level. The duration of caregiver relief during the COVID-19 emergency warrants allowing in-home respite to be provided for more than 5 days on a temporary basis where need can be documented.

Recommendations:

- 1) Allow inpatient respite to occur for more than 5 consecutive days during the emergency period if the hospice cannot safely transfer or discharge a patient (i.e. caregiver has COVID-19, caregiver is fearful that the patient has contracted COVID-19, nursing home won't admit patient from the hospital or hospice inpatient facility or other location); and
- 2) Allow hospices to provide the respite care benefit in the home on a permanent basis where circumstances prohibit use of in-facility respite care or is the preference of the patient and family. Allow such care (where need is documented) to extend beyond the 5-day respite care limit during the emergency.

3. Funding

As is the case with all types of health care providers, hospice entities are facing unprecedented challenges in the face of the COVID-19 public health emergency. Many of these are having a negative financial impact. Included among the challenges are:

- staffing costs (costs of furloughed/quarantined staff, contracting for staff to meet patient care needs, reduced productivity, establishing home work stations, and other costs)
- costs of new telecommunications systems/staff training
- costs of PPE/other supplies
- increased costs to secure medications that are in short supply
- reduced referrals, increased inpatient unit costs (unit modifications, environmental cleaning, maintaining patients that cannot be transferred in units at RHC payment rates)
- lost fundraising revenues.

Hospice providers are deeply appreciative to Congress and the Administration for the funding that was supplied under the CARES Act. However, circumstances and needs are changing on a daily basis. Given the continuing crisis, it is imperative that any future stimulus package include funds to address hospice financial concerns, ensure patient and staff safety, and mitigate losses so that these essential agencies can continue to operate throughout the crisis and into the future.

We look forward to working with the Congress on the best way to address the financial issues facing our providers and present a few different approaches for discussion:

Approaches we support: As hospice providers are affected variably throughout the nation by the public health emergency, we believe an effective approach for ensuring that the financial impact of COVID-19 on hospice entities can be addressed is establishment of a grant funding¹ program for hospice providers commensurate with the impact of the pandemic. Access to funds would be based on demonstrated need beyond what has been addressed through the CARES Act funding mechanism. In addition, 10 percent of grant money should be awarded to “hot spots” as identified by the federal government. To date, hospice providers have been awarded funding through the CARES Act Provider Relief Fund. As this pandemic continues to exist financial support continues to be needed beyond what has previously been awarded.

Justification: While we are aware that many hospice providers are severely impacted by the public health emergency, others anticipate that the CARES Act funding and other flexibilities that have been provided will be sufficient for them to maintain the operations. Leaders in the field have also indicated that the COVID-19 emergency will likely have a long “tail” in terms of its impact on hospice. We believe that establishment of a grant program provides the most prudent balance between ensuring appropriate financial support for struggling hospice programs while safeguarding scarce resources and targeting them to those programs that are able to document need resulting from the COVID-19 emergency.

4. Allow Americans to Access Community-Based Palliative Care

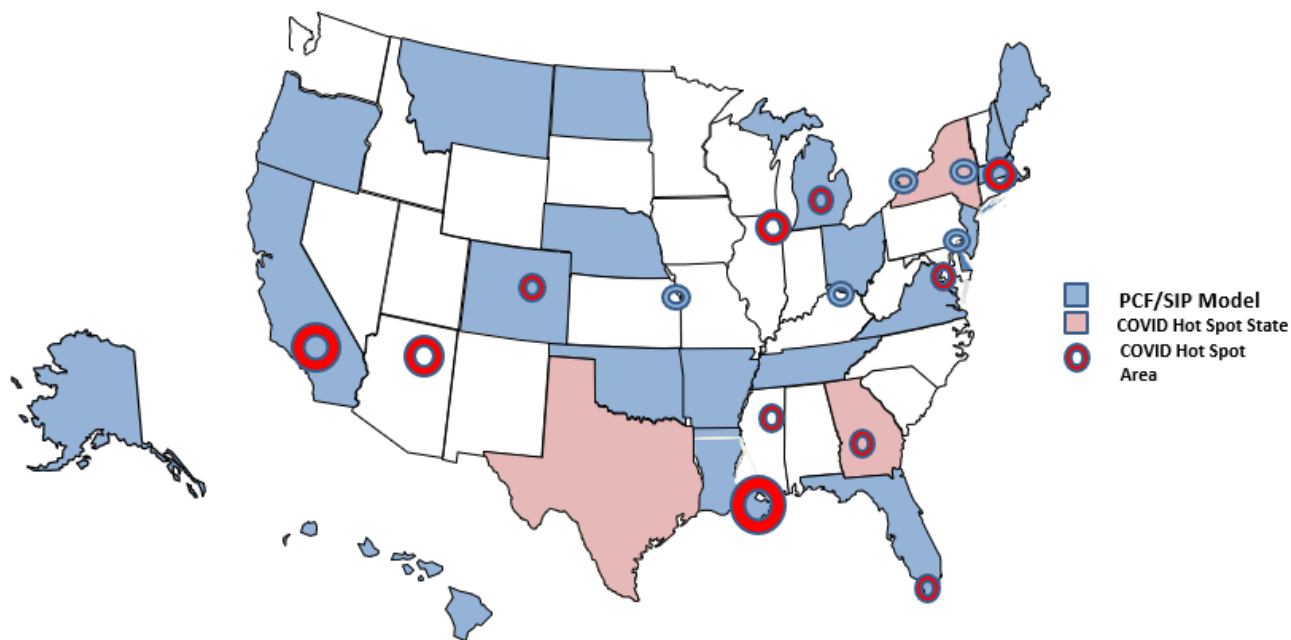
COVID-19 is an unplanned transformation of our healthcare system. The hospice and palliative care community believe this unanticipated event is an opportunity to test the parameters of a home and community-based palliative care benefit (Community-Based Palliative Care (CBPC) under the Centers for Medicare and Medicaid Innovations (CMMI). This demonstration would be targeted to individuals at an elevated risk for a poor prognosis if they contract COVID-19, including those that must sustain social distancing, as well as individuals recovering from COVID-19.

The Primary Care First/Seriously Ill Population (PCF/SIP) model was designed before the pandemic emerged. The CBPC demo will provide an alternative theory to PCF/SIP – that a co-management model is more effective at reducing costs than a transitional care model, through proactive care management to avoid and reduce urgent and emergency care. Additionally, this model will have a strong social work and community healthcare worker/aide support to decrease unnecessary interventions and cost especially in under resourced (i.e., inner city, rural) areas.

This demonstration is explicitly intended to protect the safety of at-risk individuals, reduce the occurrence of hospitalizations and ED visits, reduce the burden on workforce shortages, and lower overall costs of caring

¹ In a survey of a portion of hospice providers across the country conducted in April of 2020, hospice providers estimated that they will need approximately \$100-300 million in increased expenses and \$600-700 million in lost revenue from mid-April to the end of the FY 2020. In responding to the survey providers did express some difficulty in estimating expenses and lost revenue in the future, based on the unpredictability of the virus and how the pandemic is impacting communities in different ways.

for highly vulnerable individuals and COVID-19 patients. This model will save lives because it will reduce the risk of exposure to COVID-19 and other communicable diseases for the seriously ill population and more people with COVID-19 will be treated at home, limiting the exposure to others. The model also increases access to in-home care for the seriously ill patient population. This model should be offered nationwide, especially since many of the current COVID-19 “hot spot” areas are not currently included in PCF SIP regions (i.e. NYC, Illinois, Texas) and hot spots continue to evolve. See map below.



Sources: Centers for Medicare and Medicaid Services – CMMI PCF/SIP Model (blue) and COVID-19 Hot Spots – Johns Hopkins Coronavirus Resource Center

5. Support legislation that increases and enhances the hospice and palliative care workforce during COVID-19 and beyond

The COVID-19 crisis has underscored the need for the passage of the *Rural Access to Hospice Act* (S. 1190/H.R. 2594) and the *Palliative Care and Hospice Education and Training Act (PCHETA)* (S. 2080/H.R. 647). Both bills would alleviate workforce shortages and lack of preparedness that are being deeply felt during the COVID-19 crisis. The Rural Access to Hospice Act would allow practitioners at Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to serve as attending physicians to hospice patients. In short order, all areas of our country will be experiencing serious staffing shortages, and existing staffing limitations in rural areas will be exacerbated. This crisis has highlighted the workforce shortages in rural areas and passing this bill would help to alleviate these pressures now and into the future. Enactment of PCHETA would support the training of more palliative care professionals, the need for which has been underscored during the crisis. We recommend that Congress advance with both of these important pieces of legislation.

6. Hospice Providers Need Inclusion in Priority FEMA PPE Distribution and Testing

Hospice providers are front line healthcare workers who are increasingly being exposed to the COVID-19 disease. Hospice and palliative care providers continue to face tremendous challenges accessing personal protective equipment (PPE) due to the worldwide shortage and increases in demand. To address this continuing need, we strongly urge that Congress direct FEMA to ensure that home and community-based providers, including hospice providers, are among the provider groups considered for priority access to PPE. In addition, we request that hospice providers be given priority access to testing for both patients and staff, as directed by the federal government and States.

7. Hospice Telehealth Flexibility

- A. **Make Section 3706 of the CARES Act Permanent:** Section 3706 of the CARES Act allowed providers to use telehealth to conduct face-to-face encounter prior to recertification of eligibility for hospice care during emergency period. Given the growing concerns related to the spread of COVID-19, use of technologies, where possible and appropriate, has helped limit the spread of the virus and addressed growing concerns among seniors around exposure risk that in-home visits may pose to these vulnerable patients and their caregivers. However, under existing rules (including recent changes enacted under the CARES Act), the hospice face-to-face encounter may be conducted using telehealth, with both audio and visual capabilities, but only during this public health crisis. The additional flexibility to conduct this by telehealth will add much needed flexibility to both providers and patients. In addition, we are supportive of a GAO study to look at the efficiencies gained by the use of this new telehealth capability and the overall cost of this statutory change.
- B. **Physician Assistants Available to Conduct Face-to-Face Encounters:** In order for a patient to remain eligible for hospice care past 180 days (6 months), a hospice physician or nurse practitioner (NP) must perform a face-to-face encounter to gather information that supports continuing eligibility for hospice care. Physician assistants became eligible to serve as a hospice patient's physician as a part of the BBA of 2018, effective January 1, 2019. PAs have the skills and training necessary to fulfill the requirements of the hospice face-to-face encounter and are permitted to serve as the hospice attending physician. In some areas of the country NPs and physicians are in short supply, and PAs provide a significant portion of medical services. During the current emergency regarding COVID-19, providing hospices the flexibility to use PAs to conduct the face-to-face will allow them to utilize staff more efficiently.

Recommendation: We recommend the following legislative language: Section 1814(a)(7)(D)(i) (42 USC 1395f(a)(7)(D)(i)) is amended to add "or physician assistant" after "nurse practitioner".

8. Support Enhanced Access to Advance Care Planning

We recommend that Congress expand the types of providers eligible to bill the advance care planning codes to clinical social workers and registered nurses, waive the deductible and cost-sharing for advance care planning visits, and allow for advance directive portability. These provisions would allow for increased access to advance care planning and to advance directives, which will be particularly critical during COVID-19.