

March 17, 2020

Leader Mitch McConnell

Majority Leader, US Senate
317 Russell Senate Office Building
Washington, DC 20510

Speaker Nancy Pelosi

Speaker of the US House of Representatives
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Washington, DC 20515

FROM: National Hospice Stakeholders

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

RE: COVID-19 Funding and Regulatory Relief Request

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 challenging time. Because over 95 percent of our services are delivered in homes and other places where people live, 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, the National Association for Home Care and Hospice, National Partnership for Hospice Innovation, the Visiting Nurse Associations of America/ElevatingHOME, and LeadingAge are committed to ensuring that all Americans have access to affordable, high quality hospice care and request. America's hospice providers deeply appreciate Congress's swift and effective efforts to combat the COVID-19 crisis. Hospice providers stand ready to continue to offer expert advice on how to support to 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.

1. The costs of decreased admissions, paying out additional leave, losing staff and being able to care for a full load of patients, paying for extra PPE, and other unforeseen costs are already causing unforeseen costs for hospice providers. Any future stimulus package should include money to pay for current increased costs that programs are spending on patient and staff safety and to mitigate losses so that these essential agencies can continue to operate into the future.

Recommendations:

- A. **Sequester:** Remove the 2 percent sequestration cut to hospice for FY 2020 until the end of the COVID-19 Pandemic/End of National Disaster Declaration or December 31, 2020, whichever comes

first to help offset losses during this period. We believe that removing the sequester is one effective mechanism for providing more flexibility to continue to meet the needs of this pandemic but ask for consideration for access to other stimulus funds.

- B. PPE:** Increased funding will enable hospice providers to access personal protective equipment (PPE) due to the worldwide shortage related to decreases in exports from select countries and increases in demand. Provider PPE needs include the following: isolation gowns, masks (including n95 respirators and surgical masks), face shields and goggles, and medical grade gloves. This is an enhanced issue for our provider community because so much of our care is provided in a patient's home. Keeping this vulnerable patient population at home reduces the burden on hospital systems and limited resources. As providers who are working on the front lines of the pandemic, we strongly support provisions to help ensure continued access to personal protective equipment (PPE), including the provision to designate PPE as a covered countermeasure.

Note: Additional advocacy from Capitol Hill to CMS could help add guidance regarding associated procedures and processes that hospice providers can follow to gain access to the anticipated increase in PPE that will become available with increased funding.

- C. Additional funding for additional staffing, including overtime and contract workers:** Hospice providers report that additional financial resources are needed to pay for contract staff when current employees are quarantined or must provide care to family members or children due to the virus, providing additional IT support to enable some staff to work from home and additional management oversight.
- D. Additional funding for goals of care conversations and treatment options:** Hospice providers also face a potential surge in referrals for advance care planning and goals of care conversations to help seriously ill individuals make informed choices about treatment options and quality of life preferences to reduce the burden on hospitals and limited resources by keeping this vulnerable population at home with palliative holistic support.

Other issues:

2. Pausing Audit Activity

In the current environment, there is heavy payment audit activity in the hospice community from a variety of entities. In order to respond to these audits, hospices spend a lot of time and dollars that currently should be spent on responding to the needs of communities with COVID-19. We therefore ask that audit activity be suspended to make sure that hospice organizations can focus all of their administrative and clinical efforts on that response.

Recommendation: We ask that Congress instruct CMS to pause all audit activity for the duration of the emergency – from Medicare Administrative Contractors, Unified or Zone Program Integrity Contractors, Recovery Audit Contractors, Supplemental Medical Review Contractors, Medicaid Integrity Contractors, and any other entity that has the authority to audit hospice organizations.

In addition, ongoing audits should be paused and the timelines for submission of documentation for hospices undergoing current audits, including appeals, should be extended until two months after the declared end of the public health emergency.

3. Expanded Use of Telehealth under the Hospice Benefit

A. Use of Telehealth/Technology for Hospice Visits: Medicare-certified hospice providers are paid at prospectively-set daily rates to provide (or arrange for) all items and services determined by an interdisciplinary team to be reasonable and necessary to address the physical, medical, psychosocial, emotional and spiritual needs of a hospice patient that are connected to the terminal condition and any related conditions, and to support family members. These services include physician services, nursing services, medical social services, counseling, physical therapy, occupational therapy, speech-language pathology, dietary counseling, hospice aide and homemaker services.

With the exception of social workers (who may count telephone calls with patients and their caregivers/family as visits) all hospice services must be provided in person in order for them to be counted as fulfilling the hospice plan of care. While in-person encounters are necessary in some circumstances, a number of hospice services can be provided through alternative means, including through telehealth equipment, remote monitoring, and telephonic interactions. Technological interactions have significant potential to allow for more efficient use of scarce staff resources (including RNs) and reduce visit travel time.

Importantly, given the growing concerns related to the spread of COVID-19, use of technologies, where possible, will help to limit the spread of the virus and address growing concerns among seniors around admitting individuals into their homes that may pose a risk to these vulnerable patients and their caregivers. However, under existing law (including recent changes enacted under P.L. 116-203) hospice service visits are still not permitted to be provided via telehealth or other technologies.

Recommendations:

- **Expand telehealth waivers included under P.L. 116-123 to include hospice and home health agencies and to permit use of audio-only telephonic interactions based on technology available to patient.**
- **Permit use of telehealth technologies to fulfill the hospice face-to-face requirement.**

Suggested Language:

Expanding Telehealth Waiver Authority under Division B, Section 102 of P.L. 116-123

“(8) in the case of a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished in any emergency area (or portion of such an area) during any portion of any emergency period to an individual by a qualified provider (as defined in subsection (g)(3))—

“(A) the requirements of paragraph (4)(C) of such section, except that a facility fee under paragraph (2)(B)(i) of such section may only be paid to an originating site that is a site described in any of subclauses (I) through (IX) of paragraph (4)(C)(ii) of such section; and

“(B) the restriction on use of a telephone described in the second sentence of section 410.78(a)(3) of title 42, Code of Federal Regulations (or a successor regulation), but only if such telephone has

audio and video capabilities that are used for two-way, real-time interactive communication or the individual does not have access to a telephone that has audio and video transmission capabilities.”

“(3) QUALIFIED PROVIDER.—The term ‘qualified provider’ means, with respect a telehealth service (as defined in paragraph (4)(F) of section 1834(m)) furnished to an individual, a physician or practitioner (as defined in paragraph (4)(D) or (4)(E), respectively of such section) or a home health agency or hospice (as defined in 1861(o) and 1861(dd) respectively.....

Permitting Use of Telehealth to Fulfill the Hospice Face-to-Face Requirement:

USE OF TELEHEALTH IN RECERTIFICATION FOR HOSPICE CARE.

(a) IN GENERAL.—Section 1814(a)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395f(a)(7)(D)(i)) is amended by inserting “(including through use of telehealth, notwithstanding the requirements in section 1834(m)(4)(C))” after “face-to-face encounter”.

(From Section 10 of the CONNECT for Health Act -- S. 2781/H.R. 4932)

4. Core services

§418.64 Condition of Participation: Core Services: The federal hospice regulations require nursing, social work, spiritual care counseling, bereavement counseling, and dietary counseling to be provided by hospice employees. It is anticipated that hospice staffing will be reduced related to COVID-19 surge and associated quarantine.

Recommendation: The national hospice stakeholders are requesting that contracting for core staff positions be allowed, as these positions are critical to ensure continued hospice care for patients and their families.

5. Notice of Election (NOE)/Notice of Termination or Revocation (NOTR):

§418.24(a)(2) Standard: Election of hospice care. When a Medicare beneficiary elects hospice services, the hospice must complete an election notice with the beneficiary and file a notice of election (NOE) with Medicare within 5 calendar days. With the anticipated shortage of office staff to complete and file the Notice of Election, the national hospice stakeholders request additional flexibility in this timeframe.

418.26 Discharge from hospice care. Hospices are required to submit a Notice of Termination/Revocation (NOTR), within 5 calendar days after a hospice discharge/revocation, unless a final claim has already been submitted. With the anticipated shortage of office staff to file the Notice of Election, the national hospice stakeholders request additional flexibility in this timeframe.

Recommendation: We request additional flexibility on the timeframes for these two regulatory requirements.

6. Face-to-Face Requirements

A. Use of Telehealth to Address the Face-to-Face Requirement: In addition, the hospice face-to-face requirement (under which a physician or nurse practitioner must conduct a face-to-face encounter for the third benefit period and each subsequent benefit period for the purposes of gathering clinical information to support continuing eligibility for hospice care) may not be fulfilled through

the use of telehealth or other technological means because section 1834(m) of the Social Security Act does not include “hospice” as an originating site for purposes of telehealth. In the current environment, keeping vulnerable patients at home is required, ensuring efficient use of staff, and limiting interactions that may pose a threat or cause fear must be the highest priority.

Recommendation: Allow the use of telehealth to meet the face-to-face requirement.

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 recertification that the patient continues to meet the requirements for hospice care. The change below would clarify Congressional intent that a physician assistant (PA) can also perform a face-to-face recertification. PAs have the skills and training necessary to fulfill the requirements of the face-to-face requirement 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 and effectively.

Recommended 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”.

7. Continuous Home Care

Subpart F: Coverage Requirements §418.204 Special coverage requirements. During the COVID-19 outbreak, the requirements for continuous home care the description of periods of crisis must change, as hospices may need additional flexibility to continue to care for patients in their homes. If the patient is symptomatic of having COVID-19 infection, the hospice should work to keep the patient at home when possible, rather than sending them to a facility for inpatient care. In addition, patients may need to remain at home with more intensive hospice support for a period of in-home respite care to mitigate exposure risk for others in the community.

Recommendations: The national hospice stakeholders request the following:

1. CMS guidance that, for the period of the COVID-19 outbreak, in addition to acute symptom management for the patient, caregiver illness could be a reason for care to be provided at home for the patient on a continuous basis.
2. Remove the staffing ratio requirement for continuous home care to allow the hospice to determine the ratio of nursing and aide services necessary to meet the individual needs of patients and families on a case by case basis.
3. Allow contracting for nursing staff to provide continuous home care.
4. Reduce the minimum hour requirement for continuous home care from a minimum of 8 hours to a minimum of 4 hours during this COVID-19 outbreak.
5. Allow that the hours billed for continuous home care be in any 24-hour period, not just midnight to midnight to allow for flexibility in scheduling for the patients, families, and hospice organizations.

8. General Inpatient Care

§418.108 Condition of participation: Short-term inpatient care.

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

Recommendation: During this COVID-19 emergency, allow short-term inpatient care for someone who is not in acute crisis when the caregiver is unable to care for them.

§418.302 Payment procedures for hospice care.

(b) Payment amounts are determined within each of the following categories:

(4) General inpatient care day. A general inpatient care day is a day on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management.

Recommendation: During this COVID-19 emergency, remove the requirement for care “which cannot be managed in other settings” to enable the patient to receive care at the general inpatient level of care if needed.

§418.302 Payment procedures for hospice care.

(e) The Medicare Administrative Contractor makes payment according to the following procedures:

Recommendation: If the caregiver is ill or not able to care for the patient, respite may be necessary. During this COVID-19 emergency, the national hospice stakeholders recommend the waiver of the 5-day maximum for respite when the caregiver is unable to provide care due to illness or isolation. We also ask that respite care be available to hospice patients in their own homes, keeping the patient safe and reducing exposure to COVID-19, waiving the requirement that respite care only be provided in the inpatient setting.

9. **Hospice Aide and LPN Supervision Requirements, Hospice Aide Competency Requirements**

A. §418.76(h) Standard: Supervision of Hospice Aides.

The federal hospice regulations require the nurse to supervise the hospice aide every 14 days at a minimum. Hospice aides must be supervised at least once every 14 days by an RN. RNs must also supervise LPNs/LVNs per state requirements and hospice policies and procedures. The purpose of the supervision is to ensure the aides and the LPNs/LVNs are providing care to hospice patients according to the plan of care and proper procedures. It is anticipated that hospice staffing will be reduced related to COVID-19 surge and anticipated quarantine. Extreme RN shortages are anticipated during this pandemic and RNs available must focus on the greatest care priorities. RN visits will need to be prioritized based on patient need. Additionally, it is necessary to limit the number of individuals introduced into patient homes. Therefore, we make the following recommendations.

Recommendations: Permit telephonic supervision of hospice aides and LPNs/LVNs to meet the nurse aide supervision requirements and LPN/LVN supervision requirements where appropriate due to staffing shortages, and to minimize the risk of virus exposure during this pandemic.

B. §418.76(c)(1) Standard: Competency evaluation for hospice aides

The federal hospice regulations require that an aide’s competency must be evaluated by observing performance of the task with a patient. It is anticipated that hospice staffing will be reduced related to COVID-19 surge and anticipated quarantine. Significant staff shortages are anticipated in a workforce where some healthcare workers, especially aides, are already in short supply. Aides need to focus on provision of care to patients.

Recommendations:

- Allow hospices to utilize pseudo patients in the competency testing of hospice aides for those tasks that must be observed being performed on a patient.
- Allow qualified hospice aides to include those who are competency tested only in the areas/tasks for which they will be assigned.

C. §418.76 (d) Standard: In-service training for hospice aides

Federal hospice regulations require that a hospice aide must receive at least 12 hours of in-service training during each 12-month period. Significant staff shortages are anticipated in a workforce where some healthcare workers, especially aides, are already in short supply. Aides need to focus on provision of care to patients.

Recommendation: Waive the 12-hour annual in-service training requirement.

10. Volunteer Level of Activity

§418.78(e) Standard: Level of Activity

The federal hospice regulations require the use of volunteers for day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. It is anticipated that hospice volunteer availability and use will be reduced related to COVID-19 surge and anticipated quarantine. Many volunteers fall into the COVID19 at risk category – over 60 years old with underlying conditions. These individuals are being instructed to remain in their homes essentially depleting nearly all volunteer resources for hospices. Therefore, we make the following recommendations:

Recommendation: Waive the 5% level of activity requirement.

11. Consider ways in which hospice providers are uniquely suited to provide services outside the hospice benefit during the crisis

1. **Grief and Counseling Support:** Psychosocial support plays a critical role in the delivery of the hospice benefit and broader palliative care. Hospice and palliative care providers are uniquely suited to provide support services for those who are suffering due to prolonged isolation during the crisis and also 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.

Recommendation: Hospice organizations should be offered a separate payment (FFS codes or a bundle) for the duration of the crisis for the use of their social workers, grief counselors, and chaplains in supporting communities through isolation, grief, and decision-making throughout

the crisis. This payment should be structured as to be accessible to other organizations that may have experience providing palliative care in the community such as physician practices or home health agencies.

2. ***Utilization of hospice providers for COVID-19 care outside the hospice benefit:*** As the Congress and CMS consider alternative sites for caring for COVID-19 patients, we want to be sure that hospice organizations have the flexibility to be utilized where they are needed and have capacity.

Recommendations

1. Hospice and palliative care providers should be included as eligible providers in any program and payment structure to serve COVID-19 infected individuals either at home or in alternative care settings (temporary hospitals, nursing homes, etc.) given that they are able to perform the required services of said program.
2. Inpatient hospice units should be able to be utilized as alternative care settings/step down units for patients with COVID-19 or recovery for other conditions where there is decreased hospital capacity and should be paid accordingly inclusive of the need to increase PPE purchases.
3. Remove any barriers to hospices collecting, transporting, testing, billing for, and reporting the outcome of a COVID-19 test in order to assist with this process.