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National Hospice and Palliative Care Organization

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The Honorable Joseph R. Biden, Jr.
President-elect of the United States
1717 Pennsylvania Avenue, N.W.
Washington, DC 20006

Dear President-elect Biden:

On behalf of the National Hospice and Palliative Care Organization (NHPCO), we write to congratulate you and Vice President-elect Harris on your upcoming inauguration as our next President and Vice President of the United States. We look forward to working closely with you and your Administration in the coming weeks and months to support our health care providers as we continue to face these incredibly challenging times.

NHPCO is the largest membership organization representing the entire spectrum of hospice and palliative care programs and professionals in the United States. NHPCO represents over 4,000 hospice locations with more than 57,000 hospice staff and millions of volunteers, as well as 48 state hospice and palliative care organizations.

For over 40 years, hospice and palliative care organizations have provided comfort and dignity to millions of Americans, allowing the seriously ill at the end of life to spend their final months in peace and surrounded by loved ones. This has become more important than ever as we continue to battle COVID-19, one of the worst and most deadly pandemics in our nation's history. NHPCO is working with our members, state organizations, other national health care organizations, and all relevant stakeholders to advance our policy agenda amid the challenges brought on by the COVID-19 pandemic. This letter outlines a set of priority recommendations that we urge you to implement during your first 100 days in office as they require immediate attention.

Protect Patients and Families

Hospice and palliative care providers have been on the front lines of the COVID-19 pandemic, offering care and counseling to patients and their families during this difficult time. COVID-19 has taken a toll on seriously ill patients and their families, as well as the hospice and palliative care staff that care for them. In many communities, hospice and palliative care providers are caring for the elderly and most vulnerable Americans in the home to keep patients and families safe. They also provide care in freestanding hospice facilities, hospitals, nursing homes and other long-term care facilities or wherever patients choose to call home.

Prioritize Vaccination for Hospice Workers, Hospice Patients, and Hospice Caregivers

Like all Americans, we are heartened to see that vaccines are now being distributed throughout the country. Hospice and palliative care professionals provide services in the patient's place of residence, including their homes, nursing homes, skilled nursing facilities, assisted living facilities, and long-term care facilities. High priority designation of COVID-19 vaccines to hospice and palliative care staff, their families, patients, and caregivers would quickly help prevent further spread of COVID-19 throughout different healthcare settings and surrounding communities.

To date, hospice workers have been able to successfully adjust their safety protocols to address the reality of a pandemic with nearly uncontrolled community spread nationwide with additional personal protective equipment (PPE), quarantining when necessary, and some telehealth utilization. Now that vaccines can provide another layer of safety, it is critical for hospice and palliative care providers, just like hospital staff, to be given priority access to COVID-19 vaccines. This is not only for the safety of the interdisciplinary team but for the patients, families, and community members they encounter across every community in the United States every single day. In fact, more than 1.55 million Medicare beneficiaries avail themselves of hospice care every year. Many others receive home-based palliative, home care, and personal care in their home offered by the hospice providers. These patients and their families and caregivers should have access to vaccines immediately.

Collectively, the hospice and palliative provider sector is serving tens of thousands of patients with active COVID-19 infections, with over 70 precent of hospice providers reporting COVID-19 infected patients in service in our most recent survey. Prioritizing vaccinations for frontline hospice and palliative care staff and the high needs individuals they serve as well as their caregivers will be critical in achieving the goal of slowing or eliminating community spread of the virus.

Include Hospice Providers 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 supplies for both patients and staff, as the Department of Health and Human Services (HHS) continues to distribute Abbott BinaxNow and other tests to providers across the nation.

Extend and Expand Regulatory Flexibilities

We request that your Administration extend and expand regulatory flexibilities issued through legislation and waivers that allow hospice services to be provided through telehealth, flexibilities with training, on-site supervision, assessment, and therapeutics administration. This includes the legislation or regulation that will allow the hospice face-to-face requirement to be conducted through telehealth once the public health emergency has concluded.

Section 3706 of the CARES Act provides flexibility to providers to utilize telehealth for the face-to-face administrative encounter prior to recertification of eligibility for hospice care, but it is limited to the public health emergency. 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, we believe that HHS has the regulatory authority, as delineated in CMS–1744–IFC to extend the hospice face-to-face encounter using telehealth, with both audio and visual capabilities, after the end of the public health emergency. The additional flexibility to conduct this by telehealth outside of a public health emergency will allow patients in rural and underserved communities much needed access, as well as allow for much needed flexibility to both providers and patients.

Expand Funding for Bereavement Services

Throughout the country, families are experiencing grief and loss of loved ones due to COVID-19 in ways never before imagined. The magnitude of the losses feels even greater now during the pandemic for several reasons. For those who have lost a family member, friend, or colleague to COVID-19, in addition to grieving the actual death, there may also be the loss of not being able to be physically present during the dying process. During the COVID-19 pandemic, grieving individuals, families, and communities need access to timely, informative, and supportive bereavement care that is provided by experts knowledgeable in dealing with grief. To fulfill this need we recommend funding for a public health campaign to enhance the knowledge of grief literacy and where to find available care; the development and dissemination of resources and trainings to enhance grief professionals' ability to provide this necessary care; and most importantly for coverage of desperately needed bereavement care offered by hospice professionals. We request your support for improving access to bereavement services by hospice and palliative care providers for COVID-19 survivors and families in the community as well as survivors of other mass casualty events.

Increase Flexibility on Levels of Respite Care under Hospice

We request that your Administration provide additional flexibility on the location and duration of inpatient respite care for hospice providers, expanding the number of days allowed for hospice inpatient respite care to address the needs of patients and families during the COVID-19 pandemic and after. The COVID-19 pandemic has required hospice providers to adapt their care to the conditions of the COVID-19 crisis. In some circumstances, patients are being kept in the hospital or hospice inpatient facility longer than the current respite regulations allow, due to an inability to safely discharge or transfer patients. 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 which to discharge a patient. A change in respite length or and other flexibilities on levels of care gives both patients and providers the flexibility they need to provide care and keep patients safe.

Provider Relief Funding and Economic Support

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

worsening, for some on a daily basis. Given the continuing crisis with infection rates rising, it is imperative that any future stimulus package include economic support to ensure uninterrupted care to hospice and palliative care patients and staff safety by mitigating losses so that these essential agencies can continue to operate throughout the crisis and into the future. The costs of decreased admissions, increased staff-related costs related to sick leave or losing staff and filling in gaps that enables providers to care for patients, paying for extra PPE, and other unforeseen costs have continued to cause shortfalls for many hospice providers.

We ask for continued economic support through CARES Act and successor funding, including the extension of the sequestration moratorium past March 31, 2021, and other legislative and regulatory vehicles. We also ask that reporting requirements do not improperly penalize providers seeking economic relief through the CARES Act Provider Relief Fund or similar or related future economic relief legislation and regulatory relief.

Pause Audits During the Public Health Emergency (PHE)

We request your support for continued suspension of routine and widespread audits for hospice providers during the public health emergency (PHE) to allow providers who are already stretched thin to direct all needed resources to patient care.

Innovate How Serious Illness Care is Provided

COVID-19 has shined a spotlight on the "holes" in care for seriously ill individuals and their families. Innovative approaches are needed to provide the "right care at the right time" for patients with serious illness and their families.

Delay the Implementation of the Medicare Advantage Value-Based Insurance Design Model

Starting in January 2021, CMMI's Medicare Advantage Value-Based Insurance Design (VBID) Model now includes a hospice benefit component allowing participating Medicare Advantage (MA) plans to include hospice in their Part A benefits package for the first time. Hospice care is currently "carved out" of MA, and hospice services received by plan enrollees are reimbursed under traditional Medicare Part A.

Under the hospice benefit component, participating plans can add hospice services by contracting with hospice providers in their service area and beneficiaries may select a hospice of their choice to provide care without leaving the MA plan. After two years, the plan's network narrows and only hospices who are "in-network" will be under contract with the plan and the beneficiary's hospice choice will be significantly limited. MA plans may also add palliative care as a supplemental benefit; however, palliative care services are undefined and beneficiaries may not receive the full array of palliative care services, depending on the MA plan's specific definition.

As currently designed, the hospice component of VBID is a missed opportunity to innovate in care delivery at the end of life. Additionally, the technical difficulties faced by providers and plans imperil the quality and access beneficiaries should be able to depend on for serious illness at the end of life.

Rushing a model demonstration that could pose significant harm to beneficiaries in the middle of a national public health emergency and global pandemic is reckless. We request that your Administration halt implementation of the CY 2021 VBID model by at least one year to allow technical and operational issues to be addressed. Hospice patients and their families deserve a demonstration that improves access to high quality care at the end of life.

Create a Community-Based Palliative Care Benefit

We request your support for testing a new health care payment and delivery model that would improve access to community-based palliative care for patients and families facing serious illness. Specifically, we are urging you to implement a community-based palliative care demonstration (CBPC) model which identifies and cares for seriously ill patients whose care needs can be provided in their homes in the community through CMMI authority.

There is a significant evidence base to support the need for a CMMI supported community-based palliative care effort that would lead to improved quality and cost outcomes for beneficiaries experiencing serious illness. In fact, a 2017 study in the Journal of Palliative Medicine found that the impact of a community-based palliative care 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."[1] Additionally, a community-based palliative care demonstration would enable access to a specially trained interdisciplinary clinical team providing relief from symptom distress while the patient continues to pursue curative treatment. This is especially important for seriously ill patients with comorbidities who are battling conditions such as COVID-19.

The most feasible and expeditious way to test the impact of a national community-based palliative care benefit is by launching a community-based palliative care demonstration through CMMI, either by adding to an existing model or by creating a new one. NHPCO and the National Coalition for Hospice and Palliative Care (Coalition) have drafted a framework for a community-based palliative care model, and we have provided this information to the current team at CMMI. We strongly believe in the need for this type of benefit and request continued engagement as your Administration reviews plans for all future CMMI models.

Allow for Concurrent Care with Hospice

Currently, Medicare beneficiaries are required to forgo Medicare payment for care related to their terminal condition in order to receive access to hospice services. This puts patients in need of hospice care to make "the terrible choice" between continuing disease-directed therapies like chemotherapy and dialysis and accessing person-centered, interdisciplinary care services provided by hospice and palliative care providers.

We request your help in removing barriers to hospice care for Medicare beneficiaries seeking concurrent care by building off the successes of the Centers for Medicare & Medicaid Services Center for Medicare & Medicaid Innovation (CMMI) Medicare Care Choices

[1] Lustbader D, Mudra M, Romano C, et al. The Impact of a Home-Based Palliative Care Program in an Accountable Care Organization. *J Palliat Med*. 2017;20(1):23-28. doi:10.1089/jpm.2016.0265

Model (MCCM). The most recent evaluation report for MCCM found that concurrent care in MCCM "led to a 25 percent decrease in total Medicare expenditures" and resulted in earlier hospice elections.[2]

Support Expansion of Advance Care Planning

Discussions with family, friends and healthcare providers about health care wishes has never been more important than during the COVID-19 pandemic. Healthcare providers are looking for guidance from patients or their designated health care proxy, guided by the patient's advance directives, to make care decisions every day. We recommend that your Administration allow for advance directive portability between providers and recognition in all states, expand the types of providers eligible to bill the advance care planning CPT codes to clinical social workers and registered nurses, and waive the deductible and cost-sharing for advance care planning visits. These provisions would allow for increased access to advance care planning and to advance directives as a guide to ensuring that the patient's wishes are known and honored.

Improve Access to Hospice and Palliative Care

Hospice is an interdisciplinary, person-centered healthcare model that works to meet the unique needs of patients and families facing serious illness and the end of life. Changes to the Medicare Hospice Benefit should remove burdensome regulations that compromise patient care while implementing common-sense reforms that promote value and quality, patient choice and access, and provider accountability. The value-based model of person-centered care pioneered by hospice and expanded by palliative care should be adopted throughout the care continuum.

Reduce Racial Disparities in Access to Hospice and Palliative Care and Promote Health Equity

NHPCO recognizes that there are serious racial disparities in palliative care and hospice access among Americans. Of all Medicare decedents in 2018, 50.7% were enrolled in hospice at the time of death and over 82% of those beneficiaries were white.[3] We recognize the urgent need to make hospice and palliative care more equitable for all patients with serious illness and we are committed to advancing policies that support our community as they do all they can to provide high quality, comprehensive and holistic care.

Specifically, NHPCO supports racial and ethnic diversity in the hospice and palliative care workforce because a program must foster a culture of inclusion both internally and externally to reach the whole community. We have developed many tools and educational resources to promote this goal and stand ready to work with your Administration on this important issue.

Remove the Six-Month Prognosis Barrier to Hospice

The Medicare Hospice Benefit currently requires that two physicians must certify that they expect the patient to die within six months in order for a patient to receive hospice care. This is an outdated policy and does not account for the many diagnoses that hospice is utilized for,

[2] https://innovation.cms.gov/data-and-reports/2020/mccm-thirdannrpt
[3] https://www.nhpco.org/wp-content/uploads/NHPCO-Facts-Figures-2020-edition.pdf

but are much harder to prognosticate (e.g., neurological disorders, Chronic Obstructive Pulmonary Disease (COPD), etc.).

NHPCO firmly believes that the six-month prognosis barrier should be reformed to tie hospice eligibility to need, not an arbitrary time limit. This will expand access to hospice and palliative care utilization across all settings for patients and families by developing a model of care which allows patients and families to benefit from the care coordination, care management, and supportive services offered by an interdisciplinary team earlier in the patient's disease trajectory. We ask for your Administration's support in advancing this goal.

Increase Hospice Access in Rural and Underserved Areas

Section 132 of the Consolidated Appropriations Act, 2021, formerly known as the "Rural Access to Hospice Act" (H.R. 2494/S.1190), allows Rural Health Centers (RHCs) and Federal Qualified Health Centers (FQHCs) to furnish and bill for hospice attending physician services when RHC and FQHC patients become terminally ill and elect the hospice benefit, beginning January 1, 2022.

NHPCO is thrilled by the passage of this law because this ensures that some of the most underserved beneficiaries can choose the RHC or FQHC provider they know and trust to serve as their attending physician while receiving the hospice interdisciplinary and person-centered care they deserve nearing the end of life.

We look forward to working with CMS and HHS on the implementation of new billing rules for RHCs and FQHCs and stand ready to offer assistance with this effort.

Strengthen the Hospice and Palliative Care Workforce

There is a shortage of adequately trained hospice or palliative care providers, and the current rates of educating and training medical professionals in palliative care and hospice will not be sufficient to ensure aging Americans access to quality palliative and hospice care. Estimates show that there will be no more than 1 percent growth in the palliative care and hospice physician workforce in the next 20 years, while the number of people eligible for palliative care will increase by over 20 percent. Without a boost for palliative care education and training, there will be only one palliative physician for every 26,000 seriously ill patients by 2030. We request your support for the passage of the Palliative Care and Hospice Education and Training Act (PCHETA) to address these workforce shortages and the commensurate funding to address these shortages during the 117th Congress.

Additional Priorities

In addition to the above priority recommendations for your first 100 days, we have included additional policy priorities that we ask your Administration to consider.

Specifically, more work is needed to ensure that poor performing hospices get the additional support needed to improve or begin the decertification process. In recent years, hospice program integrity issues have been identified in HHS Office of Inspector General (OIG) reports, by CMS-contracted auditors and by Medicare Administrative Contractors. The focus has been on hospice

general inpatient care, eligibility, long lengths of stay, complaints, and fraud and abuse. Hospice providers are also surveyed on a regular basis to ensure compliance with Medicare's regulations.

NHPCO supports smart oversight when it does not hinder access to high quality care for patients and their families. We look forward to working with your Administration on implementation to ensure that new program integrity standards will not adversely impact access to hospice care.

Improve Education and Training for Auditors

Providers report that often the CMS-contracted auditors do not have the necessary knowledge of the requirements of the Medicare Hospice benefit and providers must provide education during the audit process. NHPCO has been actively involved in discussions with the OIG and in providing education and resources to hospice providers to address OIG report findings and improve operations. We recommend that your Administration work with Medicare audit contractors to ensure that auditors are knowledgeable about hospice and do not overreach in their audit findings.

Support the Role and Responsibility of the Hospice Physician

NHPCO strongly supports both the role and responsibility of the hospice physician in making determinations about initial and continuing eligibility for hospice care. NHPCO supported the decision of the court in United States v. Aseracare, Inc. (11th Cir. 2019), where when two physicians reasonably exercise their clinical judgment and come to two different conclusions about a patient's six-month prognosis (and therefore hospice eligibility), neither would be wrong. Therefore, such good faith disagreement, alone, would not support an FCA lawsuit.

A new case, United States ex rel. Druding v. Care Alternatives (3rd Cir. 2020), is being reviewed for potential consideration by the Supreme Court that a reasonable difference of opinion between physicians concerning a hospice patient's prognosis presents an issue that should be resolved by a jury. NHPCO has filed an amicus brief in support of Care Alternatives and to settle a circuit court split.

Improve the Hospice Survey Process

Through implementation of the Consolidated Appropriations Act, 2021, we request that the Administration work with HHS and CMS to improve hospice surveyor training and reporting of survey findings from both state survey agencies and accreditation organizations.

Develop a Sanctions Process for Poor-Performing Hospices

When the OIG published two reports on hospice in July of 2019, they identified that there were no "intermediate sanctions" for CMS or surveyors to use other than decertification. NHPCO is already in discussions with CMS on how the sanctions process should be developed and look forward to a collaborative effort with the Administration. We encourage HHS to place the development of the processes for sanctions for poor performing hospices as a high priority.

Implement a Special Focus Program

Some poor-performing hospice providers need extra education, support and more frequent surveys to improve. This special focus includes surveys much more frequently, as well as

regular reporting and contact to evaluate progress and improvement. A hospice would be removed from the special focus program once they have demonstrated sufficient improvement and have addressed their survey deficiencies. We recommend that your Administration work with CMS and with NHPCO to develop details for a centralized hospice special focus program to be implemented in 2022.

Implement the Hospice Quality Withhold

Since the beginning of the Hospice Quality Reporting Program (HQRP), there has been a 2% payment reduction for hospices not participating in hospice quality reporting. The Consolidated Appropriations Act of 2021 increases the payment withhold to 4% as an additional incentive to participate in hospice quality reporting. We look forward to supporting the implementation of the 4% reduction in payments for hospices not participating in quality reporting, beginning with the FY2022 data reporting year for payment impact in FY2024.

Increase Medical Review for Hospices with a High Percentage of Long Stay Patients

The IMPACT Act of 2014 has a provision that allows CMS to implement additional oversight of hospices with a "high percentage of patients qualifying as long lengths of stay (more than 180 days). The "high percentage" has not been identified and the provision has not been implemented by CMS. We ask for the Administration's help in revisiting these discussions as a way to provide additional medical review for hospices with significant numbers of long stay patients.

Thank you for your consideration of our policy priorities. On behalf of our members and the hospice and palliative care community, we look forward to working with your Administration to swiftly address the COVID-19 crisis and improve access to high quality care for all Americans. If you have questions or would like to discuss these priorities in more depth, please contact Annie Acs, Director of Health Policy & Innovation, at aacs@nhpco.org and Hannah Yang Moore, Chief Advocacy Officer, at hmoore@nhpco.org.

Sincerely,

Edo Banach, JD
President and CEO