January 5, 2024

RE: *Protect rural and frontier American's access to hospice and palliative care*

Dear Members of Congress:

The undersigned organizations – representing rural and frontier hospice and palliative care providers from across the United States – urge you to act to strengthen support for rural and frontier Americans with serious illness and at the end of life. As providers, we are integral parts of our communities but are struggling with issues threatening our ability to survive.

Hospice and palliative care are philosophies of care addressing the whole person, not just physical aspects of health or illness. Both types of care employ an interdisciplinary approach to care with assessments of multiple domains of the human experience (physical, psychological, spiritual, cultural, practical). Hospice and palliative care engage the patient and their loved ones in the care planning process to address pain and symptoms negatively impacting a person's quality of life. Hospice and palliative care empowers a patient to take charge of their care and respects the significant role families and caregivers play in supporting and maintaining health and well-being. With Medicare accounting for the overwhelming majority of hospice payments, we are at the mercy of the Federal government to continue providing high quality care. Recent research estimates hospices save Medicare $3.5 billion annually when comparing beneficiaries who use hospice and those who do not in their last year of life. Thus there is a strong financial incentive, as well as the benefits of allowing beneficiaries to access care in their community by their community to invest in and support rural providers.

Rural providers are faced with similar challenges to our peers in urban and suburban communities but are also faced with unique challenges such as:

- **Lower effective payment rates**: Due to the structure of the Medicare wage index system, rural and frontier providers face a lower payment rate without consideration of rural-specific expenses such as larger service areas. In rural and frontier communities, we are covering even more mileage to ensure all individuals who need hospice and palliative care are able to access it which incurs additional costs. With Medicare accounting for over 90% of our revenue, we can ill afford to cover costs elsewhere — unlike other types of providers. In other words, we are almost entirely dependent on Medicare payments to continue providing high quality care. In addition, the current wage index system utilizes inpatient hospitals to set labor market area wage indexes for post-acute providers such as hospices. Rural hospice and palliative care providers wages and mix of staff are not similar enough to inpatient hospitals for these wages to be accurate for us.

  Rural hospice providers are struggling to stay financially viable and for many are relying on community good will and donations to keep our doors open. Medicare beneficiaries and their families in rural communities are dependent upon us to receive medically appropriate hospice care. Without sufficient access to hospice services or palliative treatment, patients and their

families will have to turn to emergency rooms, resulting in worse patient outcomes and increased costs to Medicare.

- **Closing of partner providers and facilities**: Patients are losing access to important services due to the closure of rural providers and facilities across the healthcare system. To continue to do our work, we need to have nursing facilities and hospitals available to partner with to provide all aspects of the comprehensive hospice benefit. Congress needs to investigate the causes and impacts of these closures as well as find incentives for all providers to enter and stay in rural and frontier communities.

- **Access to Medicare certified facilities**: Certain Critical Access Hospitals (CAH) have the flexibility to provide swing bed services by using beds for either acute care or a skilled nursing facility (SNF) level of cares, which are paid based on cost. This flexibility is critical to CAHs' efforts to serve their communities but results in an unintended consequence of lower Medicare payments to CAHs for hospice general inpatient (GIP) care than skilled nursing care. GIP is short-term hospice care provided to a patient to manage acute or chronic pain or symptom control that can only be managed in the inpatient setting. All Medicare hospice providers are required to provide the GIP level of care in a Medicare certified hospice inpatient facility, a Medicare certified hospital, or a Medicare certified skilled nursing facility with a registered nurse available 24 hours a day to provide direct patient care. However, when a CAH prioritizes its beds internally it causes a shortage for hospice providers due to decreased access to CAH beds for hospice GIP services. When a patient has elected hospice at a community-based provider and the hospice does not have access to beds at the CAH, there is a disruption in services which can be jarring for both the patient and the family. These patients are required to be discharged from the hospice benefit to utilize the CAH swing bed. This discharge means patients lose the interdisciplinary team of hospices, the patient's comprehensive plan of care, and, if the patient dies in the hospital, they lose access to up to 13 months of bereavement care for the loved ones of the patient. We want patients to have continuous and seamless care from their home to the hospital and we want to partner with other providers in our community but this must be beneficial for all parties.

  In addition, a CAH providing hospice care requires the CAH to provide the services at a loss – something they are willing to do because they are committed to providing meaningful end-of-life care. But given the prevalent workforce crisis, CAHs experience their own challenges and can ill afford resource constraints while providing for their communities. We must ensure patients have access to the entirety of their Medicare Hospice Benefit in their community while rural hospitals have financially viable options to support the use of their beds.

- **Staffing shortage:** Our nation faces an unprecedented healthcare workforce shortage, which predated COVID-19 but has only been exacerbated since the pandemic began. During one of the nation's worst public health crises, we struggled to keep our doors open and serve patients largely due to a shortage of healthcare workers and growing wage pressures competing with other healthcare providers for workers. As the U.S. population continues to age, the demand for hospice and palliative care services will continue to grow.

The interdisciplinary team (IDT) is a critical requirement of hospice and palliative care benefit as the IDT drives holistic and comprehensive care for patients and families. A hospice IDT includes physicians, nurses, hospice aides, social workers, counselors, chaplains, therapists, and trained volunteers. However, we are struggling to maintain these required teams, especially for nurses, social workers, and aides. Due to IDT members completing visits in a patient's home independently, hospices generally need staff who have experience furnishing end-of-life care. This necessity further limits the pool of candidates who are qualified to serve in hospice and palliative care roles. In addition, the healthcare workforce is aging and we are not prepared for the impacts of physicians leaving the field.

With the recent proposal for staffing requirements for nursing facilities, nursing facilities will need to provide additional incentives to both attract and retain a skilled workforce . This will exacerbate the staffing shortages even more for rural and frontier hospices who cannot afford to compete with these incentives. Nursing facilities who are not able to meet the staffing minimums will likely have to close, which is one less facility in our community to meet the needs of beneficiaries.

Despite the need to provide retention bonuses and incentives to minimize staff vacancies and entice new staff to join our teams, hospices are not able to compete with hospitals, staffing agencies, and other post-acute healthcare providers. Hospices, like many post-acute providers, compete for a limited pipeline of healthcare workers and the imposition of additional staffing requirements for nursing facilities will reverberate throughout the post-acute care community – stretching limited resources particularly in rural and underserved communities. We need support in examining the causes and impacts of these workforce struggles as well as help in finding incentives for clinicians to practice in rural and frontier communities.

- **Staff safety**: Hospices meet patients where they live, most often in their home at all times of the day and night. Doctors, nurses, and social workers are increasingly finding themselves in dangerous situations in homes. Our workers are often entering a home alone and may be exposed to a variety of threats including guns and other weapons, illegal drugs, verbal abuse, and other aggregating factors such as substance abuse and serious mental illness. These threats can also be present in their patient's neighborhood.

  Beyond these potential threats in patients' homes, members of the IDT are going into remote, rural and frontier areas where they lack cell services, are traveling down unpaved roads, and interacting with a variety of other obstacles. There have been situations where members of our teams cannot find the home of their patient from unmarked roads with minimal to no access to cell service to reach out to the patient. In other situations, a team member has a vehicle issue and no way to contact the patient or their office to inform anyone where they are or able to access help.

  These threats often mean sending more than one member of the IDT to a home, connecting with protective services, and even requesting police escorts. These steps can help reduce the threat of harm but do not eliminate it. In the long run, they accumulate and escalate burnout rates for our team members as well as increasing cost without increasing access to care or quality of care.

- **Telehealth and broadband access**: Throughout the COVID-19 public health emergency (PHE), hospice and palliative care providers had access to telehealth which maintained care access for patients and communities with limited access to transportation. A key benefit to telehealth is being able to share appointment links with long distances family members so they can, with the patient's consent, be included in care planning and decision making. We have always focused on not only caring for the patient but also their loved ones. Telehealth was essential in caring for the patient's community regardless of where they are located. However, as rural and frontier providers, broadband access is an issue. Audio-only telehealth visits for limited services for rural and frontier Medicare beneficiaries would allow continued access to our patients and families. Although telehealth and specifically audio-only visits cannot address all issues and are not appropriate in all situations, it is important to provide this minimum standard for some communities.

Rural and frontier hospice and palliative care providers are committed to continuing to care for our communities despite being faced with lower effective payment rates, facilities closing in our community, and workforce struggles but we need your support. We are committed to providing access to quality care to our communities but we need partners to investigate and better understand the issues we are facing and help find creative solutions to address them.

We appreciate your commitment to rural and frontier patients, families, and providers and we look forward to collaborating with you to address these challenges to ensure Americans across the country continue to have access to high-quality hospice and palliative care in their community. For any follow up questions, please reach out to Logan Hoover, Vice President Policy and Government Relations, National Hospice and Palliative Care Organization at LHoover@nhpco.org.

Sincerely,

Hospice Providers
Avow Hospice, inc. (FL)
Big Bend Hospice Inc (FL)
Bluegrass Care Navigators (KY)
Brookestone Home Health & Hospice (NE)
Care Initiatives Hospice Greenfield (IA)
Care Initiatives Hospice Oskaloosa (IA)
Carilion Clinic (VA)
Central Wyoming Hospice & Transitions (WY)
Chadron Community Hospital Hospice Services (NE)
Chautauqua Hospice & Palliative Care (NY)
Clarion Forest VNA, Inc. (PA)
Coastal Hospice (MD)
Comforting Hands Hospice of Grove LLC (OK)
Community Healthcare and Hospice (NE)
ConnectionsPlus Healthcare + Hospice (VA)
Cottonwood Hospice (NE)
Good Samaritan Society Hospice (MN)

Grand County Hospice (UT)
Gundersen Palmer Hospice (IA)
Gunnison Valley Hospice (UT)
Halo Hospice (OK)
Harrison County Home Health and Hospice (MO)
Harry Hynes Memorial Hospice, Inc. (KS)
Hawaii Care Choices (HI)
Help for Health Hospice Inc (WY)
Hillcrest Hospice (IA)
Home Hospice of Odessa/Midland, LLC (TX)
Hope Hospice & Palliative Care (TX)
Horisun Hospice (NE)
Horizon Hospice Specialists (UT)
Hospice of Columbus Community Hospital (NE)
Hospice of Dubuque (IA)
Hospice of Guernsey, Inc. (OH)
Hospice of Huntington Inc. (WV)
Hospice of Montezuma (CO)
Hospice of Murray County (MN)
Hospice of North Idaho (ID)
Hospice of Northeast Missouri (MO)
Hospice of Northwest Ohio (OH)
Hospice of Redmond (OR)
Hospice of the North Country (NY)
Hospice of the Ozarks (AR)
Hospice of the Prairie & Prairie Home Health (KS)
Hospice of Warren County (PA)
Hospice Services of Northwest Kansas (KS)
Hospices of the Plains, Inc. (CO)
Journey Hospice (WV)
Kittitas Valley Healthcare (WA)
Meadowlark Hospice (KS)
Monarch Hospice & Palliative Care (KS)
Parentis Hospice (CA)
Pennyroyal Hospice (KY)
Sangre de Cristo Community Care (CO)
Serenity Hospice and Home (IL)
Solomon Valley Hospice (KS)
SOMC Hospice (OH)
St. Catherine Hospice (KS)
Stillwater Hospice (IN)
True Hearts and Hands Hospice, LLC (TX)
United Hospice Service (MI)
VNA of Texas (TX)
WhidbeyHealth Hospice (WA)
Zoe Hospice LLC DBA La Diferencia Hospice (TX)

State Associations
Association for Home & Hospice Care of North Carolina
Children's Hospice and Palliative Care Coalition of California
Homecare and Hospice Association of Utah
Hospice & Palliative Care Network of Maryland
Hospice and Palliative Care Association of Iowa
Hospice and Palliative Care Association of NYS
Hospice Council of West Virginia
Illinois Hospice and Palliative Care Organization
Kansas Hospice and Palliative Care Organization
Louisiana-Mississippi Hospice & Palliative Care Organization
Oregon Hospice & Palliative Care Association
South Carolina Home Care & Hospice Association
South Dakota Assoc. of Healthcare Organizations
Tennessee Association for Home Care
Washington State Hospice & Palliative Care Organization

National Organizations
Axxess
National Hospice and Palliative Care Organization