AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

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Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

RE: Request for Information; Reducing Administrative Burden to Put Patients Over Paperwork [CMS-6082-NC]

Dear Ms. Verma:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Request for Information on Reducing Administrative Burden to Put Patients Over Paperwork. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for patients facing serious illness, as well as their families and caregivers.

Below we offer our suggestions on opportunities to reduce burden for AAHPM's members and the vulnerable patients they serve. This feedback addresses concerns related to the following:

- Certification Requirements for Hospice
- Hospice Service Delivery Requirements
- Local Coverage Determinations
- Prescribing Authority of Physician Assistants
- Expanded Availability of Telehealth

Certification Requirements for Hospices

Medicare beneficiaries must have physician certification of terminal illness for hospice eligibility and must be recertified for continued eligibility with each hospice benefit period.

Face-to-Face Requirement

With passage of the Affordable Care Act in March 2010, Congress required hospice physicians or hospice nurse practitioners (NPs) to have a face-to-face encounter with Medicare hospice patients

prior to the third benefit period and every benefit period thereafter, and to attest that the encounter occurred, as part of the eligibility recertification process. CMS implemented the policies related to this new requirement (which became effective on January 1, 2011) in the Home Health Prospective Payment System Rate Update for Calendar Year (CY) 2011; Changes in Certification Requirements for Home Health Agencies and Hospices Final Rule.[1]

CMS expanded the time frame for face-to-face encounters to 30 days prior to the start of the third benefit period, and each subsequent benefit period, as specified at 42 CFR 418.22(a)(4). CMS stated, "We believe this additional time will provide hospices with the flexibility they need to meet this Congressional mandate, to provide adequate time for discharge planning when indicated, and to accommodate other logistical issues discussed in the public comments." However, a face-to-face encounter is just part of the recertification process, and the entire recertification, including the physician's certification of terminal illness, cannot be completed more than 15 days prior to the start of the benefit period under 42 CFR 418.22(a)(3). While the expanded time frame for the face-to-face visit is welcome, the recertification time period and the face-to-face encounter time period do not match. This discrepancy creates challenges with respect to tracking and coordinating completion of the multiple required activities. ***AAHPM suggests allowing both the face-to-face encounter requirements and recertification requirements to occur up to 30 days prior to the start of a benefit period, instead of maintaining the currently conflicting timelines.***

Furthermore, although we recognize that it is required under current statute, ***AAHPM strongly supports elimination of the face-to-face visit requirement for the third benefit period and beyond.*** These face-to-face visits are particularly burdensome for patients in rural and remote areas, where hospice physicians and nurse practitioners must often drive long distances to reach hospice patients in their place of care, given the challenges associated with mobility and transportation for seriously ill patients. Furthermore, there is little or no evidence to demonstrate that the face-to-face visits enhance care or prevent long stays.[2]

Newly Admitted Patients

CMS currently allows 2 calendar days after a new hospice admission for a hospice (by the end of the third day) to provide either a written or a verbal certification or recertification of a patient's terminal illness. Under 42 CFR 418.22 (a)(3), if the hospice cannot obtain the written certification within 2 calendar days after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

AAHPM has heard from our members that the 2-calendar day requirement creates a great deal of burden not only for hospices and hospice physicians, but also for beneficiaries who may need urgent or emergent hospice care. In practice, in can be difficult to get attending

[1] Since beneficiaries can go in and out of hospice, and each benefit period ends as soon as a patient leaves hospice care, the third benefit period sometimes starts before the patient has received 180 days of care. In the 2012 Hospice Final Rule, CMS stated: "We decided that the 180th-day recertification and subsequent benefit periods corresponded to the recertification for a patient's third or subsequent benefit period."

[2] Harrold J, Harris P, Green D, Craig T, Casarett DJ. Effect of the Medicare Face-to-Face Visit Requirement on Hospice Utilization. *Journal of Palliative Medicine*. 2013;16(2):163-166. doi:10.1089/jpm.2012.0349. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3569924/

physicians who are not hospice employees to respond to calls within 2 calendar days when seeking verbal certification. If an admission falls on a Friday evening, for example, a hospice nurse would be required to attempt to reach the physician over the weekend.

The current timeline can be further challenging for patients who may come on service with previous hospice experience or be transferred directly from another hospice. For these patients, it is often difficult to determine whether a face-to-face visit is needed at the time of admission and, if so, to effectuate such a visit in a timely manner, given limited availability of physicians or NPs who are available to make urgent face-to-face visits prior to admission or within 2 calendar days after admission. This is particularly true if the visit must occur emergently on a weekend, and the patient is suffering and requires immediate hospice care.

To relieve the burden associated with this requirement and ensure timely access to hospice care for vulnerable patients, ***AAHPM suggests allowing for a full week to obtain the verbal or written certification of terminal illness, including completing a face-to-face visit as needed, particularly in consideration of constraints in the hospice physician and nurse practitioner workforce. At a minimum, we request that the allowance be changed to 2 business days for these 'start of care' face-to-face visits, rather than 2 calendar days.***

Hospice Service Delivery Requirements

Continuous Home Care (CHC) Requirements

Patients that would benefit from CHC services late in the day do not have access under current Medicare rules. This is because regulations at 42 CFR 418.302 specify that a minimum of 8 hours of care must be furnished on a particular day, defined as midnight to midnight, to qualify as CHC and be reimbursed at the CHC rate. AAHPM believes this policy serves as a barrier to the delivery of clinically appropriate hospice care that can lead to patient harm and hospice burden. ***AAHPM urges CMS to take administrative action to eliminate this barrier. To begin, AAHPM requests that CMS reduce the required minimum duration of CHC care from 8 hours to 4 hours so that patients who could benefit from CHC in the evening would have access. Additionally, AAHPM recommends that CMS allow hospices to bill and receive payment for CHC if the duration of care requirement (i.e. 4 hours of CHC under the AAHPM recommendation) is met in a 24-hour period, rather than requiring those hours of care to be provided within a single calendar day.***

Alignment of Services Eligible for CHC and Service Intensity Add-on Payments

Regulations at 42 CFR 418.302(b)(2) specify that hospices may receive payment for CHC furnished during brief periods of crisis as necessary to maintain the patient at home, and also specify that CHC consists primarily of nursing care but can also include hospice aide or homemaker services or both, provided care is furnished on a continuous basis. Regulations at 42 CFR 418.302(b)(1)(i) and (ii) specify that hospices may receive a service intensity add-on (SIA) payment to their routine home care days in the last 7 days of a patient's life for up to 4 hours of care provided a day by either a registered nurse (RN) and/or a social worker.

AAHPM believes that these restrictions on the types of personnel who may provide services under CHC versus SIA creates unnecessary burden that reduces flexibility for hospices and prevents patients from receiving the services most appropriate to address their hospice care needs. Instead, ***AAHPM recommends that CMS increase flexibility with respect to the types of personnel who can provide services for CHC or SIA payment – including by allowing social worker services to count towards CHC and allowing hospice aide and homemaker services to count towards the SIA payment.*** AAHPM believes that this added flexibility will reduce burden for hospices as they schedule and arrange for care, and that it would also increase incentives to furnish CHC more generally. AAHPM also notes that the SIA payment is based on the hourly CHC payment rate, suggesting that the care requirements should likewise be equivalent across the two types of service.

Local Coverage Determinations (LCDs)

LCDs as Guidelines for Hospice Eligibility

Medicare statute and regulations specify that eligibility for hospice is based on certification of an individual's terminally ill status, as determined by the clinical judgment of the individual's attending physician and/or the hospice medical director. AAHPM has concerns that LCDs issued by Medicare Administrative Contractors (MACs) regarding hospice – when used to specify clinical criteria for hospice eligibility – undermine the role of physician clinical judgment and may create barriers to care for patients who may be certified as terminally ill but may not meet coverage criteria included in LCDs. This is particularly problematic when MACs do not update LCDs to reflect new research and evidence regarding terminal illness and prognostication. For example, the Palmetto LCD on Hospice Alzheimer's Disease and Related Disorders (L34567) requires a FAST score of 7, which in fact doesn't have solid prognostic value, while other factors that contribute to a limited prognosis have not been included, such as age of onset, rapidity of disease progression and presence of neuropsychiatric symptoms.[3] In addition, many of the existing LCDs do not adequately address how multiple morbidities relate to terminal status, yet increasingly patients present with multiple morbidities that cumulatively contribute to their hospice eligibility.

Given the above, AAHPM has serious concerns with the use of LCDs to dictate rules for hospice eligibility. ***AAHPM recommends that CMS ensure that LCDs are not used as criteria for determining hospice eligibility, but rather that they are used as guidelines only, and that CMS make clear that LCDs do not encompass the full range of diagnoses or conditions that would qualify an individual for hospice eligibility.***

Prescribing Authority of Physician Assistants

AAHPM encourages CMS to correct an outdated hospice Condition of Participation (CoP) that prevents physician assistants (PAs) from ordering medications for hospice patients. Until recently, PAs were prohibited by statute from serving as the "attending physician"

[3] Peters, M. E., Schwartz, S., Han, D., Rabins, P. V., Steinberg, M., Tschanz, J. T., & Lyketsos, C. G. (2015). Neuropsychiatric Symptoms as Predictors of Progression to Severe Alzheimer's Dementia and Death: The Cache County Dementia Progression Study. *American Journal of Psychiatry,172*(5), 460-465. doi:10.1176/appi.ajp.2014.14040480 https://www.ncbi.nlm.nih.gov/pubmed/25585033

responsible for establishing and periodically reviewing the plan of care for hospice patients. This role was limited to physicians and nurse practitioners (NPs). Federal legislation (the Medicare Patient Access to Hospice Act, enacted as part of the Bipartisan Budget Act of 2018) and, subsequently, CMS regulation have broadened the Medicare definition of hospice "attending physician" to include PAs. As of January 1, 2019, PAs are permitted to provide and manage care for hospice beneficiaries. Despite the statutory and regulatory changes authorizing PAs to serve as a hospice patient's attending physician, CMS's reliance on an outdated CoP, 42 CFR 418.106(b), prohibits PAs from carrying out an essential component of the attending physician role, which is ordering medications for hospice patients. The CoP only lists physicians and NPs as being able to order medications, but not PAs. Now that PAs are authorized as attending physicians for hospice, AAHPM believes there is no reason they should be excluded from being able to order medications. PAs are authorized to prescribe in all 50 states and the District of Columbia and have been prescribing to Medicare beneficiaries outside of the hospice benefit for decades.

AAHPM appreciates that CMS has included a proposal in the Calendar Year 2020 Medicare Physician Fee Schedule that would address this issue in part, by specifically proposing that CMS would permit a hospice to accept drug orders from a physician, NP, or PA. CMS proposes that the PA must be an individual acting within his or her state scope of practice requirements and hospice policy. However, CMS specifies that the PA must be the patient's attending physician, and that he or she may not have an employment or contractual arrangement with the hospice. AAHPM does not believe that such restrictions are appropriate or in the best interest of hospice patients. Additionally, they are not consistent with other efforts by CMS to reduce burden by allowing clinicians, including PAs, to practice within their state's scope of license. As such, ***AAHPM requests that CMS take action to allow PAs to fulfill their patient responsibilities as attending physicians, including by reopening the hospice CoPs in order to specify that PAs may prescribe medication to Medicare hospice patients, regardless of whether the PA has an employment or contractual relationship with the hospice.***

Expanded Availability of Telehealth

Removal of Geographic and Originating Site Restrictions for the Use of Telehealth to Deliver Palliative Care

AAHPM is concerned that seriously ill patients who require palliative care services may face significant barriers to accessing such services due to current geographic restrictions on the use of telehealth. Seriously ill patients requiring palliative care often have complex medical conditions, which may contribute to pain and limited mobility. And while the use of telehealth services may be most critical for patients in remote and rural areas, given distance and transportation challenges, delivery of palliative care in patients' homes through the use of telehealth can benefit patients regardless of urban or rural settings. For example, telehealth services can help clinicians intervene earlier with recommended treatments or solutions if patients experience functional decline or other new symptoms.

While we recognize that geographic restrictions for use of telehealth are specified in statute,

AAHPM strongly supports an exception from the geographic restrictions for the delivery of palliative care services, including allowing the delivery of telehealth in patients' homes and the use of telehealth for any face-to-face visits that may be required for recertification. We ask CMS to engage with Congress on the need for such an exception. Furthermore, we ask CMS to pursue all available opportunities to expand the use of telehealth for the delivery of palliative care, including through use of its waiver authority under current and pending alternative payment models, such as the Primary Care First Serious Illness Population option.

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Thank you again for considering ways to reduce administrative burden so that clinicians can best focus their attention on delivering high-quality care for Medicare beneficiaries. AAHPM appreciates the opportunity to offer feedback that aligns with the Patients Over Paperwork initiative and stands ready to collaborate with CMS to address the challenges discussed here. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,

Joanne Wolfe, MD MPH FAAHPM
President
American Academy of Hospice and Palliative Medicine