AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically via regulations.gov

June 9, 2020

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; FY 2021 Hospice Wage Index and Payment Rate Update [CMS-1733-P]

Dear Administrator Verma:

On behalf of the nearly 5,500 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the fiscal year (FY) 2021 Hospice Wage Index and Payment Rate Update proposed rule. 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.

AAHPM's members care for our nation's sickest and most vulnerable patients, including those with terminal illness who have elected the Medicare hospice benefit. Hospice and palliative care providers offer expert pain and symptom management and skilled communication as they discuss a patient's prognosis, goals and preferences for care; ease their suffering and anxiety; and support their family and caregivers. While their work always presents challenges, during the current global pandemic, our members must contend with some of the most difficult circumstances as they aim to ensure that patients with terminal illness, including those diagnosed with COVID-19, receive high-quality care that provides them with dignity, compassion, comfort, and peace of mind at the end of life. This is particularly true as facilities place restrictions on in-person visits by family members and healthcare personnel, and patients face the possible anguish of isolation in their final days. Moreover, our members report additional challenges related to securing adequate personal protective equipment (PPE); implementing policies and technologies necessary to maintain social distance and limit the spread of the coronavirus across patients, families, and the healthcare workforce; and educating patients on safety and prevention measures.

At the same time, our members have been aided by new flexibilities offered by CMS to care for patients during the pandemic, and ***we thank CMS for the many waivers and regulatory changes it has put in place to ease burdens on hospices and other healthcare providers and to facilitate delivery of care as we contend with the current public health emergency.*** These include changes such as increased flexibility to

use telecommunications systems in the delivery of routine home care, waiver of onsite visits for hospice aide supervision, postponing of annual training requirements, and more. However, we offer additional recommendations below that we believe are necessary to provide hospices with the additional resources, flexibilities, and clarification to enable them to continue to deliver high-quality patient care as the public health emergency persists.

Election Statement and Election Statement Addendum Requirements

To begin, ***AAHPM respectfully requests that CMS delay the implementation of the election statement content modifications and the election statement addendum.*** As noted above, hospices are facing significant challenges as they respond to demands of delivering care during the public health emergency. The election statement and election statement addendum requirements that CMS finalized in rulemaking last year for implementation in fiscal year 2021 require significant modifications to hospices' policies and procedures, clinical and administrative operations, and information technology systems. However, these modifications are competing with the new protocols and resource needs that hospices are facing to deal with the novel coronavirus. AAHPM believes that these requirements are placing an undue burden in light of the public health emergency and that relief is needed. To ensure that hospices have the resources and capabilities to implement these changes, we suggest that CMS delay the implementation date by at least one full federal fiscal year after the end of the COVID-19 public health emergency.

Additionally, ***AAHPM requests that CMS provide clarification on the use of electronic signatures to sign the election statement and election statement addendum.*** CMS states that "if the individual electronically signs the election statement, there is nothing prohibiting the hospice from having the addendum electronically signed." However, CMS also states that contractors have discretion as to how they address patient or representative electronic signatures, and that hospices should confirm the use of electronic signatures with their Medicare contractors. We have concerns that the use of electronic signatures is subject to local policies, and ***we ask that CMS issue clear guidance that specifies the conditions under which electronic signatures may be obtained for the hospice election statement and election statement addendum that applies across the Medicare program.*** We note that requiring in-person signatures is very difficult given the public health emergency and that, even under normal circumstances, obtaining in-person signatures can exhaust significant resources with minimal benefit relative to the use of electronic signature options. By issuing clear guidance as requested, CMS will provide hospices certainty regarding the use of electronic signature collection tools, thereby allowing hospices to rely on electronic signatures with confidence and minimize burden associated with in-person signature collection.

Use of Telecommunications Technology in Completing the Hospice Face-to-Face Visit for Recertification

AAHPM thanks CMS for its temporary policy in response to the COVID-19 public health emergency to allow hospices to use telecommunications systems to complete the administrative function of conducting a face-to-face encounter for the purposes of hospice recertification starting with the third benefit period. This policy helps to mitigate unnecessary exposure of clinicians and hospice staff to COVID-19 infection and protect patients and families who may otherwise have risked infection during face-to-face interactions. It also preserves hospices' limited personal protective equipment (PPE) for use when patients' conditions require symptom-related visits and care of the dying. Both reasons support the use of telehealth to complete the face-to-face recertification evaluation during the public health emergency.

At the same time, we also recognize that greater accommodations are required during this pandemic, when reliance on telecommunications systems to deliver care is at an all-time high. Specifically, ***we urge CMS to allow the requirements of the hospice recertification encounter to be met via an audio-only visit with the patient, including by working with Congress to secure any legislative fix that may be necessary to allow for this additional flexibility.***

Hospice patients are commonly older, frail Medicare beneficiaries who may lack access to the technology necessary to utilize the video component of telecommunications systems or otherwise be incapable or unwilling to do so. For example, our members share that they see many homebound elderly patients who have similarly elderly caregivers who cannot negotiate the installation or use of smartphone apps. Some patients, particularly in rural communities, may lack the broadband internet access necessary to engage in a video component of a telehealth visit. In such cases, a clinician's inability to meet the requirements of this encounter via audio-only capabilities necessitates an in-person visit, which is accompanied by the need for scarce PPE and potential spread of the coronavirus; otherwise, patients would be at risk of foregoing the benefits of ongoing hospice care.

CMS states that it does not believe that audio-only calls would provide the necessary clinical information for a hospice physician or nurse practitioner (NP) to determine life expectancy.[1] We respectfully disagree. We believe that the majority of the clinical information that a physician or NP will use to determine prognosis and life expectancy actually will be drawn from reports that are provided by hospice nurses who have conducted clinical visits and exams over time and that serve to define a patient's downhill trajectory. No single visit is able to provide that temporal information. Face-to-face encounters using audio and video capabilities may facilitate more efficient determinations; however the challenges of the COVID-19 pandemic have required healthcare providers to identify methods for working within social distancing constraints. In this context, any additional detail that may help complete an assessment of a patient's life expectancy may be obtained by directly questioning the patient or with the assistance of family or caregivers who can relay physical and other information about the patient. Ultimately, we believe that the benefits of relying on these strategies during the public health emergency outweigh the costs of conducting in-person assessment of those patients for whom a video connection cannot be established, and that additional flexibilities are thus needed to protect these vulnerable hospice patients and the clinicians who oversee their care.

Of course, AAHPM has long supported the use of telehealth for the hospice recertification face-to-face visit, not just in the context of the public health emergency. (The Academy is among the 130+ organizations that have endorsed the bipartisan CONNECT for Health Act, which includes a provision to permit the use of telehealth in the recertification of a beneficiary for the hospice benefit.) We note that the face-to-face visit is administrative only and does not provide a medical benefit to the patients for whom they are required. Further, the only independent research conducted to evaluate the impact of the face-to-face requirement showed the in-person face-to-face encounter does not actually have the desired effect of reducing long hospice stays.[2, 3]

[1] CMS. "COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing." Downloaded from https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf on May 5, 2020.

[2] Harrold J, Harris P, Green D, Craig T, Casarett DJ. Effect of the Medicare face-to-face visit requirement on hospice utilization. *J Palliat Med*. 2013;16(2):163–166. doi:10.1089/jpm.2012.0349

[3] Friedman TC. Facing facts: the impact of the face-to-face requirement. *J Palliat Med.* 2013 Feb;16(2):120-1. doi: 10.1089/jpm.2013.9530.

Notwithstanding the above, we reiterate our belief that, from a clinical standpoint, the recertification evaluation can be appropriately completed via telehealth. Allowing the face-to-face visit to be conducted via telehealth would therefore reduce the burden for either hospices that must conduct home visits to complete the assessment, or for those patients and their caregivers who must otherwise travel to their doctors' offices, all while having minimal impact on patient care or eligibility determinations. We would further point out that while the burdens are greatest for those in rural areas – where access to care by hospice physicians or NPs can be limited, and it is not uncommon for these clinicians to have to drive an hour each way for some patients – this scarcity also occurs in non-rural areas, especially when time-critical evaluation is needed (e.g. readmission into a third or later benefit period which requires evaluation before admission, even after hours). For late/urgent admissions, this process delays care due to the need to find a provider to get to the patient. ***We therefore request that CMS exercise all available authorities to enable hospices to continue completing the recertification evaluation via telehealth on a permanent basis, and without geographic restrictions, beyond the end of the public health emergency. To the extent that statutory requirements limit CMS' authority, we also ask CMS to work with Congress to enact legislative changes necessary to allow for this important reform.***

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Thank you again for the opportunity to provide feedback on the FY 2021 Hospice Wage Index and Payment Rate Update proposed rule and on additional policies to support hospice providers during the public health emergency and beyond. Please direct 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,

Rodney O. Tucker, MD MMM FAAHPM
AAHPM President