AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

July 12, 2024

The Honorable Earl Blumenauer
1111 Longworth House Office Building
Washington, DC 20515
Submitted electronically to
DiscussionDraft.Blumenauer@mail.house.gov

RE: *Hospice CARE Act of 2024* Discussion Draft

Dear Representative Blumenauer:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM or Academy), we appreciate your longstanding leadership to improve access to palliative care and hospice. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality, equitable palliative and hospice care.

Below, we provide comments on your discussion draft for the *Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act*.

Section 2. Ensuring the Integrity of Hospice Care Furnished Under the Medicare Program

Subsection (a). Mandatory Temporary Moratorium on Enrollment

Recent data show a worrisome escalation of new hospices being established across just a few states, with numbers far exceeding that needed to ensure access, choice, and quality of care. In many cases, these hospices are not serving patients. However, we believe it is important to allow for appropriate exceptions to target fraud while not adversely impacting patient access to hospice care. Therefore, AAHPM agrees that the Secretary should be directed to impose a temporary moratorium on the enrollment of new hospice programs for a period of 5 years and encourages you to further refine this provision to target likely bad actors rather than all hospices nationally. We support the ability of the Secretary to exempt hospice programs that would serve Medicare beneficiaries in areas with insufficient access to hospice care and suggest you require the Secretary to consider state and local data in making such determinations.

Subsection (b). Authority to Extend Oversight of Newly-Enrolled Hospice Programs

AAHPM supports providing the Secretary authority to extend oversight of newly enrolled hospice programs for up to two years. We highlight the importance of providing the Secretary discretion to apply this authority on a case-by-case basis for those hospices that present the highest risk of fraud and abuse.

Subsection (c). Increase in Survey Frequency for Certain Hospice Programs

AAHPM supports more frequent surveys for new hospices, transitioning to surveys every 36 months once initial surveys do not result in enforcement action for being non-compliant. We note that current surveys might be enhanced by including information that could be used in assessing program integrity, such as the sale or transfer of hospice certification numbers; whether owners or personnel appear on the List of Excluded Individuals/Entities; and whether the provider organization has a corporate compliance plan that aligns with guidance from the HHS Office of Inspector General. Additionally, surveyors should assess whether a hospice program is able (directly or via contract) to provide all four levels of hospice care, as well as after-hours care.

Subsection (d). Prohibition on Payment for Failure to Meet Quality Data Reporting Requirements

AAHPM agrees that hospices should be submitting quality data. At the same time, we recognize that small hospices may not have a sufficient number of cases to report and may have difficulty meeting the reporting requirements. We question whether there will be any accommodations afforded to small hospices to address this concern. We also recognize, however, that bad actors could be modifying hospice programs' organizational structure to present as small hospices, and we believe that any policies for accommodating small hospice programs should account for potential gaming, for example across hospice programs under common ownership.

Subsection (e). Independence of Attending Physician

AAHPM is very concerned that this provision could prevent patients from accessing hospice when they do not have an attending physician or do not have a clinician willing to serve as an attending. Currently, it is very common, even in a medically well-served area, for patients to choose the hospice physician as their attending physician. This is especially true for patients with the highest symptom burden and care needs – that is, those who need the most expertise. Independent attending physicians are encouraged to follow patients with whom they have a relationship (e.g., a patient's oncologist or primary care physician), but this is not the case for many patients. Therefore, AAHPM strongly recommends that the option of a hospice-employed/affiliated physician be retained as a viable option for patients electing hospice. This supports both patient choice and patient access to high quality care.

We understand your desire to target fraud, but this broad change could have a dramatic impact on timely admissions to hospice for many eligible patients. In some cases, community physicians are unwilling to serve as hospice attendings. We note that the Hospice Medicare Manual points out that patients have a right to choose the hospice physician as the attending:

> If a beneficiary does not have an attending physician or a nurse practitioner who has provided primary care prior to or at the time of the terminal illness, the beneficiary may choose to be served by either a physician or a nurse practitioner who is employed by the hospice. [40.1.3.2]

As we read this subsection of the draft legislation, it would take away Medicare beneficiaries' right to choose the hospice physician as the attending when they have not had an attending prior to or at the time of the terminal illness. Perhaps a more directly targeted approach, that would not impact patient choice and access, would be to prohibit excessive compensation and other bonus arrangements tied to certifying individuals as eligible for hospice if a physician is employed by a hospice. In addition, we note that Section 2, subsection (h) of the draft legislation would add hospice as a designated health service for the purposes of the physician self-referral law, which would address cases where a physician has a substantial stake in a hospice.

Subsection (f). Allowing Nurse Practitioners to Certify Terminal Illness

AAHPM believes that determining whether a patient has a life expectancy of less than six months if their disease follows its expected course is a high-order exercise of medical judgment that requires intensive training, careful consideration, and critical thinking. While AAHPM has been and will continue to support the interdisciplinary nature of hospice and palliative care, we do not believe that nurse practitioners have the requisite training to perform this specific task.

We note that improper certification of terminal illness creates risks for a broad range of stakeholders engaged in the delivery or receipt of hospice care. Having appropriate training in medical decision making is vital in determining eligibility for the hospice benefit. For example, if, too narrow criteria are applied, patients who should be eligible for the benefit may be excluded. And if too broad criteria are applied, patients who should not be receiving hospice care may be certified. In instances where too broad of criteria are applied hospice programs may be subject to payment recoupment if retrospective audits reveal patients were improperly enrolled. The Medicare program would also suffer from increased improper payments for eligible patients. Given the existing concerns about improper admission to hospice that have, in part, driven efforts to improve program integrity, we believe that policy options which may reduce the rigor of terminal illness certification are contrary to the current goals of the current hospice reform effort.

Finally, we question what need this provision in the draft legislation is intended to address. Based on our engagement with hospice leaders in our Academy, we have not learned – even anecdotally - of barriers to timely hospice enrollment due to lack of available physicians to certify terminal illness. We therefore believe that the risks of allowing nurse practitioner certification of terminal illness significantly outweigh the benefits, and therefore that certification of terminal illness should remain under the purview of appropriately trained physicians.

Subsection (g). Allowable Use of Supporting Material in Medical Review of Hospice Care

Our members note that the use of supporting material already happens as they use records from the hospital, labs, x-rays, etc. to document hospice eligibility.

Subsection (h). Inclusion of Hospice Care as a Designated Health Service

AAHPM agrees with including hospice as a designated health service for the purposes of the physician self-referral law.

Subsection (i). Prohibition on Certain Changes in Majority Ownership

AAHPM agrees with the change to prohibit the hospice provider agreement and billing privileges to convey to a new owner within 60 months of initial certification (or the last majority change in ownership), rather than 36 months.

Subsection (j). Medical Review of Hospice Outliers and Care Unrelated to Terminal Condition

We are concerned that, as drafted, medical review of all hospice outliers and care unrelated to terminal illnesses could be a huge undertaking that would result in substantial administrative for both the Medicare program and affected hospices. We are also concerned that this provision would severely restrict hospices' willingness to take on challenging yet unpredictable cases where long-term prognosis is uncertain – for example for beneficiaries with Alzheimer's disease and related dementias (ADRD). Therefore, we suggest more targeted reviews focused on providers and suppliers marketing their services and falsely claiming their services are unrelated to a terminal illness.

Subsection (k). Required Provision of Addendum of Non-Covered Services

We are concerned that this provision will increase the administrative burden on hospices as often there are no unrelated items for the addendum. In addition, it may not be clear what should be included in an addendum, e.g., items that are not reasonable and necessary for the palliation of management of the terminal condition.

Subsection (l). Provision of Explanation of Benefits Upon Hospice Election

AAHPM agrees that such notification furnished by the Secretary could identify fraudulent hospices enrolling patients without their knowledge, but questions whether it is feasible to send an Explanation of Benefits out within 15 days. We are unsure whether the cost of sending out this notification will have a meaningful impact in addressing fraud, especially considering how many patients are referred to hospice within days of death.

Subsection (m). Medical Review of Hospice Care Contractor Requirements

We encourage you to consider additional language to require the Secretary to consult with hospice stakeholders to determine what would be included in "specialized instruction on the philosophy behind hospice care and medical prognostication." As discussed in our response to Subsection (f), AAHPM believes that determining whether a patient has a life expectancy of less than six months if their disease follows its expected course is a high-order exercise of medical judgment that requires intensive training, careful consideration, and critical thinking. Ideally, contractors should employ physicians to conduct medical reviews who have both expertise and experience in Hospice and Palliative Medicine physicians. Further, contractors should not rely on artificial intelligence to conduct these reviews.

Also, we are concerned that the proposed reporting date of January 1, 2027, does not allow enough time for the report to Congress on activities relating to the medical review of hospice care. It will be important to include information on any denials that were overturned at the administrative law judge (ALJ) level, where most of the denials are overturned, and can take place years after the initial denial.

Subsection (n). Requiring Face-to-Face Encounters Before Recertifications of Terminal Illness

AAHPM is very concerned that this requirement, including the provision to reduce the window for these visits from 30 to 10 days prior to recertification, will result in a huge burden for hospices, taking clinicians away from true patient care, individuals needing hospice admissions, and individuals experiencing pain crisis. This is particularly concerning given that the face-to-face (F2F) hospice recertification requirement is administrative only and does not provide a medical benefit to the patients for whom they are required. Instead, the current requirement keeps physicians and nurse practitioners tied up with paperwork when they could be helping to treat patients.

If this provision were enacted, it could more than double the number of F2F visits that would have to be conducted. Further, if there is revocation followed by request for readmission, a new F2F encounter could be needed just days or weeks after the initial admission. These burdensome requirements would be difficult even for hospices in well-resourced communities to meet: hospices in rural and urban underserved communities would be further strained, limiting access to care and support for some of the most vulnerable and marginalized Medicare beneficiaries.

Given our concerns about the excessive demands of the new F2F requirements on hospice resources and the challenges hospices would have in completing the visits, we would oppose the inclusion of this provision.

We are also concerned with the provision in the draft legislation to eliminate the option of conducting the F2F visit via telehealth. The ability to conduct these visits utilizing approved telehealth technology has significantly benefited patients and increased the support available to the entire hospice community. For example, hospices often must conduct "emergency F2F" visits, where a patient has previously been in hospice and is referred back, entering their third or subsequent benefit period. These patients require an emergency/urgent F2F visit prior to admission to satisfy regulatory requirements and ensure payment. Unlike most hospice patients entering their third benefit period, for whom F2F visits can be conducted with sufficient advance planning, these emergency F2F visits are unexpected and can create significant burden on hospices to ensure timely re-enrollment. The ability to conduct such visits using telehealth has been critical for enabling access to urgent hospice services, particularly for hospices serving rural and urban underserved communities. Therefore, should this provision remain, we highlight that maintaining telehealth for F2F encounters will be critical to avoid barriers to access especially for rural programs. Therefore, we urge you to strike "(not including any such encounter conducted via telehealth)" on page 21, lines 20-21. Further, we urge Congress to advance the *Preserving Telehealth, Hospital, and Ambulance Access Act* (H.R. 8261) which would ensure the ongoing availability of telehealth for the completion of telehealth F2F visits through further extension of telehealth flexibilities.

Subsection (o). Ensuring Medical Director and Physician Availability

Although we are not aware of how many, if any, physicians serve as medical director of more than two hospice programs, we encourage you to provide flexibility since we are aware of cases where this requirement presents a challenge for small programs and could impact access to hospice for rural beneficiaries. We understand your goal of ensuring medical director and physician availability but recognize that there are reasonable explanations for why physicians may serve more than two hospice programs.

Rather than determining a number and prohibiting the action, we suggest you draft this provision to identify a potential red flag for fraud. There are reasonable explanations why a physician may serve as medical director for two or more hospice programs. In some areas, a hospice physician may be trying to cover 20 counties. That could be accomplished through one large hospice or five small hospices. To avoid inadvertently creating a barrier to care in rural or underserved areas, it may be helpful to flag such instances for further review to see if more careful oversight is needed. It may show that small hospices are benefitting from the specialized expertise of the one HPM physician in the area.

Section 3. Payment Reforms for Hospice Care Furnished Under the Medicare Program

Introductory Comments

AAHPM appreciates that the draft legislation seeks to align payments with the costs of care and that it makes an effort to increase access to medically necessary palliative services for hospice patients. Importantly, however, we highlight that many hospices are currently unable to furnish high-intensity palliative services due to the high costs of delivering those services, particularly small and non-profit hospices.

Hospices incur significant costs when furnishing high-intensity palliative care services, including for the service itself as well as for engaging in the care management and care coordination activities required to ensure services are furnished successfully. Often, hospices must partner with providers to furnish advanced therapies due to factors including limited hospice capacity, the need for specialized expertise that some advanced therapies may require, and/or the specialized equipment that may be required. For example, hospices typically do not own their own dialysis machines and must contract with dialysis providers to furnish palliative dialysis services. Unfortunately, many hospices face difficulty in identifying partners that are willing and/or able to contract for the provision of therapies at reimbursement rates hospices can afford.

Costs for furnishing medications can also be exorbitant and out of reach for many hospices. For example, tetrabenazine, which is palliative for Huntington's disease, can run anywhere from $5,000 to $11,000 for a 30-day supply. Metastatic lung cancer patients now often take erlotinib for palliation, which can cost between $6,200 and $8,400 per month. Immunotherapy drugs like pembrolizumab used for palliation for pancreatic cancer can cost more than $10,000 per month. And inotropes used for congestive heart failure can cost roughly $4,000 to $5,000 per month. When monthly hospice payments of roughly $6,000 to $7,000 per patient are expected to cover the full range of hospice services, it is unsurprising that hospices often cannot manage these additional costs.

To the issue of care management and care coordination activities, hospices can dedicate significant resources when arranging for high-intensity services. To use a simple transfusion as an example, a hospice must first identify a community partner willing to furnish the service at a reasonable cost and arrange for appointments. The hospice must then arrange for a blood draw two days in advance for blood type and crossmatch, determine the appropriate setting for the transfusion and potentially arrange for transportation, and then dedicate nursing services to support patients' post-transfusion in case they have any reactions. For small hospices, undertaking these responsibilities can place a significant burden on their limited resources.

As Congress therefore considers options for reforming hospice payment in a manner that increases hospice patients' access to medically necessary high-intensity palliative care services, we recommend that it adhere to the following principles, which we believe will support the delivery of seamless patient-centered care:

- Patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences;
- Delivery of high-intensity palliative care services should involve both the hospice and non-hospice service provider working together to implement a plan of care; and
- Neither the hospice provider nor non-hospice providers furnishing the high-intensity services should be financially disadvantaged for providing the care.

We highlight that AAHPM supports reforming the Medicare hospice benefit to address numerous structural limitations within the benefit, including to allow for concurrent access to disease-directed treatments. Not only would concurrent care address concerns about insufficient access to high-cost palliative care services, but it would also increase uptake of hospice care by removing the requirement for patients to waive access to all Medicare services related to their terminal condition. This requirement delays hospice election and deprives many beneficiaries and their families/caregivers of the supportive end-of-life care furnished by hospices to which they are entitled. Indeed, research looking at Medicare hospice patients with access to concurrent care services through the Veterans Administration found that patients receiving concurrent dialysis care had substantially longer hospice lengths of stay than those who did not.[1] A separate study on veterans with concurrent care also found that use of high-intensity palliative care services was fairly limited and that the majority of patients died with hospice-style care at home or

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[1] Wachterman MW, Corneau EE, O'Hare AM, et al. Association of hospice payer with concurrent receipt of hospice and dialysis among US veterans with end-stage kidney disease: A retrospective analysis of a national cohort. JAMA Health Forum. 2022;3(10):e223708. doi:10.1001/jamahealthforum.2022.3708.

in inpatient hospice, rather than in acute inpatient hospital settings,[2] suggesting that the ability to access concurrent disease-directed care does not translate into excessive utilization of such services among patients who have elected the hospice benefit. Overall, we believe that concurrent care could move the system further towards a future with an expanded seamless benefit for patients with serious illness, in which patients could access both palliative care services and disease-directed services based on their needs and goals, regardless of their prognosis.

We offer these thoughts as context for our comments below addressing specific provisions in the draft legislation.

Subsection (a). Adjusting Payments for Hospice Care

AAHPM appreciates the effort to align payments with costs of furnishing care. As noted above, however, we are concerned that costs reflected in hospices' cost reports do not reflect the cost of furnishing high-intensity palliative care services, which hospices are routinely unable to bear. We believe further scrutiny is needed to first determine how much it would cost hospices to fully furnish all medically necessary high-intensity palliative care services as part of routine home care (RHC), before aligning payments to that higher cost level, rather than simply looking at current cost reports that could result in reductions to RHC payment rates. We therefore appreciate that the alignment between costs and payments for RHC payment rates is not scheduled until after hospices can collect added payments for "specified hospice care" services, but we note our concerns and reservations about the draft legislation's approach for those services further below. We also highlight that many hospice providers – particularly rural providers – struggle financially, leading to limited access for patients. As such, we urge special payment accommodations to ensure that rural hospices do not face reductions in RHC payments under any final payment reforms.

With respect to deconstructing payments for RHC services to reflect direct patient care costs versus other costs not related to direct patient care, we appreciate that this approach is again seeking to align payments with costs. We also recognize that costs may vary based on setting – for example, with costs in skilled nursing facilities less than those for services furnished to patients in their homes. However, we are concerned that this proposal would lead to significant administrative burden and costs on the part of hospices related to tracking characteristics of each visit, and that such burden would not outweigh the benefits of better aligned payment. We also disagree with the decision to exclude contact conducted via telehealth or any other form of telecommunications technology from the per-visit payment. These contacts incur direct patient care costs based on dedicated staff time and resources, and they support increased access and improved health equity by enabling patients who cannot engage in in-person care to receive appropriate hospice services. We believe payments to hospices should account for the resources used to furnish services via telecommunications technology, and we highlight that recent efforts to better characterize services furnished via telehealth by the CPT Editorial Panel and the Relative Value Scale Update Committee can serve as resources for consideration how payment should be made.

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[2] Hemrajani A, Lo SS, Vahlkamp A, et al. Concurrent hospice healthcare utilization in the hematology/oncology patient population at veterans affairs. Journal of Clinical Oncology. 2023; 41(16_suppl). doi:10.1200/JCO.2023.41.16_suppl.12125

With respect to special payments for “specified hospice care,” we believe this is attempting to increase access to medically necessary high-intensity palliative care services for hospice patients, in effect a baby step towards moving towards provision of concurrent care. As noted above, we believe that hospice beneficiaries should be able to receive concurrent and that such a change would make a significant improvement in access to hospice care. However, we have numerous concerns with the approach that is reflected in the draft legislation, as detailed below.

- *Overly restrictive list of services*. The list of specified hospice care services is overly restrictive and would not allow for patients to receive a range of services or medications that are important in managing their terminal illnesses. We note that this approach is not consistent with our first principle noted above, that patients should be free to choose the mix of services they receive based on their individual needs, goals, and preferences. For example, we identified several medications in our comments above that would not receive separate payment, despite their exorbitantly high costs that cannot be readily accommodated under existing payment rates. We would recommend that the draft legislation not itemize those services that could receive supplemental payment, but rather only highlight the listed services as examples.

- *Insufficient payment rates*. The draft legislation suggests that payment would be made at 200 percent of the RHC payment rate for the fiscal year. Given the RHC payment rate for 2024 is only $218.33 for the first 60 days, the higher payment rate would only reach roughly $437 if the policy were applied for this year. In contrast, we noted costs for certain medications reaching over $10,000 for a month. Anecdotally, we also received reports that one hospice received a bill of $17,000 for two radiation treatments. These reports suggest that the amounts included in the draft legislation would not be sufficient to enable hospices to routinely furnish medically necessary high-intensity palliative care services that patients need. We highlight that this would not be consistent with our third principle above, under which hospices or other furnishing providers would not be financially disadvantaged for providing high-intensity palliative care services.

- *Lack of clarity around how payments would be made*. It is not clear if payment at the higher rate would only be made on the day that a specific service or treatment is provided, or if the higher payment would extend over a period of time. For example, assuming high-cost medications were added to the list of payable services, would the higher payment only be made the date a prescription is dispensed, or would the higher payment be made for each date that the prescription covers (e.g., for each of 30 days if the prescription is a 30-day fill)?

- *Lack of clarity around how payments for services would continue after FY 2031*. The draft legislation discontinues payments for “specified hospice care” services after FY 2031, despite the fact that the need for such services and higher payment would continue. Is it expected that the RHC payments would simply be adjusted to account for the cost of care furnished, on average, based on higher reported costs associated with these services, when the Secretary adjusts payment rates for RHC services to align with costs starting for FY 2032? As noted above, we believe that hospice providers should not be financially disadvantaged for providing high-intensity palliative care services, so a mechanism must be in place to ensure that hospices can continue furnishing such care with sufficient reimbursement beyond FY 2031.

We highlight, however, that we support the Plan of Care requirements for these "specified hospice care" services, including that a supervising nephrologist or oncologist not have a significant ownership interest or significant financial relationship with the hospice program. This requirement would be consistent with our second principle above regarding the hospice provider and non-hospice service provider working together to implement a plan of care.

Finally, with respect to allowable outlier payments, we request clarification on several aspects of the draft policy:

- What is the relationship between the outlier policy, the adjusted RHC payments, and the end of the "specified hospice care" payments that all occur starting with FY 2032? If the intent is for the outlier policy to support ongoing delivery of high-intensity palliative care services, we question whether this approach, which would require an offsetting reduction to RHC payments, would adequately compensate hospices for taking on risk associated with the provision of such care.
- How should the Secretary determine which type or amount of care would account for unusual variation that would prompt outlier payments?

Subsection (b). Wage Adjusting Caps

AAHPM appreciates the intent behind the draft legislation's provision to wage-adjust the hospice cap. However, we question whether a simple application of the wage index ratio would result in an equitable distribution of resources among hospice programs spanning different geographies. In particular, we highlight that the wage index is based on hospital costs, and we question whether the hospital wage index sufficiently takes into account the labor costs associated with the extensive travel routinely required in the delivery of hospice care. These travel costs are even higher on a per-patient per-day basis for hospices that serve rural populations with large catchment areas, where patients may be located in remote and geographically isolated areas. Likewise, rural hospices may also experience higher costs related to ambulance transfers due to long distances involved and lack of local services, as well as workflow inefficiencies related to poor cell phone and internet coverage in remote areas, which we do not believe are captured in current geographic adjustments. Wage adjusting the hospice cap using the hospice/hospital wage index, which does not account for these variables, could restrict access to hospice care for rural communities, an outcome that would raise serious concerns.

AAHPM is also concerned that reducing the hospice cap amount consistent with sequestration reductions could harm hospice programs and their ability to maintain access for Medicare beneficiaries. While we recognize that hospice programs that do not come close to approaching the hospice cap might not be affected, many that do serve a large proportion of beneficiaries with neurological or other non-cancer conditions. These patients have more unpredictable disease trajectories, which makes it more difficult to determine with certainty when they will die. This is particularly true for individuals with Alzheimer's Disease and related dementias (ADRD). Reductions to the hospice cap, including through the application of a sequestration percentage, could create major disincentives to serve these patients, threatening access to care.

Subsection (c). Modification of Requirements Relating to Short-Term Inpatient Care

AAHPM appreciates your proposal to establish a transitional inpatient benefit and looks forward to working more with you on this proposal. A transitional inpatient benefit can address a real barrier faced by many at the end of life. Many individuals find that their care needs increase and they may be reluctant to enroll in hospice due to family concerns that they will not be able to take care of their loved one at home, especially when they may need higher intensity care.

At the same time, we highlight some concerns with the approach in the draft legislation. To begin, we note that the transitional inpatient respite benefit appears as if it will be paid at the same rate as inpatient respite care. However, inpatient respite care is usually provided to fairly stable patients whose families have planned breaks from care; in these cases, intensity of care is typically minimal. For transitional patients who are moving from inpatient care to hospice care, or from general inpatient hospice care to hospice following an initial inpatient stay, however, the first few days are typically a highly resource-intensive time needed to further stabilize patients, and they are not consistent with traditional expectations for respite care. We therefore suggest that it would be more accurate to frame this care, not as respite care, but as transitional inpatient hospice care, and that a higher payment rate is warranted.

We are also concerned with the change in the draft legislation that would reduce the inpatient hospice cap from 20 percent down to 10 percent. This change is perplexing on its face as the draft legislation allows for an increased number of inpatient respite care days and transitional inpatient hospice care days, which would be expected to lead to higher inpatient utilization, yet that enhanced benefit is undermined by the expected cap reduction. Notably, new days of respite care furnished in the home would also count towards the cap under the draft legislation, further placing pressure on the cap. We also highlight that many hospice programs do not offer any general inpatient care (GIP), and only a small proportion do. Reducing the inpatient cap would, in effect, punish the programs that are appropriately furnishing GIP services.

Subsection (d). Hospital Discharge Planning Requirements

AAHPM agrees that patients should be routinely provided information on hospice care, including the availability of respite care, upon discharge.

Subsection (e). Payment for Respite Care Furnished in the Home

AAHPM appreciates your proposal to establish a short-term home respite level of care for patients receiving respite care in their homes. This benefit would ease caregiver burden and reduce disruption and unnecessary transitions for patients. We highlight, however, that the hospice industry is facing substantial workforce challenges, such that securing staffing for this benefit is likely to be difficult for hospices. We would be pleased to work with you to address these concerns further, and in particular, we point you to our advocacy efforts to bolster the hospice and palliative care workforce through enactment of the *Palliative Care and Hospice Education and Training Act (PCHETA)*, which we detail further below.

Considerations Related to Medicare Advantage

AAHPM appreciates that the reforms in this draft legislation are intended to address delivery of hospice care under the Medicare fee-for-service program. However, given recent efforts to test the carve-in of hospice benefits into the Medicare Advantage program and potential risk that such efforts are revisited in the future, we offer the following comments regarding the furnishing of hospice care through the Medicare Advantage program, should policymakers move forward with such an approach again in the future. We note that these comments reflect our deep concerns around the potential implications of restricting access to hospice care, including through the imposition of prior authorization requirements and provider network restrictions. We are particularly concerned about the risk of such policies reducing patients' ability and willingness to access high quality hospice care in a timely manner, particularly if appropriate safeguards are not put in place.

- AAHPM would be opposed to the use of prior authorization requirements for in-network hospice care furnished by Medicare Advantage plans. Implementation of prior authorization requirements could have detrimental effects on patients' ability to access medically necessary hospice services in a timely manner. Prior authorization requirements to access hospice services or to receive higher levels of hospice care could significantly impair patients' ability to receive care they need when they need it. For hospice patients in crisis, this could mean that patients experience excruciating pain or other distressing symptoms for hours or days before a prior authorization request is approved, or even that they die before being admitted to hospice.
- Implementation of hospice network restrictions should also be implemented with care and should adhere to the following principles:
    - Beneficiaries should have timely and equitable access to hospice care across all participating geographies and communities, consistent with what should be available under Medicare FFS.
    - Hospice services should be furnished in a manner that meets the individualized care needs of hospice patients and their families to ensure optimal care experience.
    - Hospice services should be consistent with services that should be available under Medicare FFS, including with respect to the quality and intensity of services that hospice beneficiaries receive. Beneficiaries should have access to higher levels of hospice care – that is, GIP or continuous home care (CHC) – when needed.
    - Beneficiaries should have the right to petition for out-of-network hospice care, including higher level appeals, and all requests for out-of-network care should be reviewed on an expedited basis.
- Finally, with respect to safeguarding beneficiary access to urgent and emergency out-of-network care, we also offer the following principles:
    - Policymakers should establish clear definitions that apply across the Medicare Advantage program for what constitutes an urgent or emergency need for hospice services. Definitions should include a holistic understanding of need that incorporates the many dimensions of individual well-being addressed by hospice care, including medical, physical, social, psychological, spiritual, and caregiver needs.
    - Patients should be allowed to access out-of-network urgent and emergency hospice services even if they are in the MAO's service area.
    - MAOs should defer to physicians' judgment regarding patients' need for urgent or emergency hospice care, consistent with the established definitions, and prior authorization should never be applied.
    - Hospice beneficiaries admitted to an out-of-network hospice on an urgent or emergency basis should not be required to transfer to an in-network hospice during the course of

    their hospice election and should not be penalized for continuing care with an out-of-network hospice in any way. However, beneficiaries should be allowed to voluntarily elect to transfer to an in-network hospice once they no longer meet the definition of having an urgent or emergency need for hospice services, if consistent with their preferences.

    - MAOs should bear full financial liability for admissions to out-of-network hospice providers that are determined by the certifying physicians to reflect urgent or emergency situations. MAO denial of ongoing coverage or payment should only be applied prospectively for dates of service after beneficiaries have exhausted all appeal rights. All appeals should be reviewed on an expedited basis.

Bolstering the Palliative Care and Hospice Workforce

AAHPM appreciates the interest in increasing access to palliative care and strengthening the hospice program for Medicare beneficiaries through this legislation. However, we highlight a major barrier that exists to achieving this goal. Despite the growing need for palliative care, the U.S. is unable to meet patient and health system demand because of a significant shortage of trained providers and insufficient numbers of faculty to train the next generation of these providers.

Students graduating from medical and nursing school have very little, if any, training in the core precepts of pain and symptom management, communication skills, and care coordination for patients with serious or life-threatening illnesses. The 2014 Institute of Medicine (IOM) report *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life* noted that "major gains have been made in the knowledge base of palliative care." The report documented, however, that "these knowledge gains have not necessarily been matched by the transfer of knowledge to most clinicians caring for people with advanced serious illnesses." The lack of provider knowledge results in too many patients with serious illness receiving painful or ineffective treatments that do nothing to prolong or enhance their lives.

The need for trained providers is borne out by other major institutions working to provide evidence-based policy recommendations. A 2019 National Academies of Sciences, Engineering and Medicine workshop convened to examine workforce issues related to serious illness care found that "to provide high-quality care to people of all ages living with serious illness, it is critical that the nation develop an adequately trained and prepared workforce consisting of a range of professionals, including physicians, nurses, social workers, direct care workers, and chaplains."

To help improve quality of care and quality of life for the growing and diverse population of patients with serious illness throughout the continuum of care, AAHPM continues to work with Congress to enact the bipartisan *Palliative Care and Hospice Education and Training Act (PCHETA)*. We greatly appreciate your past support for this important legislation and its passage by the House of Representatives during the 115th and 116th Congresses.

Thank you again for your efforts to address health care workforce shortages and gaps. If you have any questions or need additional information, please reach out to Wendy Chill, Director, Health Policy and Government Relations at wchill@aahpm.org or 847-375-6744.

Sincerely,

Vicki Jackson

Vicki Jackson, MD, FAAHPM
President