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**American Academy of Hospice
and Palliative Medicine**
(AAHPM)

**Association of
Professional Chaplains**
(APC)

**Center to Advance
Palliative Care**
(CAPC)

**HealthCare
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**Hospice & Palliative
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**Palliative Care
Quality Collaborative**
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**Physician Assistants in Hospice
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Palliative Care Network**
(SWHPN)

**Society of Pain and Palliative
Care Pharmacists**
(SPPCP)

October 13, 2023

Dear House Budget Committee Health Care Task Force:

Thank you for the opportunity to submit comments on how to modernize and personalize the health care system. The National Coalition for Hospice and Palliative Care (Coalition) believes it can recommend specific solutions to assist the House Budget Committee as it continues to explore these important topics. The Coalition represents the thirteen leading professional organizations dedicated to advancing equitable access, delivery, and quality of hospice and palliative care to all those who need it. Our Coalition represents the interdisciplinary workforce and programs that deliver serious illness and hospice care. This includes more than 5,500 physicians, 1,000 physician assistants, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs and 5,300 hospices caring for millions of patients and families each year across the United States. We bring a broad, multidisciplinary perspective on serious illness care which is helpful as you consider multiple ways to improve outcomes while reducing health care spending.

Our Coalition

The goal of our Coalition is to ensure that all patients, families, and caregivers who need it will have equitable access to quality hospice and palliative care.

Palliative care is an interdisciplinary model of care focused on relief of the symptoms and stresses of serious illness. Its goal is to relieve suffering and provide the best possible quality of life for patients and their families. By its very nature, palliative care is patient-centered care — translating patient goals to appropriate treatments. By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve quality of care and quality of life, and to generate reductions in avoidable spending. *We encourage the House Budget Committee to delve deeper into the overall benefits of expanding beneficiary access to palliative care.*

Concern for Health Equity and Reducing Racial Disparities

Our Coalition seeks to present a united, yet diverse voice to Congress and the Administration on behalf of providers and other professionals who are interested in advocating for equitable healthcare policies and programs that will improve the care of patients and families living with serious or life-threatening illnesses. As you consider healthcare legislation, we urge you to consider the impacts of these policies on diverse communities and the imperative to reduce health inequities and disparities.

SUPPORTING CARE OF THE SERIOUSLY ILL

Despite the benefits to patients, families, clinicians, and payers,¹ reliable access to hospice and palliative care remains the exception rather than the norm. The recommendations below will help ensure person-centered care and improved quality of life for the millions of Americans living with serious illness and those who care for them.

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¹ <https://www.capc.org/the-case-for-palliative-care/>

Support Telehealth for Medicare Beneficiaries and All Patients

The Medicare telehealth flexibilities introduced during the COVID-19 public health emergency (PHE) and continued through 2024 via Congressional action have enabled increased access to critical services for beneficiaries.² A January 2021 survey of palliative care programs by the Center to Advance Palliative Care found that 87% are now delivering patient care via telephone or audio/visual technologies. These programs report 15-20% increases in the number of patients seen, including reaching new patient populations in the home setting (44%), the emergency department (25%), and long-term care settings (20%). A separate survey of hospice providers conducted in May 2020 by the National Association for Home Care & Hospice (NAHC) found that more than 95% of responding hospices were unable to provide in-person visits to patients due to the risks associated with COVID-19 transmission. As a result, hospices incorporated the use of telecommunications into their daily operations and found that their use supported the delivery of high-quality care.

The Coalition believes that permanent expansion is needed to support care for patients with serious illness. Such patients may experience mobility and/or cognitive limitations. They also often contend with pain, frailty, or medical instability and/or rely on caregivers to assist with transportation, increasing the need for and benefits of accessing health care remotely. Notably, these patients have benefitted from the use of audio-only communications to maintain access to medically necessary care when they have been unwilling or unable to access telehealth services using audiovisual telecommunications technology. This includes audio-only evaluation and management (E/M services) as well as audio-only advance care planning services.

Recommendations: To maintain these gains and address ongoing needs, Congressional action is needed to remove underlying barriers to telehealth on a permanent basis. Specifically, the Coalition recommends that Congress:

Eliminate statutory geographic and originating site restrictions for the Medicare program that are slated to apply again after 2024. Use of telehealth during and after the COVID-19 pandemic has proven that telehealth can be provided safely and effectively when the patient is in the home, and that urban, suburban, and rural areas alike all benefit from telehealth services.

Permanently allow audio-only evaluation and management (E/M) services and advance care planning services for both new and established patients when two-way audio-visual technology is not available. Use of audio-only services has enabled patients with serious illness to maintain access to medically necessary care that could be furnished in a clinically appropriate manner via audio-only telecommunications technology, as determined by treating physicians, rather than forgoing care. Indeed, audio-only E/M and advance care planning services – when needed to accommodate lack of video communications – have enabled patients with serious illness to receive more timely and efficient care – for example, to hold discussions about goals of care, treatment options, values, and preferences; to allow for assessment of disease progression and symptoms; and to facilitate prescribing of medication and counseling services. Moreover, we note that older people and those in rural and under-resourced areas who are harmed by structural disadvantages such as limited options for connectivity

² <https://www.johnhartford.org/blog/view/is-availability-of-telehealth-for-older-adults-a-covid-19-silver-lining>

would be the most likely to benefit.

Eliminate unnecessary telehealth frequency limits. Person-centered care would preclude arbitrary limits on telehealth visits. Instead, their frequency should be based on medical necessity and the acuity of illness.

Allow for supervision via communications technologies. Consideration should be given to allowing for direct supervision via virtual presence for a subset of services for which virtual supervision may be of high value and low risk of patient harm on a permanent basis. This would include community-based palliative care services furnished to patients in their homes.

For hospice services:

Allow the use of telehealth for face-to-face visits required for the recertification of a beneficiary for the hospice benefit. Additionally, permit use of audio-only telecommunications technology under exceptional circumstances (where access to audio-video is not available and in-person visits would risk harm to the patient or practitioner).

Establish modifiers that allow for reporting of technology-based hospice visits on claims. This will ensure that claims data fully reflects interactions between the various hospice disciplines and patients/family members and allow the Centers for Medicare & Medicaid Services (CMS) to assess the impact of technology-based visits on quality of care.

Expand reporting of hospice visits (in-person and virtual) to include chaplains/spiritual counselors, and other appropriate disciplines.

For home health services:

Allow the use of telehealth for home health face-to-face certification and recertification, including use of audio-only visits where necessary.

Support Interoperability for Hospice and Palliative Care

Hospices and home health agencies have historically been excluded from the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program, which has precluded the development of certified EHR technology (CEHRT) for these provider types. Lack of CEHRT limits these providers' ability to exchange interoperable health information, which can impede effective care coordination and increase patient safety risks.

Recommendation: The Coalition urges Congress to provide financial assistance to hospices and home health agencies to encourage the adoption of CEHRT. Such assistance could include incentives such as small business loans, tax incentives, and grants from the Medicare and Medicaid programs and other private sector solutions.

Increase timely access to the Hospice Benefit, a Program that Saves Medicare Billions of Dollars

Beyond its proven ability to improve patient and family quality of life, a number of important research studies have recently confirmed that utilization of the Medicare Hospice Benefit (MHB) is associated with large aggregate cost-savings to the broader Medicare program. A seminal March 2023 analysis from NORC at the University of Chicago³ found that in the last year of life, the **total costs of care for Medicare beneficiaries who used hospice in 2019 was \$3.5 billion less than the adjusted spending of beneficiaries who did not use hospice**, representing a 3.1% reduction in costs attributable to hospice utilization. Additionally, NORC found that **hospice stays of six months or more in the last year of life drive savings to Medicare, including for those patients with terminal neurological conditions like Alzheimer's Disease or Parkinson's Disease**. NORC's findings of the MHB's cost-saving impacts have been highlighted in additional recent academic research as well^{4 5}.

Despite the fact that only about half of the people with Medicare who die each year access any hospice at all, and almost a quarter of patients are on hospice for a week or less, in recent years CMS and others have implemented or called for policies that would serve to discourage longer-stays on hospice, including payment model changes and an increased audit focus on long length of stay. Unfortunately, some research⁶ has shown that these policies likely contributed to a decrease in access to hospice care for patients with diagnoses like dementia, which are very difficult to prognosticate for and therefore can be more likely to stay on hospice longer than people with other terminal illnesses. Supporting eligible patients' earlier enrollment in hospice and increasing their lengths of stay on the benefit (median length of stay is currently only 18 days) would likely reduce Medicare spending even more. Congress should recognize the value hospice brings to patients, families, and taxpayers, and support policies and programs that protect and increase more timely access to the Medicare Hospice Benefit.

Recommendations: Oppose any calls for drastic cuts to hospice payment rates, such as MedPAC's recommendation to reduce the hospice benefit's aggregate payment cap by 20%. A blunt cut such as this would not only threaten to reduce access to this special kind of care, but the emerging research shows it is fiscally shortsighted and does not account for the significant savings MHB utilization drives to the Medicare program as a whole.

Encourage CMS and its oversight contractors to reexamine its current audit focus areas and practices to ensure they do not continue to target mostly compliant hospices that are operating in good faith and often, after great time and expense, have their claims denials overturned on appeal. The intense audit scrutiny centered on retroactive second-guessing of hospice patient eligibility has created a chilling effect across the hospice community, such that some providers are hesitant to take patients with certain terminal diagnoses that may result in longer stays on the benefit.

³ NORC at the University of Chicago. [Value of Hospice in Medicare](#). (March 2023).

⁴ Aldridge, et al. [Association Between Hospice Enrollment and Total Health Care Costs for Insurers and Families, 2002-2018](#). (Feb 2022).

⁵ Aldridge, et al. [Health Care Costs Associated with Hospice Use for People With Dementia In The US](#). (Sept 2023)

⁶ Gianattasio et al. [Evaluation of Federal Policy Changes to the Hospice Benefit and Use of Hospice for Persons with ADRD](#) (May 2022).

Improve Medicare Part A

Home health and hospice benefits are essential for optimizing the quality of life for Medicare beneficiaries living with serious illness. As our nation contends with a pervasive healthcare workforce shortage, we support solutions that facilitate continued access to care for patients and promote positive outcomes in a cost-effective manner. With a limited pipeline of workers available, expanding practitioner access, testing innovative models and continuing program integrity efforts can help safeguard the Medicare trust fund and improve beneficiary care.

Recommendations: The following actions will strengthen both access to and quality of these services:

Permit physician associates/physician assistants (PAs) to perform the hospice face-to-face encounter for the purposes of hospice recertification. Recent legislative changes permit PAs to serve as a hospice patient's attending physician, but statute still prohibits PAs from performing the hospice face-to-face recertification encounter. Our Coalition supports all members of the interdisciplinary team to perform at the top of their license.

CMS should test a model of care that would allow terminally ill Medicare beneficiaries to elect their Medicare Hospice Benefit concurrently with the SNF skilled benefit if eligible, without financial penalties to the patient and family. This can enable hospice care during post-acute stays, addressing unmet needs and potentially avoiding hospital transfers. Such a model could be effective in evaluating potential cost savings under the Medicare trust fund while improving care quality and outcomes for patient beneficiaries.

CMS should continue to address hospice program integrity concerns. We support CMS efforts to address program integrity concerns in the Medicare Hospice Benefit and do not believe any additional congressional action is necessary. These efforts, we believe, will help address improper spending while maintaining access to appropriate hospice care for Medicare beneficiaries.

Preserve Access to Opioids for the Seriously Ill Population

Our Coalition appreciates that our nation is facing a public health crisis characterized by staggering rates of opioid use disorder and overdose death. At the same time, we must consider how best to ensure that the millions of patients with pain receive high-quality care, including treatment with opioids when they are medically indicated and can be taken safely. We are particularly concerned that, in recent years, efforts to curb the opioid epidemic have yielded numerous federal and state reforms designed to address inappropriate use of controlled substances, some of which have unnecessarily restricted access to pain medications for patients with serious illness or those who are in hospice care.

Recommendation: The Coalition offers the following recommendations:

Policymakers should apply caution to further efforts to curtail use of controlled substances and give appropriate consideration to patients receiving palliative and hospice care to ensure timely access to such medications and to limit prescriber burden. We are especially concerned about policies that limit opioid production, availability, and/or dosage and duration of prescriptions and would impede the individualization of treatment to patient needs.

Ensure ongoing access to telemedicine prescribing of controlled substances without a prior in-person medical evaluation for seriously ill patients, including those at the end of life. In response to the COVID-19 PHE, the Drug Enforcement Administration (DEA) instituted flexibilities that allowed for the prescription of controlled substances via telehealth without a prior in-person medical evaluation. Following implementation of a temporary extension of such flexibilities after the PHE, DEA is currently considering which flexibilities should be extended and under what conditions. The Coalition believes that in-person evaluation requirements should not apply to patients enrolled in hospice, as the hospice program includes guardrails that protect against potential diversion or misuse and hospice patients have a particularly urgent need for ready access to opioids and other medications. Additionally, we support DEA establishment of a special telemedicine registration that would allow qualifying practitioners to prescribe controlled substances without an in-person medical evaluation, including for patients with serious illness. We support robust requirements for special registration, for example, demonstration of specialized training in palliative care or pain management, to protect against inappropriate prescribing.

Community Based Palliative Care in CMS Models and Demonstrations

Our Coalition supports the utilization of payment and care models to demonstrate the value of person-centered care that people with serious illness need now. Initiation of a successful Medicare demonstration at CMS could allow every Medicare beneficiary to benefit from high-quality serious illness care at any time during their disease progression and not just at the end of life.

Our Coalition supports efforts to integrate community based palliative care into all serious illness models and encourages CMS to continue to view all of their serious illness models through a palliative care lens – that is ensuring that Medicare beneficiaries have access to palliative care alongside their serious illness treatments. Our Coalition was encouraged to see CMS announce the Guiding an Improved Dementia Experience ([GUIDE Model](#)), which has the potential to integrate palliative care services into dementia care.

Building and Sustaining the Workforce

We encourage the House Budget Committee to support Congressional efforts to help build a healthcare workforce more closely aligned with the nation’s growing and changing health care needs. Efforts to close the large gap between the number of health professionals with palliative care training and the number required to care for the expanding population of patients with serious illness or multiple chronic conditions should be supported. The National Academy of Sciences, Engineering and Medicine (NASSEM) and the Medicare Payment Advisory Commission (MedPAC) have highlighted the need to increase education and training opportunities for those caring for patients with serious illness.⁷

Given the critical shortage of health professionals with expert knowledge and skills in palliative care, investment in the interdisciplinary palliative care workforce can help ensure appropriate care and improve access and outcomes for patients living with serious illness.

⁷ <https://nap.nationalacademies.org/catalog/25789/building-the-workforce-we-need-to-care-for-people-with-serious-illness>

Improving Serious Illness Care through Education, Training, and Supports

Recommendation: Enact the Palliative Care and Hospice Training and Education Act (PCHETA) passed by the House during the [115th](#) and [116th](#) congresses and introduced in the Senate (S. 2243). The legislation will:

- Expand opportunities for interdisciplinary education and training in palliative care and end-of-life care through the establishment of education centers and career incentive awards for physicians, nurses, advanced practice nurses, physician associates/physician assistants, social workers, and other health professionals.
- Enhance existing health professions education programs by providing incentives to incorporate palliative care and hospice training.

Recommendation: Enact the *Provider Training in Palliative Care Act* (S. 2117), which would allow participants in the National Health Service Corps to defer their obligated service to receive training in palliative care. This legislation will help ensure that we build a healthcare workforce more closely aligned with America's evolving healthcare needs and build on a program which is vital to increasing access to care in rural and underserved areas.

Increase Investment in the Nursing Workforce Development Programs Under Title VIII of the Public Health Service Act (PHSA)

Recommendation: Our Coalition recommends the House Budget Committee help meet the nation's demand for nursing services by supporting efforts to address all aspects of nursing education, practice, recruitment, and retention through the Title VIII Nursing Workforce Development programs.

Support Graduate Medical Education (GME)

We are very grateful that Congress, as part of the *Consolidated Appropriations Act, 2021* and the *Consolidated Appropriations Act, 2023*, acted to expand federal funding for graduate medical education (GME) for the first time in nearly 25 years by including 1,200 new Medicare-funded residency slots. However, narrowing the current and projected healthcare workforce gap to address the growing number of patients with serious illness will require both a further increase in graduating clinicians and training more academic faculty to teach and train future health professionals in palliative care.⁸ At the same time, meaningful supports are essential to sustaining this workforce, including to address clinician wellbeing and provide enhanced mental health resources for clinicians.

Recommendations: The Coalition urges Congress and CMS to:

Further increase the number of residency slots funded by Medicare and ensure distribution of these positions address specialty shortages, as provided in the bipartisan *Resident Physician Shortage Reduction Act* (H.R. 2389). Hospice and Palliative Medicine (HPM) fellowship training programs are not eligible to receive federal funds since HPM was recognized as a formal subspecialty in 2006, and Medicare GME funding was capped in 1997. This cap should be updated to address evolutions in medicine and patient needs, especially given the current demographics and demands.

⁸ <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00018>

Ensure adequate support for the Children’s Hospitals Graduate Medical Education (CHGME) program to encourage training for those specializing in pediatric palliative care.

Include palliative care training in all appropriate GME programs to ensure that future health professionals in other fields are equipped with the skills to diagnose and treat pediatric or adult patients with serious illness.

Research: Appropriations

The Coalition recommends Congress support the research base to improve the care of people living with a serious illness across the lifespan. This spring, the Coalition [submitted testimony](#) to Congress supporting an intra-institute strategy for this type of research at National Institutes of Health, National Institute on Aging (NIH/NIA). The Senate has included this funding in its FY24 appropriations for the (NIH). Recently, the [NIA National Advisory Council on Aging \(NACA\)](#) announced the new Consortium for Palliative Care Research Across the Lifespan which will bring together coordinated research and funding opportunities for the field. [Consortium for Palliative Care Research Across the Lifespan](#) We encourage the House Budget Committee to support this Consortium for Palliative Care Research Across the Lifespan as it will expand and intensify palliative care research across NIH. The proposed consortium will be supported through a cooperative agreement that allows for multiple cores, involvement from project scientists across NIH, and encourages interaction with other NIA- and NIH-supported networks and centers. The overall consortium goals include:

- creating new scientific knowledge, in part through supporting pilot and exploratory studies;
- fostering development of early- and mid-career investigators;
- serving as a national platform to provide research resources and facilitate high-quality research;
- engaging health care systems and community-based organizations as research partners and settings;
- and disseminating research findings, best practices, data, and other impactful resources to the research and clinical communities.

An important focus will be research that addresses disparities in access, quality, and use of palliative care services for underserved populations.

Recommendation: The Coalition urges the House Budget Committee to support this long-term approach to support palliative care research across the lifespan which will lead to quality-of-life improvements for all patients and families living with serious illness.

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Thank you for all your work to address the ways health care outcomes can be improved while lowering costs. Our Coalition is pleased to offer the expertise of our members and look forward to working with you and your staff as you work on tackling the nation’s most pressing healthcare challenges. If you have any questions, please contact Jessica Hausauer, Executive Director, Jessica@nationalcoalitionhpc.org.