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The Honorable Jason Smith
Chairman, House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20101

RE: Request for Information: Improving Access to Health Care in Rural and Underserved Areas

Dear Chairman Jason Smith and Members of the Committee:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit comments on *Request for Information: Improving Access to Health Care in Rural and Underserved Areas*.

NHPCO is the nation's largest membership organization for hospice providers and professionals who care for people affected by serious and life-limiting illness. NHPCO members provide care in more than 4,000 hospice and palliative care locations and care for over two-thirds of the Medicare beneficiaries served by hospice. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

We have focused our comments on the potential impact on hospice providers serving patients with serious and life-limiting illness and their families in rural communities.

Geographic Payment Differences

1. Wage Index
   The Medicare Payment Advisory Commission (MedPAC) recommended in their June 2023 report to (1) use all-payer, occupation-level wage data with different occupation weights for the wage index of each type of provider and (2) reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas. Rural hospice and palliative care providers wages or mix of staff are not similar enough to inpatient hospitals for these wages to be accurate for hospice providers. By having a wage index system more reflective of different provider types, payment rates will be more closely aligned to the cost to provide care.

   NHPCO recommends this committee explore MedPAC's recommendation to use all-payer, occupation-level wage data with different occupation weights for the wage index of each type

of provider and (2) reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas.

However, NHPCO strongly urges Congress not to adopt MedPAC's recommendation to wage adjust and reduce the hospice aggregate cap by 20%. Reducing the hospice aggregate cap will adversely impact care access and could drive beneficiaries to more costly care settings. This will be particularly devastating for patients in rural communities, where wage indices are lower and workforce challenges are heightened. Indeed, a study conducted by NORC at the University of Chicago found total Medicare costs for beneficiaries who utilized hospice care was 3.1% lower than those who did not, while Medicare spending for patients who received hospice care was $3.5 billion less than had they not elected hospice care. Depriving beneficiaries' access to hospice care in rural communities will only increase spending and reduce positive outcomes.

2. Rural Hospice Add-On Payment

   Rural hospice providers are struggling to stay financially viable and for many are relying on community good will and donations to stay in business. Medicare beneficiaries in rural communities are dependent upon these providers to receive medically appropriate hospice care. Without sufficient access to hospice services or palliative treatment, patients and their families may turn to care settings outside the hospice benefit to relieve suffering and achieve comfort, resulting in reduced patient experience outcomes and increased costs to our healthcare system.

   A Medicare rural payment similar to the Home Health Rural Add-On[1] should be extended to hospice. Hospice providers meet patients wherever they call home which can result in long drives for the interdisciplinary team (IDT). In rural areas, providers are covering even more mileage to ensure all individuals who need hospice are able to access it which endures additional costs. With hospices receiving over 90% of their payments from Medicare, they can ill afford to cover costs elsewhere — unlike other providers. In other words, hospices are almost entirely dependent on Medicare payments to continue providing high quality care. Therefore, we urge Congress to extend a Medicare rural add-on payment for hospice providers. This will enable hospices to better address patient disparities in rural communities by increasing appropriate palliative care access and improving care quality.

Sustainable Provider and Facility Financing

1. Incentive to Start Up Hospice and Palliative Care in the Community

   As we continue to see the closure of rural providers and facilities across the healthcare system, patients will lose access to necessary services. Many rural hospice providers are reliant on donations from the community to ensure they are able to continue their work but are being

[1] Section 50208 of the Bipartisan Budget Act of 2018 increased Medicare payments for home health services provided in a rural area. Section 4137 of the Consolidated Appropriations Act of 2023 extended the rural add-on payment policy for calendar year 2023.

stretched thin. Providers have large geographical service areas with smaller staffs all while nursing facilities and hospitals are closing. Congress needs to investigate the causes and impacts of these closures as well as find incentives for providers to enter rural communities. For example, Congress could consider a temporary add-on payment for hospices to open or expand operations into rural areas where beneficiaries lack access to hospice. This would incentivize providers to provide care in more rural areas where the payment is currently inadequate to support operations.

2. Swing Beds

   Certain Critical Access Hospitals (CAH) have the flexibility to provide swing bed services by using beds for either acute care or a skilled nursing facility (SNF) level of cares, which are paid based on cost. This flexibility is critical to CAHs' efforts to serve their communities, but results in an unintended consequence of lower Medicare payments to CAHs for hospice general inpatient (GIP) care than skilled nursing care. GIP is short-term hospice care provided to a patient to manage acute or chronic pain or symptom control that can only be managed in the inpatient setting. All Medicare hospice providers are required to provide the GIP level of care in a Medicare certified hospice inpatient facility, a Medicare certified hospital, or a Medicare certified skilled nursing facility with a registered nurse available 24 hours a day to provide direct patient care. However, when a CAH is struggling financially, it must prioritize its beds internally which causes a shortage for hospice providers due to decreased access to CAH beds for hospice GIP services. Congress should provide a payment add-on for GIP provided in CAH. This reimbursement will ensure patients have access to the entirety of their Medicare Hospice Benefit in their community while rural hospitals have financially viable options to support the use of their beds.

3. Rural Designations

   Currently, there is no rural designation for hospices similar to other sectors of the healthcare system, such as Critical Access Hospitals or Sole Community Hospitals. We recommend Congress direct the Government Accountability Office (GAO) to assess the effectiveness of current and potential rural provider designations to provide additional information on the effectiveness of a rural hospice designation to improve payment mechanisms.

4. Hospice Market Basket Payment

   In FY 2021 and FY 2022, the final hospice market basket payment updates published by CMS were 2.4% and 2.7%, respectively. However, the data used to set this update did not take into account the record high inflation or the substantial increases in staffing costs, the cost of medical supplies, and the cost of drugs over the previous two years. NHPCO analysis of the actual market basket update for 2021 is 3.0% and for 2022 is 5.7%, using the IHS Global Inc. (IGI) 2022Q4 forecast. This represents a 3.7% variance from the combined FY 2021 and FY 2022 actual market basket updates.

The FY 2024 market basket adjustment of 3.1% does not take into account the inflationary pressures hospices, specifically rural providers, are facing, the continued challenge with the cost of staffing in a highly competitive market, or the extreme financial pressures on hospices today.

NHPCO requested a one-time retrospective adjustment, using CMS' special exception and adjustment authority to revise the Hospice Wage Index and Quality Reporting final rule but CMS stated they were unable to make such an adjustment due to statutory requirements. We requested a 3.7% adjustment for the combined FY 2021 and FY 2022 market baskets to ensure Medicare payments more accurately reflect the cost of providing hospice care. We request Congress consider these adjustments to ensure hospice providers can continue to care and support their communities. These adjustments are particularly vital to the continued delivery of hospice care in rural and underserved regions.

Aligning Sites of Service

1. Incentivize Hospitals and Nursing Homes to Utilize Hospice Providers

   Hospices often find nearby hospitals are unwilling to contract with the hospice, either because it only contracts with the hospice in their own health system and cannot, or will not, consider contracting with others. A hospice may attempt to establish a one-time contract to ensure a specific patient can access general inpatient (GIP) care, a level of care required of all Medicare hospices, in a specific hospital, with very limited success. Hospices may resort to contracting with more distant hospitals, but patients and families may be unwilling to accept care in a location requiring significant travel time. Providers have stated:

   > *We have problems meeting the need of GIP and inpatient respite. Not because we're not willing or have the staff, but our contracted facilities (Nursing Home and Hospital) don't have enough staff and are not able to accept our patients. We're often on the bottom of the priority list. We're not able to provide these services (particularly inpatient respite) in other facilities like assisted living or group homes.*
   >
   > *Our hospice contracts with a neighboring hospice with an inpatient unit for GIP care. The hospice with whom we contract requires us to transfer our patients to their hospice for GIP care, and then transfer back to us when GIP is concluded.*

   Hospice providers want to contract and work with their local hospitals but are competing with higher reimbursement for other patients types and services as well as hospital connected hospices. Patients have a right to choose their provider and when rural communities do not have access to multiple hospitals and nursing facilities, hospitals and nursing facilities should be incentivized to work with multiple community providers. The Medicare Hospice Benefit is predicated on the autonomy of patient choice – if a hospital only contracts with one hospice

and refuses others, Medicare beneficiaries and their caregivers are deprived of a critically important aspect of hospice care at a time when the need for patient choice is most paramount.

Health Care Workforce

1. Workforce Struggles

   For years, hospices and palliative care facilities have experienced workforce shortages, like many other providers. This issue predated COVID-19 but has only been exacerbated since the pandemic began. During one of the nation's worst public health crises, hospices struggled to keep their doors open and serve patients largely due to a shortage of healthcare workers and growing wage pressures competing with other healthcare providers for workers. As the U.S. population continues to age, the demand for hospice and palliative care services will only grow.

   Hospice providers are seeing critical staffing shortages among nurses, social workers, aides, and other members of the interdisciplinary team (IDT). Hospices generally need staff who have experience furnishing end-of-life care, further limiting the pool of candidates who are qualified to serve in hospice care roles. Additional concerns include burnout and an aging workforce which is plaguing all of healthcare.

   Providers report for 2022, nursing wages increased by as much as 23%, aide wages increased by as much as 12% and wages of other members of the interdisciplinary team increased by 5-6%. Due to the highly competitive marketplace, hospice providers also needed to provide retention bonuses and incentives to minimize staff vacancies. Hospices are not well positioned to compete with hospitals, staffing agencies, and other post-acute healthcare providers to recruit qualified care team members without significantly increasing their compensation costs. This is particularly troubling as the need for a robust and skilled hospice workforce will grow given the nation's aging population and the increasing demand for hospice services.

   Legislation such as the *Palliative Care and Hospice Education and Training Act* (PCHETA) (S. 2243) are crucial to provide much needed funds to expand the pipeline of doctors, nurses, social workers, and chaplains into the hospice and palliative care fields. PCHETA will give providers the support needed to serve an ever growing patient population.

2. Staff Safety

   Hospices meet patients where they live, most often in their home at all times of the day and night. Doctors, nurses, and social workers are increasingly finding themselves in dangerous situations in homes where either their patient or members of the patient's family are suffering from substance abuse or serious mental illness. Our workers are often entering a home alone and may be exposed to a variety of threats including guns and other weapons, illegal drugs, verbal abuse, and other forms of violence. These threats can also be present in their patient's neighborhood.

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

These threats often mean sending more than one member of the interdisciplinary team to a home, connecting with protective services, and even requesting police escorts. These steps can help reduce the threat of harm but do not eliminate it. In the long run, they accumulate and are a significant factor in burnout rates for healthcare providers.

We encourage the committee to investigate these risks and make investments in our communities by supporting those suffering from substance abuse and serious mental illness. In addition, we recommend creating grant programs for healthcare workers to fund additional training for ways to identify and minimize the risks in providing care in the community.

3. Nurse Practitioners and Physician Assistants
   Nurse practitioners (NP) and physician assistants (PA) are essential providers in rural communities; however as the Medicare Hospice Benefit currently stands, these providers are unable to work at the top of their license. For example, NPs and PAs are unable to complete the certification of terminal illness (CTI) and PAs are unable to complete the face-to-face visit. By allowing these providers to fully utilize their clinical knowledge and skill to support hospice medical directors, hospice organizations will be able to relieve some of the workforce issues they face.

4. Graduate Medical Education (GME) Slots
   Rural hospice and palliative care providers have reported not seeing significant advancements in workforce issues from rural GME slots. Providers need more support in bringing new clinicians into rural areas because they cannot compete with urban area salaries and benefits to entice new clinicians. Congress should investigate ways to improve the hospice and palliative clinician pipeline through GME slots to help new rural providers.

Innovative Models and Technology

1. Telehealth
   Throughout the COVID-19 Public Health Emergency (PHE), hospice and palliative care providers had access to telehealth for the routine home care (RHC) level of care. Telehealth can be beneficial in accessing patients and communities who have limited access to transportation and allow check in with patients. Through telehealth, providers can share

appointment links with long distances family members so they can, with the patient's consent, be included in care planning and decision making.

For rural and frontier providers, broadband access is an issue. Medicare hospice providers should be allowed to utilize audio-only telehealth visits for limited services for rural and frontier beneficiaries. Although audio-only visits cannot address all issues and are not appropriate in all situations, it is important to provide this minimum standard for some communities.

Temporary flexibility allowed for the use of telehealth for face-to-face visits prior to recertification for the hospice benefit was also allowed through the CARES Act. This flexibility has since been extended, including through the Consolidate Appropriations Act, 2023, through CY 2024. Telehealth is appropriate for these low-touch, administrative visits, and increases provider efficiency by reducing drive time for overworked physicians and nurse practitioners. We encourage this flexibility to be made permanent.

2. Hospice Benefit
   New national research shows hospice provides significant cost savings to the Medicare system, including when the length of stay is greater than 266 days. Specifically, the research found the total costs of care for Medicare beneficiaries who used hospice in 2019 was 3.1% lower than those who did not use hospice, and earlier enrollment in hospice and longer lengths of stay likely reduce overall Medicare spending. The report calculates this reduction in spending translates to an estimated $3.5 billion less in Medicare outlays for beneficiaries in their last year of life. Hospice continues to not only be a patient-centered Medicare benefit but a benefit to the Medicare trust fund. Increased support for hospice is a benefit to Medicare beneficiaries and their families.

Thank you for your consideration of NHPCO's comments on this request for information. We welcome continued engagement with you and your staff and the opportunity to meet to discuss our comments. If you have any questions or would like to schedule a meeting, your staff should feel free to contact me at lhoover@nhpco.org.

Sincerely,

/s/

Logan Hoover
Vice President, Policy and Government Relations