NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

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The Honorable Mitch McConnell
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
United States House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Minority Leader
United States Senate
Washington, DC 20510

The Honorable Kevin McCarthy
Minority Leader
United States House of Representatives
Washington, DC 20515

Re: Recommendations for Phase 4 COVID-19 Legislation

May 5, 2020

Dear Speaker Pelosi and Leaders McConnell, McCarthy, and Schumer:

The thirteen organizations from the National Coalition for Hospice and Palliative Care thank you for the enormous, multiple, bipartisan actions already taken to address the novel coronavirus (COVID-19) pandemic. As Congress considers additional legislation (COVID 4) responding to this global pandemic, our Coalition urges you to adopt the recommendations herein, which would help mitigate the devastating impact of the pandemic on patients and families fighting COVID-19 and the health care professionals caring for them.

Hospice and Palliative Care and COVID-19: The COVID-19 pandemic has demonstrated that access to high-quality palliative care and hospice is essential to the well-being of our citizens and our health care system. These interdisciplinary teams are on the front lines caring for affected patients – managing symptoms (including breathlessness), supporting shared decision-making, supporting family members, and coordinating care transitions. Hospitals in hot-spots have deployed their palliative care experts to emergency departments (EDs) and ICUs, optimizing communications and symptom relief, while hospices and community-based palliative care programs are caring for unprecedented numbers of people with serious illness, reducing the risk of community spread and easing pressure on overburdened hospitals. Palliative care professionals have provided incomparable emotional support to patients and families, helping them navigate excruciating decisions and facilitating connections between loved ones despite the challenges presented by social distancing.

Despite these invaluable contributions during the COVID-19 pandemic, hospice and palliative care programs face real threats to their survival. With hospital revenue decimated, staff furloughs and layoffs are becoming commonplace, and are including palliative care team members. In the community, continued lack of reliable financing threatens access to community-based palliative care while inadequate training, education and access to PPE continue to threaten the adequacy of the workforce. Without expanded investment in hospice and palliative care, we are jeopardizing access to high-value palliative care in all settings.

The organizations within the Coalition, representing the people and institutions caring for these patients, recommend that Congress consider the following specific priorities for inclusion in the next Congressional legislative package to combat COVID-19.

Essential Priorities in 4th COVID-19 Legislative Package

1) COVID-19 Workforce Issues

- **a. *Palliative Care Hospice and Education Training Act* , PCHETA (H.R. 647, S. 2080)**
- **b. *Rural Access to Hospice Act*, (S. 1190, H.R. 2594)**

The shortage[1] of palliative care specialists is exacerbating the COVID-19 epidemic.[2] Skilled communication and symptom management are precisely the skills needed to care for COVID-19 patients and families in all settings. PCHETA, has already passed the House by unanimous consent and has demonstrated widespread bipartisan support in the Senate. We urge you to finalize this legislation to begin addressing the shortage of trained clinicians as this legislation would provide the necessary building blocks to train more clinicians in these skills as waves of COVID-19 patients continue to confront the health care system.

The Rural Access to Hospice Act would allow practitioners at Federally Qualified Health Centers and Rural Health Centers to serve as attending physicians to hospice patients, thereby reducing already acute staffing shortages while maintaining the highest level of quality.

Recommendation: The Coalition urges Congress to include PCHETA and the Rural Access to Hospice Act in COVID 4. These bills will help ensure better care for the COVID patient population by (1) alleviating the shortage of trained palliative care and hospice professionals through expanded opportunities for interdisciplinary education and training in palliative care and (2) addressing rural healthcare shortages exacerbated by the current pandemic.

2) Support for Bereavement and Trauma Informed Care

Grief and Counseling Support: Across the country, hospices often serve as the expert source for grief and psychosocial support in the community for a range of situations involving loss. Hospice and palliative care providers are uniquely positioned through their expertise with the grieving and healing process to provide care to communities coping with trauma. By statute, hospices are required to provide grief and bereavement counseling services to family members for 13 months after the death of

[1] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00018

[2] https://www.wsj.com/articles/coronavirus-crisis-drives-demand-for-palliative-care-11585825201

a loved one. Hospices routinely provide this service to families and patients they have served, but they are also called upon to provide bereavement care in communities that have faced a difficult event, such as a terrorist attack, or natural or manmade disaster. Hospice providers have the ability to provide support services for those who are suffering due to prolonged isolation during the crisis, to those families who may suddenly lose a family member or have to make a difficult decision about a family member's care due to COVID-19 and to healthcare professionals in nursing homes, hospitals and other healthcare settings who have experienced extensive losses while caring for patients.

Hospices, and other qualified entities, stand ready to support those individuals and families coping with COVID-19. If Congress agrees that the need is there, hospices would be honored to serve in this capacity by scaling their grief counseling programs to meet the needs in communities around the country for those suffering losses, related to the pandemic, both physically and mentally.

Recommendation: We recommend funding grants for community support to provide bereavement and delayed grief reaction services for both individuals and in group settings. We would recommend that the parameters for participation be targeted to hospice and palliative care programs, and other qualified entities, with a history of providing grief counseling and/or trauma informed care to their communities as well as requiring that programs have licensed staff delivering the services.

3) Physician Assistants (PAs) in Hospice

As Congress has affirmed time and time again, PAs are qualified medical professionals who diagnose illness, develop and manage treatment plans, prescribe medications, and often serve as a patient's principal healthcare practitioner. PAs practice in every state and in every medical setting and specialty, including in hospice and palliative care. PAs have also been recognized as key members of the interdisciplinary team that provide palliative and hospice care for those with serious-illness and at the end-of-life.[3]

Last fall, CMS was able to clarify with the CY2020 Medicare Physician Fee Schedule Final Rule, that PAs were recognized as hospice attending physicians and fully authorized to order needed services and medications for patients on hospice when practicing in the community. However, CMS did not authorize the same level of autonomy for PAs employed directly by hospice organizations, and this prohibits PAs from completing hospice face-to-face visits required for recertification, and thus operating up to their full scope of practice in hospice. This effectively prohibits the use of PAs in hospice. CMS also finalized that hospices could also not accept medication orders from PAs employed or contracted by a hospice entity. Existing regulatory limitations on hospice-employed PAs arbitrarily restricts their ability to provide much needed care to this patient population. CMS has indicated this requires a legislative change, or at a minimum, a recommendation from Congress to remove this regulatory barrier.

Recommendation: The Coalition urges Congress to allow PAs to serve up to their full scope of practice by making statutory changes necessary to permit PAs who are employed or contracted

[3] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp.

directly by hospices to perform face-to-face visits required for hospice recertification and permit hospice entities to accept medication orders from PAs that they employ.

4) Advanced Care Planning, Role of Social Workers

During the pandemic, advance care planning discussions allow individuals to express their desires for care in the event they contract COVID-19 or other serious illness. They also provide an opportunity to designate a decision maker if the individual is incapacitated. Both are critically important, as COVID carries a high risk of complications, including the need for hospitalization and ventilator support. Despite some growth in the frequency of these discussions, barriers to widespread advance care planning persist.

One of those barriers is the lack of support for some qualified clinicians to deliver advance care planning services. The licensed clinical social worker is a member of the interdisciplinary palliative care team, is trained to conduct these conversations[4] and is permitted to bill Medicare for services. Currently, it is often social workers on palliative care teams who initiate advance care planning discussions, and with whom patients and families are most comfortable talking. Permitting these licensed clinical social workers to bill for these essential services (CPT codes 99497 & 99498) could improve access to these services for Medicare beneficiaries. Congress should also encourage CMS to consider a mechanism for payment for all certified clinical social workers to bill for these codes under the Medicare program. These advanced certified social workers (APHSW-C or ACHP-SW) are also often the member of the interdisciplinary palliative care team initiating and conducting these conversations. Currently, however, certified and non-certified social workers are not eligible to bill the Medicare program directly for services.

Recommendation:

Immediately permit licensed clinical social workers to bill for advance care planning codes (CPT codes 99497 & 99498) under the Medicare program (without a related mental health diagnosis code) and encourage CMS to consider a payment mechanism for other social workers delivering this service.

5) Provide Community Based Palliative Care for At-Risk and Recovering COVID-19 Patients

COVID-19 is an unplanned transformation of our healthcare system. The hospice and palliative care community believe that now, due to this unanticipated event, it is imperative that Medicare beneficiaries have access to a home and community-based palliative care benefit (Community-Based Palliative Care (CBPC)) under a Centers for Medicare and Medicaid Innovation demonstration. This demonstration would be targeted to seriously ill individuals who are at an elevated risk for a poor prognosis if they contract COVID-19, including those that must sustain social distancing, as well as individuals recovering from COVID-19.

The Primary Care First/Seriously Ill Population (PCF/SIP) model was designed before the pandemic emerged. A new CBPC demo will provide an alternative concept to PCF/SIP – that a co-management

[4] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp

model is more effective at increasing care quality and reducing costs than a transitional care model, through proactive care management to meet beneficiary and caregiver needs while reducing urgent and emergency care. Additionally, this model will have a strong psychosocial component and include other supports and services to help decrease unnecessary interventions and expand access to high-quality care, especially in under-resourced (i.e., inner city, rural) areas.

This demonstration is explicitly intended to focus on the greatest need – to protect the safety of at-risk seriously ill individuals, reduce the occurrence of hospitalizations and emergency department visits, reduce the burden on workforce shortages, and lower overall costs of caring for these highly vulnerable individuals and recovering seriously ill COVID-19 patients. This model reduces the risk of exposure to COVID-19, treats more people with COVID-19 at home using increased telehealth services and limits exposure to others. The model will also increase access to in-home care for the seriously ill patient population. This model should be offered nationwide, especially since many of the current COVID-19 "hot spot" areas are not currently included in the current PCF SIP regions (i.e. NYC, Illinois, Texas), and hot spots continue to evolve.

Recommendation: The Coalition recommends Congress urge CMS to proceed working with the stakeholder community to develop a Community-Based Palliative Care (CBPC) model under a Centers for Medicare and Medicaid Innovation demonstration.

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Thank you for all your work to address the current and ongoing pandemic facing the nation and for your consideration of these urgent COVID-19 priorities. If you have any questions, please contact Amy Melnick, Executive Director, at 202-306-3590 or amym@nationalcoalitionhpc.org

Signed,

Members of the National Coalition for Hospice and Palliative Care

American Academy of Hospice and Palliative Medicine
Association of Professional Chaplains
Center to Advance Palliative Care
HealthCare Chaplaincy Network
Hospice and Palliative Nurses Association
National Association for Home Care & Hospice
National Hospice and Palliative Care Organization
National Palliative Care Research Center
Palliative Care Quality Collaborative
Physicians Assistants in Hospice and Palliative Medicine
Social Work Hospice & Palliative Care Network
Society of Pain and Palliative Care Pharmacists
Supportive Care Coalition