April 24, 2024

The Honorable Cathy McMorris Rodgers
Chair
Energy and Commerce Committee
U.S. House of Representatives

Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
U.S. House of Representatives

The Honorable Brett Guthrie
Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives

The Honorable Anna Eshoo
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives

RE: Health Subcommittee Hearing, "Legislative Proposals To Support Patient Access To Telehealth Services."

Dear Chair McMorris Rodgers, Chairman Guthrie, Ranking Members Pallone and Eshoo:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit a letter for the record for the Health Subcommittee hearing entitled "Legislative Proposals To Support Patient Access To Telehealth Services." The growth and usage of telehealth has been the silver lining outcome from the COVID-19 Public Health Emergency (PHE) and the opportunity to conduct the required face-to-face (F2F) encounter under the Medicare hospice benefit via telehealth has yielded benefits for both providers and patients. **Specifically, we support the CONNECT for Health Act (H.R. 4189 / S. 2016) and the Telehealth Modernization Act of 2024 (H.R.7623 / S. 3967), both of which include language that would make this provision permanent.**

NHPCO is the nation's largest and oldest 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 across the country and care for over two-thirds of Medicare beneficiaries served by hospice. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

**Face-To-Face Requirement**
The Patient Protection and Affordable Care Act (ACA, Pub. L. 111-148) requires that a hospice physician or nurse practitioner (NP) must have a F2F encounter with every Medicare hospice patient to determine the continued eligibility of that patient prior to the start of the third benefit period, approximately 180 days (about 6 months), and every 60 days thereafter for recertification.

In March 2020, Congress included a provision in Section 3706 of the CARES Act (Pub. L. 116-136) to allow hospices to perform the F2F via telehealth for the PHE. This provision has been extended legislatively[1] and is set to expire at the end of this calendar year.

**Origins**
This provision was originally recommended by the Medicare Payment Advisory Commission (MedPAC) in 2009 to "ensure an adequate level of accountability for the hospice benefit" and deter inappropriate

[1] Consolidation Appropriations Act, 2022 (Pub. L 117-103) and Consolidated Appropriations Act, 2023 (Pub. L 117-328)

long stays.[2] Since CARES' enactment, there has been little evidence which demonstrates that face-to-face visits prevent long stays. In fact, an NIH funded study found the "F2F visit requirement may decrease hospice discharges, contrary to its intention."[3]

By design, the F2F visit is a low-touch, administrative component of the recertification process. It is intended to collect clinical information to determine continued eligibility. To put it another way, this visit is not a care delivery visit, and is purely administrative in function. Recertification decisions are broadly informed by the collective interdisciplinary team through the course of care delivery to a beneficiary, not in abstract from one in-person visit by a physician or NP.

It is worth considering whether the F2F requirement, regardless if the encounter happens in-person or via telehealth, is necessary. An analysis[4] of nearly one million Medicare beneficiaries conducted by NORC at the University of Chicago showed use of hospice care contributed to $3.5 billion in savings for Medicare in 2019, while providing multiple benefits to patients, families, and caregivers including increased satisfaction and quality of life, improved pain control, reduced physical and emotional distress, and reduced prolonged grief and other emotional distress. Medicare savings were even found for beneficiaries whose hospice length of stay was greater than 180 days.

**Burdensome**
The F2F visit is an unnecessary burden. A 2020 study on F2F visits found them to impose significant burden for hospice providers.[5] This is especially true for hospices with patients in rural and remote areas. These F2F visits use up valuable physician or NP time, often unnecessary driving time, on an administrative visit. Physicians and NPs should instead spend their time and resources dedicated to delivering critical and timely care to as many patients in need as possible. Telehealth visits allow these providers to see more patients by decreasing time spent traveling to various locations.

**Causes Delays in Care**
Patients who have previously had a net 180 days of hospice and were discharged must receive a F2F visit to enroll back into hospice, regardless of who the provider is. This can and does cause delays in delivering hospice care while a provider rushes to get a physician or NP in to see the patient for a F2F visit. Allowing the option for a F2F visit to occur via telehealth ensures timely access to hospice for these patients, especially when the enrollment occurs on the weekends when staffing can be more challenging.

**Patients Receive In-Person Care**
Hospice is holistic, interdisciplinary care, meaning beneficiaries receive visits and care from the entire interdisciplinary team consisting of a physician, nurse, hospice aide, social worker, chaplain, volunteer, and bereavement specialist. As of January 1, 2024, this may now also include a marriage and family therapist or mental health counselor. Together, with the patient and family, this team constructs an individualized plan of care to meet patient and family needs, which reflect their desired outcomes and goals. Hospice services are delivered around the clock based on the patient's

---

[2] MedPAC Report to Congress: Medicare Payment Policy, Chapter 6: Reforming Medicare's hospice benefit | March 2009. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar09_Ch06.pdf

[3] Harrold J, Harris P, Green D, Craig T, Casarett DJ. Effect of the Medicare Face-to-Face Visit Requirement on Hospice Utilization. Journal of Palliative Medicine. 2013;16(2):163-166. doi:10.1089/jpm.2012.0349. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3569924/

[4] https://www.nhpco.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf

[5] Moore, S. L., Portz, J. D., Santodomingo, M., Elsbernd, K., McHale, M., & Massone, J. (2020). Using Telehealth for Hospice Reauthorization Visits: Results of a Quality Improvement Analysis. Journal of pain and symptom management, 60(3). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7276118/

individualized plan of care. Conducting a F2F via telehealth doesn't detract from in-person care, it enhances it. It allows a physician or NP to spend more time with patients who need in-person care and less time on administrative paperwork.

**Rates of Recertification**
The information gained from a F2F visit can be collected as successfully via telehealth as it can be in-person. Recent research concluded that there was no "statistically significant differences in reauthorization recommendations were found between telehealth and in-person visits." [6]

Unfortunately, Medicare doesn't collect whether a F2F visit was conducted in-person or via telehealth. NHPCO has advocated to the Centers for Medicare & Medicaid Services (CMS) to create a modifier, or HCPCS codes, for telehealth visits and add via claim form.[7] MedPAC, in its March 2022 Hospice Chapter, also recommended that CMS "should require that hospices report telehealth services on Medicare claims."[8] CMS has opted not to make the necessary changes to collect this information.

NHPCO believes that data collection will reaffirm prior research's conclusion that F2F telehealth visits are just as accurate as in-person visits, and we continue to advocate for CMS to collect this information. We also encourage Congress to require CMS collect it.

**Cost**
In addition to supporting patients, families, and hospice providers, permanently allowing the use of a virtual option to conduct the F2F visit would not impose additional costs on the Medicare program, as there is no separate payment for the F2F visit. F2F visits are covered under the current daily capitated payment structure of the Medicare Hospice Benefit, so permitting them to be performed virtually is cost neutral.

**Conclusion**
Allowing physicians and NPs the option to conduct the F2F visit via telehealth is a critical flexibility that should be made permanent. It allows physicians and NPs to spend more time on care delivery and less time on administrative tasks and travel. This is especially true for hospices with patients in rural and remote areas allowing our providers expand access to this benefit. We encourage Congress to include this provision in any telehealth extension or permanency legislation before the end of the year. 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,

Logan Hoover

Logan Hoover
Vice President, Policy and Government Relations

---

[6] Moore, S. L., Portz, J. D., Santodomingo, M., Elsbernd, K., McHale, M., & Massone, J. (2020). Using Telehealth for Hospice Reauthorization Visits: Results of a Quality Improvement Analysis. Journal of pain and symptom management, 60(3). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7276118/

[7] NHPCO comment on the FY22 Hospice Rule (July, 7 2021), NHPCO letter to CMS (February 4, 2022), NHPCO comment on the FY23 Hospice Rule (May 22, 2022), NHPCO letter to Senate Finance and Ways and Means leadership (September 12, 2022) and NHPCO comment on the FY24 Hospice Rule (May 30, 2023).

[8] https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch11_SEC.pdf