March 5, 2025

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

**Re: Telehealth Flexibility for the Hospice Face-To-Face Recertification Visit**

Dear Congressional Leaders:

Thank you for your leadership and support in expanding access to quality healthcare through telehealth. These flexibilities have helped improve patient care delivery across the United States. As organizations representing the full array of hospice and community-based palliative care providers, professionals, and volunteers, we write to you today in strong support of extending the telehealth flexibility for the face-to-face (F2F) encounter required during recertification of hospice eligibility. This flexibility has yielded benefits for patients and providers, allowing hospice providers to focus on direct patient care, reducing unnecessary burdens, and improving patient and family satisfaction and it is critical that this flexibility be maintained going forward.

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 reflects their desired outcomes and goals. Hospice services are delivered around the clock based on the patient's individualized plan of care.

The F2F requirement is a low-touch, administrative component of the recertification process intended to collect clinical information to determine continued eligibility, making it an excellent candidate for telehealth. This process can be conducted as successfully via telehealth as it can in-person. Recent research concluded there were no "statistically significant differences in reauthorization recommendations found between telehealth and in-person visits."[1] As it is not a care visit, it cannot be billed separately like other hospice physician visits. Extending this telehealth flexibility does not have an associated cost.

The in-person requirement is burdensome on hospice providers[2] using up valuable physician and nurse practitioner (NP) time commuting to patients' homes for paperwork visits rather than visiting other patients who need critical and timely care. This is especially true for providers operating in rural and high-traffic urban areas where the time spent on travel is measured in hours. By allowing this telehealth flexibility, physicians and NPs can spend more time delivering care and less time traveling between patient locations.

This flexibility is always important and there are circumstances where it is invaluable. One instance our collective members discuss with frequency is for patients starting hospice with a new provider at a time that coincides with the required administrative timing for a F2F. While the F2F itself is not a direct care visit, the

[1] 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/ it

[2] Moore

inability to conduct it via telehealth could delay this administrative process necessary to initiate hospice services with a new provider, taking away focus from actual care delivery. Given that research and anecdotes from our members support that this visit is equally effective whether in person or virtual, this example of the importance of expediency should underscore the need for this flexibility to continue for the benefit of patients, families, and hospice providers.

In the previous Congress, provisions extending this flexibility were included in various telehealth proposals including the CONNECT for Health Act (H.R. 4189 / S. 2016), the Telehealth Modernization Act (H.R. 7623 / S. 3967), the Preserving Telehealth, Hospital, and Ambulance Access Act (H.R. 8261) – which was unanimously passed out of the Ways and Means Committee, and the Hospice Recertification Flexibility Act (H.R. 8278), demonstrating broad bicameral and bipartisan support. It was last extended in the American Relief Act (P.L. 118-158) and expires March 31, 2025.

Telehealth is an effective means of conducting these administrative visits without increasing Medicare costs. Extending this flexibility, especially in rural and high-traffic urban areas, will significantly benefit both patients and providers. We strongly urge Congress to ensure the Hospice F2F telehealth flexibility is included in any telehealth package before it expires at the end of March. Failing to extend this flexibility risks serious disruptions in care and decreased access to hospice, an unacceptable outcome.

Thank you for your attention to this critical issue. We look forward to working with you to support the needs of hospice patients, families, and providers across the country.

Sincerely,

American Academy of Hospice and Palliative Medicine
Association of Professional Chaplains
Coalition for Compassionate Care of California
HealthCare Chaplaincy Network
Hospice & Palliative Nurses Association
LeadingAge
National Alliance for Care at Home
National Coalition for Hospice and Palliative Care
National Partnership for Healthcare and Hospice Innovation
Physician Associates in Hospice & Palliative Medicine (PAHPM)
Society of Pain and Palliative Care Pharmacists
Social Work Hospice & Palliative Care Network