C+TAC
COALITION TO TRANSFORM ADVANCED CARE

June 1, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-4201-P
P.O. Box 8013
Baltimore, MD 21244

Re: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

Submitted electronically via www.regulations.gov

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule regarding its effect on those living with serious illness.

C-TAC is a national, non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC comprises 200 national and regional organizations, including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness as a health condition that carries a high risk of mortality and either negatively impacts a person's daily function or quality of life or excessively strains their family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). Serious illness also differs by geography. People living in rural areas are older, sicker, and lack access to the full range of health care, and we advocate for improved care for any with less access to it.

Here are our comments on aspects of this proposed rule. They are offered from the perspective of patients living with serious illness and their family caregivers, whose experience of hospice depends on timely access, clear communication, coordinated care, and protection from avoidable financial and administrative burdens.

Mandatory hospice election statement addendum

While we appreciate the good intention behind this proposal, we do not support making this election statement mandatory. We supported the addition of this statement in 2020 as patients

and family caregivers often elect hospice during periods of crisis, exhaustion, and emotional stress. In practice, many do not know which items, services, or medications the hospice will cover, what the hospice considers unrelated to the terminal illness, or when they may be exposed to Medicare cost sharing outside the hospice benefit.

However, while the addendum helps with those issues, making it mandatory will not improve on that and will instead contribute to administrative burden for hospice providers and potential confusion for patients/families. Not all hospice patients need such an addendum as some of their care will be relatively simple and, unfortunately for too many, short. For those who would benefit from such an addendum, they should already be receiving one. Our hospice members report that the requirement to have the addendum signed by the patient or representative is a time-consuming and often fruitless process. Tracking down the decision maker to sign an updated addendum is logistically difficult. If CMS makes the election statement addendum mandatory in the final rule, we implore the agency to eliminate the signature requirement and allow documentation in the medical record that the addendum has been provided. Unless CMS has data that these have not been appropriately issued, we fear that making it mandatory will be burdensome with likely little benefit to patients and families who may be confused to get such an addendum when it doesn't apply to them.

Language in the proposed rule also indicates that a reason for the mandatory addendum is so that non-hospice providers can request it and make determinations to address non-hospice spending after a hospice election. However, in our discussions with our hospice members, we have found no instances of such requests and believe that the implementation of a mandatory addendum will not curtail non-hospice spending.

One additional suggestion would be to consider including this information in the hospice patient rights materials. The move to plain language is also a good idea to make sure patients and families understand any information provided.

Non-hospice spending and cost shifting

C-TAC shares CMS' concern about the increase in non-hospice spending. Yet, from the perspective of patients and family caregivers, rising non-hospice spending often signals fragmentation rather than choice. When services that appear closely related to the principal hospice diagnosis are billed outside the hospice benefit, patients and families may face avoidable financial liability, confusion about who is responsible for care, and delays in getting necessary symptom management. They may also lose confidence that hospice is truly coordinating care.

Even further, hospices are not the entities that can police such spending as it usually occurs outside of their awareness or influence. A family who calls 911 for a hospice patient, rather than calling the hospice team, or a patient who continues seeing their healthcare provider for their terminal illness, are not situations a hospice organization knows about or can always prevent. Instead, we recommend that CMS use data analysis to better understand what is driving such spending and provide that information to the hospice where the patient is

enrolled, along with guidance on how the hospice can take steps to reduce the spending. CMS must also develop more pragmatic guardrails based on those findings. A patient's diagnosis matters, as well as the medications they take. Some are more related to such non-hospice spending.

CMS should also closely monitor whether spending patterns reflect differential access problems for patients with serious illness. These patients are especially vulnerable to under-service because their needs can be prolonged, complex, and less predictable than those of patients with a short trajectory, such as with some cancers.

Discharge authority and beneficiary protections

We support the proposal that there should be protections as for patients with serious illness and family caregivers, discharge from hospice can be destabilizing and traumatic, particularly if it is poorly communicated or perceived as abrupt. Expanded discharge authority should not make it easier for hospices to discharge patients prematurely, especially patients with long, uncertain trajectories such as those living with dementia, heart failure, or neurodegenerative disease. Consistently high levels of live discharges are a well-known sign of inappropriate hospice enrollment and possibly fraudulent hospice providers.

The agency should also reiterate expectations for careful interdisciplinary review, timely notice, explanation of the reason for discharge, and concrete transition planning. Family caregivers should receive clear information about what happens next, including medication continuity, durable medical equipment, and how to access other services. Ideally palliative care services should be available and patients referred to such services to maintain support for them and their families and avoid unnecessary ED visits or hospitalizations. CMS should also monitor whether discharge patterns change after this policy is implemented.

Telehealth face-to-face recertification

C-TAC supported the use of telehealth for recertification during the pandemic as it allowed for prompter and more efficient recertifications. Hospice staffing is always lean and allowing providers to do recertifications via telehealth avoids the long drive times that otherwise would occur, particularly in rural areas. That is the case now that the pandemic has ended and will continue to be the case going forward.

Request For Information (RFI) on Community-based palliative care

We appreciate this RFI on enhancing community palliative care services outside of hospice and view it as one of the most important parts of the proposed rule. Patients with serious illness and family caregivers can benefit from interdisciplinary palliative care long before a six-month prognosis is clear or before they are ready or willing to elect hospice.

Too many patients live for months or years with escalating symptoms, caregiver strain, fragmented care plans, and repeated emergency department visits or hospitalizations without access to reliable home or community-based palliative care. Family caregivers are often asked to manage pain, shortness of breath, delirium, functional decline, and medical decision-making

with little formal support. The result is emergency department (ED) visits and hospitalizations that could have been prevented.

Palliative care now encompasses care well before that end-of-life period and is focused on symptom management, communication, education, and support associated with a serious illness and concurrent with other treatment. In fact, CMCS' approval of Hawaii's Medicaid State Plan Amendment categorizes palliative care as a "preventive service", which allows people to get it throughout a serious illness to prevent crises and suffering. More recently, New Jersey has requested a State Plan Amendment and the state has already begun implementation of their community-based palliative care benefit for fee-for-service and managed care plan members, including dual eligibles and children.

Community-based palliative care is slowly growing from the field's historical base in hospitals. This is because those with serious illness spend more time in the community, and avoiding ED and hospital visits is also how palliative care helps reduce cost, a secondary benefit. A 2021 narrative review found high-quality data supporting the cost effectiveness of community-based palliative care as the growing literature base confirms the benefits for patients, families, and informal caregivers by managing symptoms, reducing unwanted hospitalizations, and providing earlier hospice referrals.

We therefore propose a more robust Medicare pathway for community-based palliative care with these recommendations:

- Clarify and standardize palliative care as a covered service
    - Categorize palliative care as a preventive service, aligning the services more closely with the codes on the fee schedule reimbursing for care coordination, assessments, and ongoing management.
    - Ensure that palliative care specialists can be documented in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Because palliative care is a subspecialty, too few palliative care specialists are documented because of the lack of awareness that multiple specialties can be selected. This makes it more difficult for them to be identified and accessed by beneficiaries. While private health insurers and Medicaid programs have utilized Z51.5 as an indicator of a palliative care encounter when utilizing advanced illness management and palliative care billing codes, this is not consistently used as either a billing mechanism alone or an indicator that the service was completed by a palliative care specialist.
    - Adopt and operationalize a consistent definition of palliative care across Medicare rules, clearly distinguishing it from "comfort care" and end-of-life-only care, building on C-TAC's prior comments correcting misuse of the term in hospice rule preambles.
    - Provide explicit CMS sub-regulatory guidance that pre-hospice palliative care is covered when it is reasonable and necessary for symptom management, decision support, and quality of life for patients pursuing disease-modifying

treatment, and that auditors and MACs should not deny such care solely because such care is ongoing.

- Use existing payment structures more effectively with no new benefit needed yet
    - Health plans and Medicaid agencies have been reimbursing for palliative care services using their existing claims payment systems by leveraging billing codes that are not currently payable by Medicare. We recommend the administration evaluate the claims submitted by palliative care providers and teams for community-based palliative care to better understand reimbursement for these services and the mechanisms health plans are currently using to support payment for them.
    - While there have been improvements in the recent physician fee schedule to reimburse for community-based palliative care services, it is still difficult for palliative care teams to cover the full interdisciplinary team required to deliver high-quality palliative care services. The composition of palliative care teams as outlined in community-based palliative care certification requirements from The Joint Commission, ACHC, and CHAP require multiple disciplines involved in a person's care, including those unable to bill independently for services (e.g., nurses, social workers, and chaplains). In addition, home-based palliative care requires intensive time to complete in addition to travel time to get to a patient's home. Because people receiving community-based palliative care services often experience functional or cognitive decline, telemedicine is also not always the best option to deliver care to them or to support their family caregivers. This greatly reduces the number of people a palliative care team can see in a community setting. It is estimated that under optimal billing, palliative care teams can only cover 20-60% of total annual expenses for community-based palliative care with current fee-schedule codes

      We recommend the administration:
        - Issue detailed examples and coding guidance for palliative care under current benefits (e.g., E/M office/home visits, transitional care management, chronic care management, principal care management, behavioral health integration, and telehealth), emphasizing multi-disciplinary, longitudinal serious-illness care. Guidance should also include the interplay between concurrent care services for children and pediatric palliative care services.
        - Test and disseminate "palliative care templates" for HCPCS/CPT coding combinations (physician/APP, social work, chaplain, nursing) that reflect holistic team-based encounters but remain billable under existing rules (e.g., separate same-day billing for different disciplines within scope).
        - Categorize ACP (ACP) as a preventive service and work with Congress to allow it to be billed independently by social workers and waive copayments for ACP under all circumstances. An analysis in 2021 found that only 50% of ACP was billed with the annual wellness visit, and the

other half was billed independently, often by specialty care providers. This means that patients receiving ACP from palliative care specialists incur a specialty co-pay.

- Introduce comprehensive specialty palliative care assessment HCPCS codes. Palliative care interdisciplinary teams do an initial assessment to evaluate a person's and caregiver's needs and develop a plan of care. In addition, they periodically re-evaluate the person's needs to maintain that plan of care. By introducing palliative care assessment codes, teams can be reimbursed for the time-intensive development and maintenance of a person's care plan. In addition, the introduction of such HCPCS codes can serve as documentation that community-based palliative care services have begun and continue, rather than relying on the Z51.5 code to document palliative care encounters for reimbursement purposes. This approach has been implemented in Medicaid programs and health plans reimbursing for palliative care services utilizing S0280 and S0281 and have been combined with the monthly bundled payment code for palliative care services S0311.
- Enable home health and hospice agencies to deliver community-based palliative care services through specified HCPCS codes. Utilize the revenue code set 0690-0699 (pre-hospice/palliative care services) to differentiate home health, palliative care, and hospice services.
- Identify an approach to quality measurement so that those receiving palliative care services through home health agencies are not subject to all the same quality measurement requirements, which no longer may be appropriate, and that the quality of palliative care services can be monitored in an alternative way in line with the treatment goals for community-based palliative care services.
- Maintain the capability for multiple providers to be reimbursed for chronic care management, transitional care management, advanced primary care management, and other care coordination codes and allow social workers to bill for these codes.

- <u>Encourage structured models within existing authorities like CMMI and FFS</u>- Design a demonstration focused on community-based serious-illness palliative care outside hospice that uses existing codes and tests prospective per-beneficiary-per-month payments for interdisciplinary case management layered on FFS and quality measures tied to symptom relief, patient and caregiver experience, and goal-concordant care. If a separate demonstration is unlikely, find ways to incorporate and test these elements in other existing or planned models. Align these efforts with the pilots that have already been undertaken by Medicaid agencies and private health plans.

- <u>Data, measurement, and transparency for palliative care</u>
    - Align palliative care quality measures with quality measurement systems already in place, including HEDIS. HEDIS measure sets have included an exclusion for

advanced illness based on a common set of diagnosis codes. In addition, HEDIS and Star Ratings exclude patients from the preventive measure set when HCPCS S0311 is billed. from While S0311 is recognized in the HCPCS manual, it is considered a non-Medicare temporary national code. Many Medicare Advantage and commercial plans accept it specifically for tracking palliative and advanced illness management.

- Create a palliative care "add-on" dataset or modifier on claims (e.g., a palliative care modifier or new condition code) so CMS can identify where palliative care is happening now and track outcomes and costs, similar in spirit to CMS's new Service and Spending Variation Index focus on patterns of use.
- Ensure ACP is tracked for all palliative care patients and considered a quality measure to be documented. The new measure requiring a care plan for all patients 18+ could be used once it's validated for non-acute settings. In addition, consider adding ACP to the preventive service list that is documented as part of HEDIS and Medicare Star Ratings.
- Promote adoption of validated patient-reported experience and symptom measures in community palliative care, leveraging instruments we have previously recommended, such as:
  - Ambulatory Palliative Care Patients' Experience of Receiving Desired Help for Pain.
  - Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (MIPS #495).

  CMS could endorse these tools for use in demonstrations and voluntary reporting, and test whether they can be adapted for Medicare FFS reporting programs.

- Explicit access expectations- Encourage CMS to prioritize models and technical assistance that support community-based palliative care in safety net settings (FQHCs, RHCs, Indian Health Service/tribal sites, and small rural providers), including flexibility for telehealth and community health worker integration in serious-illness care teams.

- Support for workforce and interdisciplinary teams
  - Issue clarifying guidance that palliative care is inherently interdisciplinary and that non-physician clinicians (nurses, social workers, chaplains, psychologists) can be appropriately billed when services meet benefit definitions (e.g., incident-to, behavioral health codes, care management) and urge development of codes or modifiers that better capture team-based serious-illness care.
  - Explore allowing explicit recognition and payment for care coordination, family meetings, and ACP as core elements of palliative care, including ensuring ACP codes are widely usable in community settings and can be billed on the same day as related E/M visits when medically necessary.

Medical aid in dying and non-abandonment

This is a sensitive area, and C-TAC has historically been neutral on it due to strong feelings and ethical issues on both sides. However, several principles are clear from the standpoint of patients and family caregivers: They need clear communication about what hospice can and cannot do under federal law. They also need assurance that hospice will not abandon them if questions arise about medical aid in dying in states where it is lawful. Hospice patients in these states have a legal right to explore and access these services and their hospice enrollment should not be a barrier to that.

CMS should emphasize that hospices must continue to provide high-quality care, including aggressive symptom relief and compassionate communication, while remaining compliant with federal funding restrictions. Policies in this area should minimize fear, confusion, and disruptions in care.

Quality reporting and public reporting

We support the proposed updates to the Hospice Quality Reporting Program, including future public reporting and a Care Compare icon related to data submission as they are meaningful changes. Better information for patients and families is essential, but implementation details matter.

Patients and family caregivers need quality information that helps them assess whether a hospice communicates well, manages symptoms promptly, supports caregivers, provides skilled visits when needed, and avoids burdensome transitions. Measures and public reporting approaches should reflect what matters most at the bedside and in the home, not only administrative compliance.

However, while the icon may be helpful, we wonder if that is enough to help patients and families make informed hospice choices? The proposed icon for noncompliance with data submission requirements may improve transparency, but CMS should ensure it is understandable to the public and accompanied by plain-language explanation. The agency should also provide technical assistance so that smaller, rural, and community-based hospices serving high-need populations are not disproportionately disadvantaged by reporting transitions.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

Marian Grant, DNP, ACNP-BC, ACHPN, FPCN, FAAN, RN
Senior Regulatory Advisor
Coalition to Transform Advanced Care (C-TAC)