AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

June 1, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1851-P
7500 Security Boulevard
Baltimore, MD 21244

Subject: Medicare Program; FY 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements [CMS-1851-P]

Dear Administrator Oz:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment in response to the Centers for Medicare & Medicaid Services (CMS) Fiscal Year (FY) 2027 Hospice Wage Index and Payment Rate Update proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below:

- FY 2027 Payment Update. CMS should pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2027. To the extent that CMS's hands are tied by statutory formulas for updating hospice payments, CMS should work with Congress to address this need.

- **Non-hospice Spending During a Hospice Election.** CMS should recognize that certain non-hospice spending is reasonable and appropriate, and that the hospice physician and the interdisciplinary group (IDG) are best positioned to determine whether a prescription drug or other medical treatment is related or unrelated to a beneficiary's terminal illness. CMS should also ensure that claims processing edits are in place to prevent inappropriate non-hospice utilization.
- **Services and Spending Variation Index (SSVI).** CMS should revisit the purpose and methodology for the SSVI, including its approach for incorporating non-hospice spending into the index.
- **Election Statement.** CMS should not finalize its overly burdensome proposal to require the provision of hospice election statement addendum to all Medicare beneficiaries.
- **Clarifying Regulation Text Changes.** CMS should finalize its proposals for proposed clarifying regulation text changes addressing discharge from hospice care and statutory face-to-face encounter requirements.
- **Palliative Care Request for Information (RFI).** AAHPM appreciates CMS's focus on improving access to outpatient palliative care and would be pleased to work with CMS to effectuate payment reforms consistent with our recommendations and feedback. In particular, AAHPM strongly recommends that CMS establish an initial comprehensive palliative assessment and care plan development code, as well as ongoing monthly case rate payment for the delivery of comprehensive, team-based community-based palliative care services. Additional details and recommendations are included in our comments below.
- **Hospice Wage Index/Geographic Adjustments.** CMS should analyze hospice cost data to determine the extent to which costs vary based on geographic location and incorporate findings from such analysis into appropriate geographic payment adjustments.
- **Medical Aid in Dying (MAID).** AAHPM underscores that hospice remains the best way to support the needs of patients facing terminal illness, as well as their families and caregivers, and that hospices can institute clear policies and procedures to effectively serve patients who pursue MAID in a manner that is consistent with federal laws and regulations.
- **Medicare.gov Compare Tool Icon.** CMS should finalize its proposal to add an icon to the Medicare.gov Compare Tool identifying hospice facilities that have failed to meet Hospice Quality Reporting Program (HQRP) reporting requirements, as well as pursue stronger action to hold hospices accountable.
- **Hospice Care Index (HCI).** CMS should pursue further refinement of the HCI consistent with recommendations and feedback provided in our detailed comments below.
- **Hospice Outcomes and Patient Evaluation (HOPE) Tool.** CMS should refine HOPE-based measures to enable use of two-way telecommunications technology for follow-up visits. CMS should also pursue additional quality measure concepts that would be meaningful to hospice patients, including measures addressing hospice patients' access to hospice teams and measures addressing patients' psychosocial or spiritual needs.

Proposed FY 2027 Hospice Payment Update Percentage

CMS proposes a net hospice payment update percentage of 2.4 percent for FY 2027. As with previous years, AAHPM members report the proposed payment update is insufficient to keep pace with hospices' rising costs. In particular, hospices continue to report increased costs associated with recruiting and maintaining staff with the experience and training to support hospice care, and they struggle to remain competitive with other potential employers, which could lead to understaffing and potential quality of care concerns. Further, new requirements associated with implementation of the Hospice Outcomes and Patient Evaluation (HOPE) tool require an increase in staffing that the proposed update does not take into

account. Hospices' revenues are also challenged by instability in payments under the Medicare Physician Fee Schedule, which often help to offset the costs associated with hospice physicians' services, as well as other rising input costs (e.g., gas and drug prices). ***AAHPM therefore again urges CMS to pursue all possible administrative options available to support hospices and provide a higher payment update for FY 2027. To the extent that CMS's hands are tied by statutory formulas for updating hospice payments, we also ask CMS to work with Congress to address this need.*** Protecting hospices' financial viability is critical for ensuring patient access to appropriate end-of-life care. Notably, hospice care is associated with reduced rates of emergency department visits and readmissions,[1,2] which further underscores the value of hospice care and the importance of supporting hospice sustainability.

Non-Hospice Spending During a Hospice Election and Proposed Services and Spending Variation Index (SSVI)

CMS discusses its analysis regarding non-hospice spending during a beneficiary's hospice election, noting significant increases in such spending since FY 2020, and highlighting how high non-hospice spending may suggest hospice non-compliance with statutory and regulatory requirements. CMS then proposes to calculate and publicly report a Service and Spending Variation Index (SSVI) value for each hospice that could identify hospices raising potentially higher levels of concern. The SSVI would be calculated using nine-claims-based measures, including 8 utilization metrics and 1 metric on total non-hospice spending; thresholds for assigning points would be calculated for each metric; and points would be added together across metrics to assign a total SSVI score.

Non-Hospice Spending

AAHPM acknowledges that trends in non-hospice spending among hospice beneficiaries are concerning and appreciates CMS's review of these data to identify program integrity risks. Indeed, we share some of CMS's concerns regarding inappropriate utilization of Medicare services outside of the hospice benefit, including with respect to pressure ulcers and use of skin substitutes, which we agree appear to reflect unscrupulous activity.

However, ***we underscore that certain non-hospice spending is reasonable and appropriate***, and beneficiaries frequently elect hospice care with pre-existing conditions that clearly have nothing to do with their terminal illness and for which medications and other medical interventions remain necessary up to the last days of life. ***We emphasize that the hospice physician and the interdisciplinary group (IDG) are best positioned to assess and address the complexity and multiplicity of chronic illnesses that are present in the vast majority of beneficiaries electing hospice and that the expertise of the hospice physician and IDG must be what guides any determination as to whether a prescription drug or other medical treatment is related or unrelated to a beneficiary's terminal illness***.

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[1] Kelley AS, Deb P, Du Q, et al. "Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay." Health Affairs, 2013. 32(3. https://doi.org/10.1377/hlthaff.2012.0851

[2] Holden TR, Smith MA, Bartels CM, et al. "Hospice enrollment, local hospital utilization patterns, and rehospitalization in Medicare patients." J Palliat Med, 2015. 18(7):601-12.

We also highlight the limited ability of hospices to control patients' behavior related to ongoing medication use or other medical treatments, as well as the lack of visibility hospices have into their patients' use of such treatments. We continue to be perplexed at the ongoing coverage of and payment for non-hospice services and medications by Medicare Administrative Contractors (MACs) and Part D sponsors without first confirming non-relatedness with the hospice. MACs and Part D sponsors should have edits in place to review payments for treatments for hospice beneficiaries, to prevent inappropriate utilization, and ***we strongly recommend that CMS ensure such edits are in place***.

We also call attention to additional analysis that could enhance CMS's and stakeholders' understanding of non-hospice spending during hospice election. Specifically, we encourage CMS to assess and report on spending based on location of care, with particular attention paid to patients in nursing homes or other facilities, as we understand that facility actions may be contributing to non-hospice spend.

Services and Spending Variation Index

Regarding CMS's proposal to calculate, publicly report, and monitor SSVI values for hospices, ***AAHPM has several concerns and questions regarding CMS's proposed approach***. While we agree that many of the metrics CMS proposes for inclusion are likely to identify high program integrity risks, we question the over-emphasis on non-hospice spending, including for many of the reasons we detailed in our comments above. More specifically, we question the extent to which non-hospice spending is a good indicator of program integrity risk, particularly given lack of hospice control over and visibility into non-hospice spending. We also disagree with CMS's proposed approach for integrating performance on the non-hospice spending metric into the SSVI. To begin, we note that CMS's proposed approach considers total non-hospice spend, without adjusting for patient days or patient count. This approach would therefore inappropriately place large hospices at a disadvantage over smaller hospices, which naturally would have lower non-hospice spending given their smaller patient population. We also disagree with the high weight assigned to non-hospice spending; we do not believe performance on one measure should account for up to half of the total points assignable under the SSVI. Additionally, rather than identifying an appropriate threshold that identifies outlier performers, CMS assigns points to all hospices regardless of where their non-hospice spending falls relative to other hospices. We believe points should only be assigned to outlier hospices, to focus attention on potential bad actors.

We also question CMS's approach for setting a threshold for the continuous home care (CHC) and general inpatient care (GIP) metric, which only assigns a point if a hospice completely foregoes delivery of any CHC or GIP days in a fiscal year. We question whether this could be gamed by hospices providing a single day of either CHC or GIP, without meaningfully improving the care provided to enrolled patients. At the same time, we recognize that some hospices – and particularly those in rural areas – may face significant barriers and resource constraints for providing CHC or GIP, so we appreciate that this is just one variable in CMS's analysis of hospice performance, and we encourage CMS to take such constraints into account when considering potential additional targeted education or oversight.

Finally, it is unclear what value the SSVI offers more broadly, given that many of the same or similar metrics are tracked and reported separately. For example, there is substantial overlap between the proposed SSVI and the Hospice Care Index measure, which includes metrics that are already publicly reported. Paired with our concerns regarding the new non-hospice spending metric, we question whether the SSVI will offer any meaningful new insights into the program integrity risks that hospices may present.

Proposed Election Statement Addendum Changes

CMS proposes to require that hospices provide the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for hospice elections beginning on or after October 1, 2026. CMS would require hospices to furnish the addendum within the first 5 days of the effective date of a hospice election, and any updates to the addendum within 3 days of changes to the plan of care that impact the addendum determinations, in writing, to the individual (or representative), and to make the addendum available for non-hospice providers and Medicare contractors.

AAHPM has significant concerns with this proposal, which we believe would create a significant new burden for hospices that would divert resources away from patient care. Our members report that, in their experience, it is very unusual for patients or families to request the election statement addendum. As a result, the burden imposed on hospices by making the addendum mandatory will be tremendous, requiring significant time and attention for hospice clinical and non-clinical staff to complete for the majority of patients for whom the addendum is not currently prepared. This includes time extracting information from medical records, providing written clinical explanations in easily understandable language, obtaining review and sign off from a hospice medical director or hospice physician, traveling to patients' homes, and more. This added burden is particularly problematic given that, when patients do receive the addendum, it does not appear to have much benefit, including because patients already understand that they are agreeing to forego most non-hospice care. For these reasons, ***we urge CMS not to finalize its proposal to require the provision of the hospice election statement addendum to all Medicare beneficiaries.*** As noted above, we believe that claims processing edits that prevent inappropriate payment of non-hospice services would be more effective in ensuring delivery of comprehensive hospice care.

Proposed Clarifying Regulation Text Changes

Discharge from Hospice Care

AAHPM supports CMS's proposal to update regulations related to discharge from hospice care to state that the hospice may obtain the written physician's discharge order from the physician designee or a physician member of the interdisciplinary group (IDG), in addition to the hospice medical director. This change would align with previous regulatory changes CMS has recently made to clarify the functions that physician designees and physician members of the IDG can perform, thereby providing consistency in regulatory requirements and reducing administrative burden.

Face-to-Face Encounter

CMS proposes to amend regulations to align with statutory requirements to:

- Extend the use of telehealth to conduct a face-to-face encounter for the sole purpose of recertifying the patient's eligibility for hospice, through December 31, 2027;
- Prohibit the use of telehealth for the face-to-face encounter if the individual is located in an area that is subject to a moratorium, if the hospice is subject to enhanced oversight, or if the physician or nurse is not enrolled in Medicare or has not opted out;
- Require that hospice claims include one or more modifiers or codes to indicate that such encounter was conducted via telehealth. For this requirement, CMS proposes that the hospice would report a G-code identifying applicable encounters.

AAHPM is generally supportive of these proposed changes and appreciates the ongoing flexibility Congress furnished to conduct the face-to-face encounters using telehealth.

Furthermore, in recognition of the precedent that CMS's G-code proposal sets, and in light of hospices' ongoing ability to utilize telecommunications technology in the delivery of patient care, AAHPM suggests that CMS establish a clear mechanism for hospices to report services furnished via telecommunications technology via hospice claims. Doing so would enable documentation, tracking, and evaluation of the impact of telehealth services for hospice beneficiaries.

Requests for Information (RFIs)

Provision of Palliative Care Outside of Hospice Care

CMS discusses how community-based palliative care plays an essential role in improving the quality of life for individuals living with serious illness, and notes that palliative services are offered across existing Medicare programs but not through a dedicated palliative care benefit. CMS solicits input regarding ways it can optimize current coverage and billing practices for palliative care services under various outpatient or home-based benefits, with questions addressing specific aspects of palliative care. ***AAHPM is pleased to see this focus on improving access to outpatient palliative care, which closely aligns with longstanding Academy efforts to increase patient access to community-based palliative care services.***

AAHPM has long promoted the value of palliative care in managing the debilitating effects of serious illness in a patient- and family-centered manner that focuses on matching treatment to achievable patient goals to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients traverse throughout the course of a serious illness. High-quality palliative care also supports caregivers by offering education and information, emotional support, tools and strategies for supporting loved ones, social work assistance, and more. Notably, the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care (NCP Guidelines) describes the core concepts, structures, and processes necessary for the delivery of high-quality palliative care by interdisciplinary care teams across care settings.

Unfortunately, current policies and payment systems continue to pose numerous barriers that limit palliative care teams' ability to receive adequate reimbursement for providing comprehensive palliative care services consistent with the NCP Guidelines, and therefore limit patients' ability to receive high-quality palliative care, as discussed in further detail below. However, improvements to payment under the Medicare Physician Fee Schedule (MPFS) – paired with broader regulatory and legislative reforms to bolster the palliative care workforce, increase funding for palliative care research, and protect access to multimodal pain management therapies – could serve to expand access to palliative care services nationwide. ***AAHPM would be pleased to work with CMS and other policymakers and stakeholders to effectuate such payment reforms in the Medicare program to best support delivery of comprehensive, interdisciplinary team-based palliative care to patients with serious illness.*** We offer preliminary recommendations and feedback below, including both high-level comments and responses to specific CMS questions.

Overarching Comments

The most significant challenge with current Medicare payment is the absence of adequate reimbursement mechanisms for the services performed by the non-physician, non-advanced practice provider (APP) members of the palliative care interdisciplinary team, including social workers, pharmacists, non-APP nurses, and chaplains and other spiritual care providers. Licensed clinical social workers can bill for behavioral health services under Medicare Part B, but the social work central to palliative care—caregiver assessment, benefits navigation, discharge planning, family conferencing, social needs screening and referral—does not fit the behavioral health billing framework. Pharmacists have extremely limited billing authority under Part B despite being essential to safe, effective symptom management—particularly in safe opioid use, methadone dosing, and polypharmacy reconciliation. Chaplains and spiritual care professionals have no Medicare billing pathway at all, and RN services conducting symptom triage and caregiver training are not independently billable. While we recognize that some of these services could potentially be captured under E/M codes or care management codes, like Chronic Care Management, Complex Chronic Care Management, or Principal Care Management codes, the documentation requirements for these services complicates their use, as further detailed below.

To address these limitations, CMS could develop codes for comprehensive palliative care services furnished by an interdisciplinary care team across facility and non-facility settings. This could include a code for an initial comprehensive palliative care assessment and care plan development, which would require multidisciplinary assessment across physical, psychological, social, and spiritual domains, along with a resulting care plan that addresses patients' needs and goals across the domains. CMS could also develop additional codes that would allow for ongoing delivery of palliative care services pursuant to the care plan under a monthly case rate that would cover comprehensive palliative care furnished in a manner consistent with NCP Guidelines. Eligibility for these payments should require palliative care teams to meet interdisciplinary staffing and quality standards consistent with the NCP Guidelines. Additionally, the monthly case rate codes should account for progressive levels of patient acuity, with tiered case rates that would cover services based on patient need, including initial comprehensive assessments, ongoing patient education, development of care plans and goals of care, communication with other providers and coordination of related services, 24/7 availability to respond to requests for information or assistance, in-person and telehealth visits, symptom management, and more. ***AAHPM strongly recommends that CMS work to establish such codes and provide Medicare coverage through the MPFS in order to support comprehensive, team-based palliative care; reduce provider administrative burden; and facilitate care consistent with patients' goals and preferences.*** As a starting point, monthly case rates could be modeled after the Advanced Primary Care Management (APCM) services that CMS recently finalized, including by bundling care management and principal illness navigation codes, with a targeted focus on delivery of palliative care rather than primary care.

Notably, AAHPM has advocated for dedicated palliative care payment, along with quality and cost accountability, through a CMS Innovation Center alternative payment model. Indeed, we submitted a proposed model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and worked with other stakeholders to inform CMS about critical elements that should be incorporated into such a model. While we support implementing new monthly palliative care payments under the MPFS consistent with our recommendation above as a starting point, we recognize innovation and experimentation may help to further refine how such payments are structured. ***We therefore encourage CMS to consider testing alternatives to monthly MPFS payments under its Innovation Center authority, to gain a better understanding of how best to ensure adequate coverage and payment of these critical services for patients with serious illness. Innovation Center authority should also be pursued to the extent***

that statutory constraints limit CMS's ability to provide coverage and reimbursement for comprehensive community-based palliative care services.

We also note that we have supported payment changes in the MPFS that allow for increased access, including changes that allow for billing and payment of care management services, communication technology-based services, caregiver training services, community health integration (CHI), and principal illness navigation (PIN) services. ***As an interim step, AAHPM further encourages efforts to increase availability and utilization of these and similar services to bolster palliative care teams' tools for meeting the needs of seriously ill patients, including to allow caregiver training services to be furnished on an "incident to" basis and to allow services comparable to CHI and PIN services to be furnished by clinical staff under physician supervision in institutional settings.***

Responses to Specific CMS Questions

Do the evaluation and management (E/M) codes, care management codes, and advance care planning (ACP) codes represent the majority of the billing codes providers use to capture community palliative care services?

AAHPM agrees that E/M codes, care management codes, and ACP codes represent the majority of billing codes used to capture community-based palliative care services. However, we note that these codes generally reimburse time spent by physicians and APPs, but they do not adequately reimburse time spent by other members of the interdisciplinary palliative care team and therefore only cover a fraction of the clinical care furnished by palliative care teams. For example, these codes do not reimburse:

- the social worker navigating a Medicaid spend-down while the patient is still pursuing disease-modifying treatment;
- the pharmacist reviewing a complex opioid regimen;
- the chaplain conducting a spiritual assessment that shapes a goals-of-care conversation;
- the registered nurse (RN) providing after-hours symptom triage that prevents an avoidable ED visit at 2 a.m.

Notably, palliative care programs sustain these roles through institutional subsidies and/or philanthropy, or by covering them at a loss. Such arrangements are fragile and inequitably distributed: well-resourced academic medical centers can absorb the subsidies, while rural and safety-net programs cannot, leading to disparities in access to comprehensive community-based palliative care.

What services are typically provided when Z51.5 is billed?

There is significant variability in the use of the Z51.5 ICD-10 code, which contributes to a lot of "noise" when analyzing data on its use. In one study, this code was found to have only a 50% sensitivity for detecting specialty palliative care use in adults.[3] For some institutions, the code is applied for all comfort care patients whether Specialty Palliative Care consultation has occurred or not; in others, use of the code is less consistent, with many palliative care services furnished without accompanying reporting of the code. Notably, the code does not define a distinct service package or clinical expertise. Our members report that encounters coded with Z51.5 can

[3] Frydman JL, Arora A, Chen Y, et al. A novel billing-based approach to measuring receipt of specialty palliative care consultation. J Pain Symptom Manage. 2026 Apr;71(4):e451-e455. Doi:10.1016/j.jpainsymman.2025.12.015. Epub 2025 Dec 24.

represent comfort care provided by non-palliative care specialists or those provided by board-certified specialists, without differentiation. For example, care coded with Z51.5 can include symptom assessment and management, goals-of-care discussions, medication reconciliation, care coordination across treating teams, psychosocial screening, and hospice enrollment.

While the underlying data is noisy and reflects variability in service delivery, AAHPM nonetheless recommends that CMS explore whether Z51.5 reporting, in conjunction with E/M and care management codes, could be used to identify and characterize a palliative care utilization cohort for analytic purposes – particularly if CMS intends to evaluate access patterns, geographic distribution, and spending trajectories for community palliative care populations. Identification of a palliative care cohort would be a valuable first step toward evidence-based benefit design.

Are there challenges in meeting documentation requirements or integrating nonbillable team members, such as social workers, chaplains, or nurses who are crucial to palliative care delivery?

As noted above, the documentation requirements for E/M and care management codes complicate their use in reporting and receiving payment for services furnished by non-physician/non-APP members of the interdisciplinary palliative care team. These codes either require the physician/APP to perform the service directly (e.g., for E/M or ACP services) or allow clinical staff time to count toward billing thresholds but may not offer sufficient flexibility as a result of "incident to" rules to allow for contributions from the disciplines in question; in effect, this often excludes most of the interdisciplinary work that comprises high-quality palliative care. Additionally, many of our members report that their infrastructure does not support use of these codes, due to additional uncompensated administrative burden and overlap with primary care roles and responsibilities.

Is there uncertainty about compliance requirements or concern that billing for palliative care will result in claims denials?

Our members report some of their institutions do not support utilization of principle illness navigation, chronic care management or advance care planning billing codes due to concern for claims denials. Billing requirements are often complicated and onerous for these codes. In many cases, practices are required to meet extensive requirements simply to be eligible to bill the codes, which may be untenable for many small practices. For example, these codes require use of certified electronic health record technology (CEHRT), which many small programs do not utilize given prohibitive costs and lack of CEHRT that is tailored to hospice and palliative medicine practices. Members also report concerns about the ability to use clinical staff time for these codes, including as a result of questions about which clinical staff types may contribute to the time totals. We also note that documentation requirements for these codes are also burdensome, and complexity around overlap across services can cause further uncertainty.

As noted above, we also have concerns about involving certain members of the care team in services pursuant to "incident to" rules. Rules for "incident to" services require the services to be "integral, although incidental" to the physician's professional service and the types of services to be "commonly furnished" in a physician's or other practitioner's office or clinic. It is not clear that chaplaincy services meet these requirements under any circumstances, and social work services for caregiver assessment, benefits navigation, and family conferencing also may not qualify.

What non-medical services, such as caregiver training or spiritual care, would most benefit patients if reimbursed? And what enhancements to existing benefits (not requiring legislation) could strengthen palliative care?

AAHPM would welcome coverage of non-medical services that would support the delivery of comprehensive community-based palliative care. In particular, we believe coverage and payment of following services through tiered palliative care case rates paid on a monthly basis, as recommended above, would enable palliative care teams to furnish care consistent with NCP Guidelines and best contribute to improving patient experience, reducing caregiver burden, and reducing avoidable utilization:

- Palliative-specific social work services. Coverage and payment of palliative-specific social work services, such as caregiver assessment, social needs navigation, and family conferencing, would provide patients and caregivers utilize available assistance and resources to address their multifaceted needs. For example, closed-loop referral for housing, food insecurity, transportation, and benefits enrollment would directly address upstream drivers that contribute to avoidable utilization and inequity in this population.
- Caregiver training and support. Caregivers manage medications, operate medical equipment, provide personal care, and make real-time triage decisions—often without structured preparation. While CMS currently pays for caregiver training services furnished by billing professionals, such services cannot be furnished on an "incident to" basis. Furthermore, the foci of the existing caregiver training codes (e.g., behavioral modification, functional performance, wound care, etc.) do not align well with the type of care for which caregivers of patients with serious illness require training, which might include activities such as opioid administration, symptom recognition and triage decision making, and navigating emotional and spiritual dimensions of caregiving. Reimbursing caregiver training sessions delivered by nursing, social work, or pharmacy staff that address palliative care needs would increase the availability of caregiver training, reduce caregiver distress, and prevent avoidable ED visits driven by caregiver uncertainty.
- Spiritual care. Spiritual distress is independently associated with worse symptom burden, lower treatment adherence, and higher healthcare utilization in seriously ill populations.[4,5] Coverage of spiritual care services would increase access to spiritual care services to mitigate such negative outcomes.
- Medication management. Pharmacist provision of medication management services for palliative care patients under a collaborative practice model would help improve symptom management, promote safe opioid use, and prevent harmful medication interactions.
- After-hours symptom triage. Most avoidable emergency department visits for seriously ill patients occur outside business hours. Structured nurse triage lines funded as a covered service would reduce acute utilization and align with CMS's interest in lowering non-hospice spending.

And while these services would ideally be funded holistically through monthly palliative care payments, to the extent that CMS can also modify current policies (e.g., by allowing caregiver

[4] Balboni TA, VanderWeele TJ, Doan-Soares SD, et al. Spirituality in serious illness and health. *JAMA.* 2022;328(2):184–197. doi:10.1001/jama.2022.11086.

[5] Austin PD, Lee W, Keall R, Lovell MR. Efficacy of spiritual interventions in palliative care: An umbrella review of systematic reviews. *Palliat Med.* 2025 Jan;39(1):70-85. doi: 10.1177/02692163241287650. Epub 2024 Oct 16.

training services to be furnished on an "incident to" basis), we recommend that CMS pursue such changes to support palliative care delivery when specialized palliative care teams are unavailable.

Finally, separate from the above scope of services, AAHPM also recommends that CMS pursue the creation of standardized codes or definitions for identifying the population of patients with serious illness. Such codes or definitions would enable CMS and providers to better target interventions for such patients, as well as evaluate their effectiveness.

What aspects of palliative care are financially unsustainable for providers?

As reflected in our comments above, AAHPM contends that the interdisciplinary team itself is financially unsustainable under current payment. The Center to Advance Palliative Care and the National Palliative Care Research Center report that programs in for-profit hospitals (49%) and rural hospitals (34.5%) lag substantially—not because of clinical ignorance, but because the business case under fee-for-service is lacking.[6] Specific unsustainable elements include:

- After-hours coverage. 24/7 clinician availability is essential to prevent avoidable acute utilization but generates no fee-for-service revenue.
- Home-based care. Home visits are reimbursed at rates that do not cover travel time, team coordination, or the higher per-encounter clinical intensity typical of seriously ill patients at home.
- Care transitions. Coordinating across inpatient, outpatient, home-based, and hospice settings requires significant team time that falls between billing categories.
- Equity-responsive services. Language access, culturally adapted care, and partnerships with community organizations serving marginalized populations require dedicated resources that current payment ignores entirely.

What documentation requirements do providers typically use, or suggest using, to identify the provision of palliative care?

While palliative care practitioners may use Z51.5 to identify the provision of palliative care, as noted above, the use of the code is inconsistent and non-specific. AAHPM would be pleased to work with CMS to develop new reporting protocols. For example, if CMS were to develop one or more palliative care payment codes consistent with AAHPM recommendations, reporting of the code would clearly reflect provision of specialty, interdisciplinary palliative care. In the interim, CMS could also develop one or more palliative care modifiers to report specific elements of palliative care delivery.

Do providers commonly refer patients for home health services when a patient needs palliative care concurrently with curative or life-sustaining care?

Our members report that referral to home health services is common when a patient needs palliative care concurrently with curative or life-sustaining care. As a result, home health agencies take on a large role in managing the care of patients with serious illness, yet their accountability structures do not take this into account. AAHPM therefore believes that – until more comprehensive community-based palliative care payment is established – it could be beneficial to distinguish between traditional home health patients and those who are receiving home health care as part of a palliative care plan by placing the palliative care patients in a separate "palliative

[6] Rogers M, Dumanovsky T. How we work: Trends and insights in hospice palliative care. The Center to Advance Palliative Care and the National Palliative Care Research Center. February 2017.

track." Patients in this track should have a written "coordination agreement" between a palliative care physician or APP and the home health agency. CMS could also assess home health agencies on different quality measures that are more relevant to their care. This could include, for example, the proportion of patients with a symptom assessment, a psychosocial assessment, and a spiritual assessment; patient's experience of feeling heard and understood (see MIPS measure #495); or improvement of distress burden.

At the same time, we underscore that such an arrangement creates fragmentation: the palliative care team manages goals of care, symptom management, and psychosocial support, while the home health agency provides skilled services under a separate plan of care, separate documentation, and separate clinical oversight. The patient experiences two teams, two sets of visits, and two care plans that may or may not communicate effectively. The home health benefit's homebound requirement also creates challenges for some seriously ill patients who are functionally declining but not yet homebound by CMS definition—excluding them from services they need.

AAHPM underscores that this fragmented referral pattern is itself evidence of a payment gap. Patients with serious illness need integrated, team-based home care. The current structure forces providers to split that care across benefit categories designed for different populations.

What services do providers typically offer patients who are not eligible or ready to elect hospice care but require palliative services?

For patients with serious illness who are not hospice-eligible or not yet ready to elect hospice – e.g., patients with advanced cancer continuing active treatment, progressive heart failure with uncertain prognosis, neurodegenerative disease on a multi-year trajectory, multimorbidity with functional decline – our members report that providers often offer the following services to support patients' palliative care needs:

- Physician/APP-led symptom management and goals-of-care conversations
- Care coordination across oncology, cardiology, nephrology, and primary care

These services are generally fully or partially billable, including through the use of Medicare-covered E/M and care management codes.

To the extent that palliative care programs can support the following services, which the NCP Guidelines specify are integral to quality palliative care but which remain largely uncovered by Medicare, programs may also offer the following services:

- Social work support for caregiver distress, benefits navigation, and advance directive completion
- Pharmacy consultation for complex symptom regimens
- Spiritual care
- After-hours symptom triage
- Caregiver training furnished by non-billing professionals

Establishing coding and billing to support the provision of comprehensive, interdisciplinary palliative care – including through a comprehensive monthly case rate – would help to ensure that patients with serious illness who require community-based palliative care are able to access the care they need.

Construction of a Hospice Specific Wage Index and Geographic Variation

CMS considers a new approach for constructing a hospice specific wage index and seeks feedback on unique considerations applicable to hospice.

AAHPM contends that hospices experience differences in cost based on geographic setting that extend beyond differences in local area wages and occupation mix. For example, different geographic regions may have different labor costs associated with the extensive travel routinely required in the delivery of hospice care. These travel costs are likely highest on a per-patient, per-day basis for hospices that serve rural populations with large catchment areas, where patients may be located in remove and geographically isolated areas. Likewise, rural hospices may also experience higher costs related to ambulance transfers due to long distances involved and lack of social services, as well as workflow inefficiencies related to poor cell phone and internet coverage in remote areas, which we do not believe are captured in current geographic adjustments.

AAHPM therefore urges CMS to analyze hospice cost data to determine the extent to which costs vary based on geographic location and to incorporate findings from such analysis into appropriate geographic payment adjustments, in order to protect and promote access to hospice care for rural beneficiaries with terminal illness.

Medical Aid in Dying

CMS notes that more states are passing laws allowing medical aid in dying (MAID), creating challenges for hospices and other providers that participate in Federal health programs. CMS is interested in hearing from stakeholders about their experiences when Medicare hospice patients request MAID.

AAHPM acknowledges the complexity that MAID presents to hospice programs, which aim to maximize patients' end-of-life care. AAHPM recognizes that MAID is permitted on a state-by-state basis, and that it is governed by state and federal rules, including the federal prohibition on funds used to facilitate MAID. Therefore, AAHPM maintains that any hospice interface with MAID processes should be conducted in a manner consistent with state and federal laws and regulations.

AAHPM underscores that hospice remains the best way to support the needs of patients facing terminal illness, as well as their families and caregivers. For such patients, the hospice benefit is intended to ease many of their stressors, including pain and other symptoms, thereby contributing to increased comfort and improved quality of life in their final days, weeks, or months. It offers a comprehensive and holistic approach to management of care for terminally ill patients, provides physical, psychosocial, and spiritual support in a manner that minimizes burden on the patients, families, and caregivers, while also offering support throughout the grieving process for families and caregivers.

AAHPM contends that hospices can effectively take on these functions, even when patients pursue MAID, and in a manner that is consistent with state and federal laws and regulations. Detailed state and federal guidance have informed the development of clear hospice policies and procedures that delineate the limitations on hospice staff involvement in MAID, thus ensuring compliance.

Updates for the Hospice Quality Reporting Program (HQRP)

Medicare.gov Compare Tool Icon

CMS proposes to add an icon to the Medicare.gov Compare Tool identifying hospice facilities that have failed to meet reporting requirements for the Hospice Quality Reporting Program (HQRP). The proposed icon will identify hospices failing to submit any data or submitting less than the required 90 percent of Hospice Outcomes and Patient Evaluation (HOPE) submissions within 30 days of the patient's admission or discharge date within a year period.

While AAHPM supports this proposal as a meaningful step toward greater transparency, we encourage CMS to take stronger action to hold hospices accountable for not meeting reporting requirements under the HQRP. For example, CMS could also separately identify on the Medicare.gov Compare Tool those hospices that have failed to report Hospice CAHPS survey data. The Hospice CAHPS survey is the only measure in the HQRP that captures the lived experiences of patients and their families, making it a critical tool for understanding if hospices are meeting the needs and goals of the patients they care for. CMS could also work with Congress to increase the penalty for those hospices that do not comply with reporting requirements.

Future Measures Update – Hospice Care Index

CMS discusses potential future changes to the Hospice Care Index (HCI) measure, based on feedback from a Technical Expert Panel (TEP) that identified concerns with several of the HCI indicators and preference for alternative indicators.

AAHPM supports further refinement of the HCI, and we offer suggestions related to individual indicators below.

- Hospice provided continuous home care (CHC) and general inpatient (GIP) service. AAHPM agrees with the TEP's concerns that this indicator is not a good measure of hospice quality on its own. We highlight that billing requirements for CHC are overly burdensome and limit billing of CHC-level services, such that hospices cannot get credit for furnishing CHC even when they do so. For example, a hospice could furnish 7 hours and 45 minutes of CHC, but because it is not a full 8 hours, the hospice cannot bill. Likewise, a hospice could furnish 8 consecutive hours of care over a time period that crosses midnight, thereby not meeting the 8-hour threshold for billing in a single calendar day. Additionally, challenges with GIP billing also exist, particularly for small, under-resourced hospices. While AAHPM believes that patients should have access to all levels of hospice care, the CHC and GIP indicator should not be included in the HCI as a standalone indicator, and instead, CMS should consider options that tie CHC or GIP provision to other indicators that would better reflect quality of care, as discussed further below. CMS should also consider revisions to CHC billing requirements to
- Burdensome transitions (type 1): Discharges from hospice followed by hospitalization and hospice readmission. AAHPM agrees with the TEP's concerns that this indicator may not be a good measure of hospice quality, particularly for small hospices. In many cases, the patients who trigger this indicator change their minds about hospice care and instead seek to "reset" treatment through pursuit of hospital-based, disease-directed care, including care that hospitals

would not provide under GIP arrangements with hospices. In such cases, a hospice may be penalized for discharging the patient from hospice even though it best aligned with patient and family preferences. Additionally, there are many scenarios where hospices have little control over whether patients are sent to the hospital, particularly with patients receiving hospice care in facilities. Holding the hospice accountable for such a hospitalization does not reflect the quality of care the hospice furnishes and, further, creates disincentives for hospices to readmit the patient to hospice after hospital discharge even when doing so is clinically appropriate or aligns with the patient's preferences.

- Burdensome transitions (type 2): Discharges from hospice followed by the patient dying in the hospital. AAHPM encourages CMS to consider tying this indicator to no provision of GIP service. Hospices that would trigger such a combined indicator are those that discharge their patients from hospice to go into the hospital to die without hospice services. Such behavior reflects an unacceptable dereliction of duty in the delivery of end-of-life care, and hospices that engage in such activity should be held responsible.
- Discharge-related indicators. The TEP raised concerns about the two indicators focused on live discharges – i.e., live discharges in the first 7 days of hospice and live discharges on or after the 180th day of hospice. The TEP also supported the addition of an indicator focused on a hospice's overall live discharge rate. AAHPM agrees that an overall live discharge rate would be preferable to the existing live discharge indicators that are included in the HCI. We note that the indicator focused on live discharges on or after the 180th day can be readily gamed, with hospices discharging patients before the cutoff to improve their scores.
- Provision of respite care. While the TEP considered the addition of an indicator related to the provision of respite care, AAHPM has concerns that the same challenges will exist for respite care as apply for CHC related to burdensome billing requirements. AAHPM therefore cautions against adding a provision of respite care indicator to the HCI at this time.

Hospice Outcomes and Patient Evaluation (HOPE) Tool Implementation

AAHPM appreciates CMS's update on HOPE implementation and public reporting of performance on HOPE measures. We take this opportunity to provide feedback on implementation.

To begin, we note ongoing concern regarding burden associated with the two process quality measures that are based on HOPE data collection – Timely Reassessment of Pain Impact and Timely Reassessment of Non-Pain Symptom Impact. ***While AAHPM agrees that both measures are important in managing hospice patients' care, we continue to believe that hospices need flexibility to furnish the reassessment via two-way telecommunications technology.*** This includes services furnished via audio-only modalities when the patient is either unable or unwilling to complete visits using audio-video capabilities. We understand that the in-person reassessment requirement that currently applies creates significant burden on hospices, particularly those in rural areas that may have to travel long distances to complete the reassessment. Furthermore, in many cases, the in-person visits are burdensome to patients and families, who may find it stressful to have numerous people, sometimes strangers, in and out of their homes, especially in the last days of life; in these cases, requiring visits to take place in-person would not be concordant with patients' needs or preferences.

We also encourage CMS to consider additional measure concepts that could be collected through the HOPE tool. For example, CMS could consider an additional concept for future quality measure development that focuses on hospice patients' access to hospice teams. Too often, we have heard of

situations where patients in crisis required assistance, but hospices were unable to send appropriate clinical staff in a timely manner and instead referred patients to emergency departments or left patients and caregivers to manage on their own. A measure addressing, for example, the percentage of triaged calls that convert to hospice visits could address such scenarios and increase hospices' accountability for providing appropriate and timely follow-up care.

We also highlight that the HOPE tool only minimally addresses patients' psychosocial or spiritual needs. While there is a question that addresses whether the patient and/or caregiver was asked about spiritual/existential concerns, there is no further exploration of what those concerns might be or whether concerns are addressed or resolved over time. AAHPM believes patients' spiritual and psychosocial experience can be a core part of patients' experience of hospice and therefore should be included in patient evaluation tools. We therefore encourage CMS to pursue changes to the HOPE tool that would assess the spiritual and psychosocial aspects of the hospice experience, in addition to the indicators of physical well-being that are already included therein.

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Thank you again for the opportunity to provide feedback on the important issues addressed in this proposed rule. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Wendy Chill, Senior Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,

Kimberly Curseen, MD, FAAHPM
President, American Academy of Hospice and Palliative Medicine