



June 1, 2026

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

RE: CMS-1851-P Medicare Program; Fiscal Year 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements

The National Coalition for Hospice and Palliative Care (NCHPC) welcomes the opportunity to provide comments and recommendations from our Coalition on CMS-1851-P Medicare Program; Fiscal Year 2027 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program Requirements (Proposed Rule). Like the Centers for Medicare & Medicaid Services (CMS), the Coalition supports improving transparency, strengthening program integrity, and safeguarding beneficiaries, while emphasizing that new policies must preserve access to high-quality hospice and palliative care for patients and families across diverse communities.

To inform these comments, the NCHPC convened experts and professionals from across the interdisciplinary field of hospice and palliative care that comprise our Coalition.

The NCHPC represents 14 leading professional organizations dedicated to advancing access to high quality care for serious illness. Our member organizations represent the interdisciplinary workforce that delivers palliative care and hospice care. This includes more than 5,500 physicians, 1,000 physician associates, 7,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs and 5,300 hospices. Our members also include organizations focused on patient advocacy. Our vision is that all patients, families, and caregivers have access to equitable, high-quality palliative care and hospice across the lifespan.

We appreciate the opportunity to provide our recommendations on the Proposed Rule.

Hospice Payment Update

CMS proposes a net hospice payment update of approximately 2.4 percent for FY 2027, which the Coalition views as insufficient to keep pace with the real costs of delivering high-quality end-of-life care and sustaining access, particularly for higher acuity and underserved populations. The Coalition appreciates that CMS is providing a positive update rather than a reduction; however, we remain concerned that the proposed rate increase does not adequately reflect persistent workforce pressures, inflation in key input

costs, and the additional administrative burden associated with new transparency and oversight initiatives.

There is a continued pattern in which hospice payment growth lags well behind rising expenses for nursing, social work, aide services, pharmacy, durable medical equipment, and other core elements of hospice care. This is especially challenging for smaller hospices, rural hospices, and those caring for underserved and/or pediatric populations as they often have limited ability to cross-subsidize losses and are at heightened risk of service reductions or closure when payment updates are not aligned with actual cost trends. Not to mention, the update does not consider the cumulative effect of previous payment updates that have not kept up with inflation in recent years. Without a more realistic payment adjustment, hospices may face increasing pressure to absorb these costs by limiting services, reducing staff, or slowing adoption of innovative care models that could benefit patients and families.

For these reasons, the Coalition urges CMS to reassess the adequacy of the proposed FY 2027 update considering current cost and workforce data. We recommend that CMS consider whether application of the full productivity adjustment is appropriate in the current environment, or whether it can and should be moderated or suspended for FY 2027 and evaluate whether additional targeted support or adjustments are needed for hospices that serve disproportionate shares of complex, dual-eligible, or underserved populations.

A payment update that more accurately reflects the realities hospices face is essential to sustaining access, supporting the workforce, and ensuring that the other policy changes in this rule do not inadvertently weaken the very providers CMS relies on to deliver high quality end-of-life care.

Services and Spending Variation Index (SSVI)

The SSVI calculates a 0–16 point score for each hospice, combining a 0–8 point non-hospice spending score and a 0–8 point utilization score based on multiple claims-based metrics. The non-hospice spending component is derived by ranking hospices on their total non-hospice spend and dividing them into eight groups of roughly equal size, with higher total-spend groups assigned progressively higher point values. Because this component uses aggregate dollars rather than a normalized rate (e.g., per-beneficiary or per-day spending), larger hospices with more beneficiaries and more days of care will naturally accumulate higher total non-hospice spending. This is true even when their per-beneficiary non-hospice spending is at or near the national average.

The Coalition supports the intent to use data to identify patterns of performance and behavior suggestive of potential fraud or inappropriate utilization and appreciates the recognition that many hospices provide high-quality care in challenging environments. Data-driven approaches can help focus attention on truly aberrant utilization and non-hospice spending patterns. Utilization of an index can be a powerful tool to identify hospices that may warrant further investigation or oversight. It is because of the significance of the index that it is critical that the indicators comprising it accurately

identify outliers of significant disproportionate performance. The Coalition is concerned that the current SSVI design, particularly the non-hospice spending component, may systematically bias scores against larger hospices whose total non-hospice spending is high due to volume rather than atypical care patterns. Larger hospices, by virtue of serving more patients, will inevitably include more individuals who require medications, skin substitutes, and other specialized treatments that are billed outside the hospice benefit.

To understand how SSVI relates to the broader universe of CMS-issued data, Coalition members examined how hospice-level SSVI scores compared with Hospice Quality Reporting Program (HQRP) data and the list of hospices whose Medicare certification has been revoked. That review found that high SSVI scores did not align closely with more direct indicators of potential concern, such as non-compliance with HQRP reporting requirements or a revoked Medicare provider agreement. This lack of correlation suggests that, as currently specified, SSVI may not reliably distinguish hospices that pose the greatest program integrity or quality risk. This underscores the need for CMS to utilize only refined and validated indices for program integrity actions and oversight as well as public posting for transparency.

Stakeholders have raised concerns that the SSVI could potentially create a chilling effect on hospice utilization. Scores that are posted publicly could unfairly drive legitimate patients and referring practitioners away, even with non-hospice spending being out of the hospice's control. Higher SSVI scores will likely be interpreted by contractors, referral sources, payers, and the public as indicative of inappropriate care. If the non-hospice spending component systematically pushes larger hospices into higher SSVI ranges, these providers may face disproportionate audit targeting, reputational harm, and network or referral disruptions based largely on their size rather than on true aberrancy. This could have unintended access-to-care consequences, especially where large hospices play a critical role in serving complex patients, underserved communities, or broad geographic areas.

In addition, high SSVI scores driven by volume-based non-hospice spending may create counterproductive incentives. To avoid crossing total-spending thresholds, hospices might hesitate to support appropriate non-hospice services for high-need patients or might seek to avoid patients with conditions that predict higher non-hospice utilization, even when such care is clinically indicated. This would be inconsistent with CMS's goal of ensuring timely access to comprehensive, patient-centered care.

The utilization portion of the SSVI is built from metrics derived from the Hospice Care Index (HCI). The HCI is a composite claims-based measure that is not currently endorsed by the national Consensus Based Entity (CBE). CMS has indicated that it plans to respecify the HCI and resubmit it for endorsement, which means that a substantial portion of the SSVI rests on a measurement framework that is still under active redevelopment and has not yet undergone updated consensus review. Relying on these HCI-based utilization metrics within SSVI and then using SSVI for public reporting or oversight targeting, therefore, raises additional concerns about validity and stability at a time when CMS acknowledges that the underlying measure requires refinement.

The Coalition encourages CMS to delay any public reporting or enforcement uses of SSVI until these methodological issues are addressed and sensitivity analyses are available for stakeholder review. The Coalition further believes it is far more appropriate for CMS to first share any index results directly with hospices, in a confidential manner, along with comparative information against peer groups and national benchmarks. This will allow providers to identify potential data calculation issues and take corrective action when warranted without premature and potentially inaccurate public labeling, especially when on an index whose validity and calibration are in question.

We further urge CMS to not publicly report SSVI or index scores or use them to flag hospices for enforcement targeting at this time. Posting scores that are influenced heavily by non-hospice spending that is not normalized and by utilization metrics derived from a measure to be respecified and not currently endorsed, risks misinforming beneficiaries and referral partners and other stakeholders about true quality and/or program integrity concerns of a particular hospice. As stated elsewhere, such reporting could have a chilling effect or inadvertently create a perverse incentive.

We support CMS's goals of improving transparency and targeting oversight resources appropriately, but believe these modifications are necessary to avoid unintended bias against larger hospices and to ensure that SSVI accurately identifies hospices with truly aberrant care patterns rather than those that merely serve more patients.

Election Statement Addendum and Non-hospice Spending

CMS proposes to require hospices to furnish the hospice election statement addendum to all Medicare beneficiaries at the time of hospice election for admissions beginning on or after October 1, 2026. The Coalition appreciates CMS's efforts to enhance transparency and beneficiary understanding through the hospice election statement addendum and share the Agency's goal of ensuring that patients and families receive clear, actionable information about coverage responsibilities at the time of hospice election. The Coalition appreciates that hospices are expected to cover nearly all items, services and drugs that are needed by a hospice patient. At the same time, the Coalition is concerned that the proposed requirement to furnish the addendum to all Medicare beneficiaries at admission, beginning October 1, 2026, does not meaningfully address the primary drivers of non-hospice spending and may impose additional burden on hospices while misdirecting accountability.

We are particularly concerned that the proposal treats universal addendum distribution as a central solution to rising non-hospice Medicare spending during hospice episodes, even though most of that spending arises from claims submitted by other Medicare-participating providers such as hospitals, DME suppliers, physicians and pharmacies. These providers and suppliers must code a claim as explicitly unrelated to hospice care in order for the claim to process for payment. These coding and billing practices are not under the direct control of the hospice. Providing the addendum to every beneficiary at admission does not ensure that these non-hospice providers adjust their coding and billing behavior or that unsupported non-hospice claims are identified and addressed. The proposal, as outlined

in the rule, risks reinforcing the perception that hospices are principally responsible for all non-hospice claims during an election, even when they neither order nor bill the services in question.

CMS already has clear regulatory and operational mechanisms to address unsupported non-hospice spending at its source. Under existing documentation requirements, the provider that submits a claim is responsible for maintaining records sufficient to support coverage, coding, and payment for the services billed. CMS and its contractors have long stated that when the medical record does not substantiate the billed services, there is no basis for payment, and any amounts paid may be denied initially or subsequently recovered as overpayment. In other words, the burden of justifying payment rests with the entity seeking payment, not with the hospice that did not submit or code the non-hospice claim. The hospice election statement addendum, indicating that an item, service or drug is unrelated, can and should serve as this justification. This framework reinforces the Coalition's view that non-hospice billing providers, not hospices, should be the primary focus of efforts to address unsupported non-hospice spending.

The Coalition is also concerned about the potential burden and unintended effects on beneficiaries. Presenting every beneficiary with a detailed legalistic document, regardless of diagnosis, expected course of care, or likelihood of receiving non-hospice services, could increase confusion rather than reduce it. It could also inadvertently discourage appropriate use of hospice or necessary non-hospice services if beneficiaries interpret the addendum as a warning or limitation on needed care.

The Coalition is also concerned that the election statement addendum may unintentionally increase, rather than reduce, beneficiary confusion about coverage. As currently structured, it focuses on items, services, and drugs the hospice has determined are unrelated to the terminal illness and related conditions, but does not address common situations in which services are related yet not reasonable and necessary under Medicare standards or not separately payable because payment has been waived through the hospice election. In this context, beneficiaries may reasonably infer that if a service does not appear on the addendum, it will be covered by Medicare through hospice or on a fee-for-service basis, even though that is often not the case. Because it does not explain these related-but-not-payable scenarios, the addendum falls short of the comprehensive clarity CMS anticipates and may instead foster a false sense of certainty while leaving the most challenging coverage issues unresolved.

The gap in the explanation is a result of a gap in the Medicare coverage and payment structure. It is not the fault of hospices, or any provider sector, or beneficiaries. There are situations occurring daily that exemplify this gap. In urgent or emergent situations, for instance, a caregiver may appropriately call 911 rather than contact the hospice first. The resulting ambulance transport and emergency department services may be related to the terminal illness and not listed on the addendum. At the same time, those services are not separately payable under Medicare because payment for related care has been waived through the hospice election. The transportation, emergency department visit and any

subsequent hospitalization is billed by the provider as unrelated in order to secure payment.

CMS must also consider that there are conflicting regulatory requirements that may result in non-hospice spending. Specifically, 42 CFR § 483.30(c) requires that nursing facility residents “be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. Per the Medicare Claims Processing Manual, Ch. 12 § 30.6.13, “Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits.” While hospice physicians may fulfill this requirement, rarely is a nursing facility accepting of this substitution.

In these situations, the addendum does not mitigate the problem as it does not alert the family to the coverage consequences and does not influence the non-hospice provider’s coding decisions, allowing the very billing outcomes CMS is seeking to avoid. These situations were not as prevalent when the Medicare Hospice Benefit was initially implemented as the population of beneficiaries receiving hospice care was not diverse. It was primarily cancer patients with more predictable trajectories that often did not include emergent situations. It also was not common to see physicians and practitioners outside of the attending physician and/or hospice physician or receive treatments and services from other non-hospice providers.

The Coalition also notes that the addendum is most closely tied to the comprehensive assessment rather than the election of hospice care. Information from the assessment is needed to determine what conditions, services, items and drugs are related and which are not. Throughout the course of care, updates to the comprehensive assessment are used to update these decisions. Most importantly, throughout the course of care beneficiaries or their caregivers often seek items, services, or drugs on their own. Hospices are usually not aware of these decisions by beneficiaries and caregivers prior to the beneficiary or caregiver making the decision. It is impossible for hospices to update the addendum prior to the beneficiary receiving the item, service or drug. In some cases, the Advance Beneficiary Notice (ABN) should be used by the non-hospice provider to explain coverage and payment parameters to the beneficiary and caregiver. This assumes the non-hospice provider is aware of the beneficiary’s election of hospice care. This may not be the case as it does take some time for the hospice Notice of Election to process and other providers to have visibility into this in the HETS system.

For these reasons, the Coalition urges CMS to reconsider its approach. Instead of expanding the election statement addendum to all beneficiaries as a proxy for controlling non-hospice spending, the Coalition recommends that CMS focus on strengthening data sharing and enforcement mechanisms aimed at non-hospice billing providers whose claims contribute to inappropriate spending during hospice episodes. CMS should also provide hospices with confidential, comparative feedback on patterns of non-hospice spending, benchmarked to peer groups and national averages. In addition, detailed information on non-hospice spending by Medicare provider and linked to the hospice’s patients should be available to the hospice so that the hospice has actionable information to address the issue. This information will assist hospices in identifying the types of

situations where non-hospice spending is occurring for their population and to develop plans to mitigate the instances of such spending.

The Coalition appreciates CMS' continued refinement of non-hospice spending analyses and urges CMS to clearly distinguish between non-hospice spending patterns that are expected, e.g. unrelated conditions, concurrent non-hospice services in complex comorbid patients; and patterns that may indicate under provision of hospice care or inappropriate hospice enrollment.

Conforming Regulations for Telehealth Extension

Through this proposed rule, CMS indicates that it is adopting the language of the Consolidated Appropriations Act of 2026 (the Act) which prohibits the telehealth flexibilities being utilized by a hospice in the case of a face-to-face encounter with an individual occurring on or after January 31, 2026, in certain circumstances. The Coalition appreciates that CMS will be issuing a Change Request (CR). Until the time it is published, the Coalition strongly encourages CMS to put in writing to the Medicare Administrative Contractors (MACs) and audit contractors that claim denials should not occur until the CR is published. Additionally, we offer the following for consideration for each of the telehealth restrictions contained in the Act as the CR is being developed.

- Individual is receiving hospice care from a provider that is subject to enhanced oversight under this title pursuant to section 1866(j)(3)

The Coalition assumes that 'enhanced oversight' is limited to the Provisional Period of Enhanced Oversight (PPEO) program. CMS often refers to PPEO and Expanded Prepayment Review (EPR) simultaneously. There are currently six states where these programs are being administered. However, these are different programs and only PPEO falls under 'enhanced oversight'.

The Coalition further assumes that a patient of any hospice that has been *notified* that it is under PPEO would be subject to the telehealth prohibition as opposed to all hospices meeting the PPEO definition of "new" in the applicable state. The effective date of the telehealth prohibition should be no earlier than the date the hospice received notification that it is under an active PPEO review. Because the F2F encounter can be completed up to 30 days prior to the start date of the benefit period, it is possible for an encounter to occur prior to the effective date of a hospice's PPEO review, and this encounter supports claim dates of service during the PPEO period.

- Such encounter is performed by a hospice physician or nurse practitioner who is not enrolled under section 1866(j) and is not an opt-out physician or practitioner (as defined in section 1802(b)(6)(D))

Currently, only certifying physicians for hospices are required to be enrolled or validly opted out.

Sufficient time is needed for these practitioners to enroll or opt out. This must be considered and allowed for implementation. CMS must also consider whether the telehealth prohibition will apply to all F2F encounters by a physician or NP or only those performed via telehealth.

Hospices are able to see in the Ordering & Referring Data File (ORDF) the enrollment status of physicians. Additionally, this file is set up for certification allowances not F2F encounter privileges. Hospices will need to identify and look up the status of the NP. Currently, the Order & Referring file is only for certification (not F2F encounter) and only for physicians. CMS must consider how the necessary detail regarding the NP will be available to hospices in order to implement this parameter.

Furthermore, hospice claims currently do not include the F2F visit as it is a non-billable visit. The claims also do not identify the physician or practitioner who performed the F2F encounter. CMS will need to determine how the F2F practitioner will be identified on the claim as well as the identifying information, such as the NPI, that will be required on the claim and whether the F2F encounter date will need to be added to the claim.

- In the case of such an encounter occurring on or after January 1, 2027, any hospice claim includes 1 or more modifiers or codes (as specified by the Secretary) to indicate that such encounter was conducted via telehealth after “as determined appropriate by the Secretary.”

This provision should be considered concurrently with the provision requiring NPs to be enrolled or validly opted out in order to perform the F2F encounter via telehealth.

Overall, the Coalition recommends that CMS not enforce any of these provisions until there is a code signifying the encounter was performed via telehealth.

Regulations Regarding Who May Discharge a Patient

To align with the current payment and CoP regulations at §§418.22(c)(1)(i) and 418.102(b), respectively, CMS proposes to add the text “or the physician member of the hospice interdisciplinary group” at § 418.25(a) and (b) to indicate that, in addition to the medical director or physician designee, the physician member of the hospice IDG may also determine admission to hospice care. CMS states that aligning the language at §418.25(a) and (b) with the language at §§418.102(b) and 418.22(c)(1)(i) would allow for greater consistency between key components of hospice regulations and policies.

The Coalition supports this proposal and agrees that this change will align the regulations such that they will consistently describe the physicians that can certify terminal illness and determine patient admission to hospice care, helping to ensure that terminally ill beneficiaries can access hospice services.

Hospice Quality Reporting Program

CMS proposes displaying an icon on Care Compare to indicate when a hospice is not compliant with the HQRP requirements. The Coalition shares CMS's commitment to robust quality reporting and transparency, and we appreciate that a binary icon is a first step.

The Coalition agrees that consistent, accurate quality reporting is fundamental to accountability and quality improvement and supports public reporting on Care Compare identifying hospices that do not participate in quality reporting.

We caution the use of the icon in situations that reflect data submission errors, temporary system failures, or narrowly defined shortfalls in one reporting period as opposed to sustained disregard for quality reporting obligations. Treating all such scenarios identically on a public-facing platform does not give beneficiaries, referral sources and the public meaningful context and may inadvertently steer them away from hospices that, in practice, provide excellent care but have experienced a limited reporting issue. A visible icon can quickly become a shorthand indicator that overshadows more nuanced quality information. This is particularly troublesome where the underlying issue is administrative or technical rather than clinical, and where the hospice has already taken corrective action. We recommend the icon is applied only when it is confirmed the hospice has had opportunities to correct administrative or technical errors, so the icon truly reflects lack of participation in quality reporting.

CMS could 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.

Hospice Care Index Re-specification

CMS has indicated plans to respecify the Hospice Care Index (HCI) and resubmit it to the national consensus-based entity for endorsement. The Coalition appreciates CMS's ongoing commitment to refining claims-based measures and recognizes that re-specification may improve the measure's construct validity and alignment with current practice. Simultaneously, Coalition members have previously emphasized that composite measures must be carefully tested to ensure they do not inadvertently penalize hospices serving populations complex social and clinical needs.

The Coalition encourages CMS to make detailed HCI re-specification methodologies, testing results, and impact analyses available to stakeholders prior to finalizing changes.

And, to evaluate how respecified HCI performance varies by hospice size, geography, and patient mix to identify potential inequities. CMS should provide a preview period during which hospices can review their re-specified HCI scores and offer feedback, before the measure is used in public reporting or payment policy. This collaborative approach will help ensure that HCI continues to reflect meaningful aspects of hospice care while supporting quality improvement rather than punitive oversight.

Requests for Information (RFIs)

Ways to Enhance the Provision of Palliative Care Outside of Hospice Care: Current Coverage, Billing Practices, and Opportunities for Improvement

The Coalition applauds CMS for exploring ways to improve access to high-quality palliative care. An essential component of high-quality palliative care is access to an interprofessional team of experts that can provide medical, psychological, social, emotional, and spiritual support. While the Physician Fee Schedule includes many codes to account for palliative care services (evaluation & management, principal care management, psychotherapy, caregiver training, and others), it leaves significant gaps, particularly for social service coordination, pharmacist consultation, spiritual care, and 24/7 response in community settings. This includes insufficient coverage and payment for the intensive work involved in initial assessment and coordination across multiple domains and professionals is not adequately accounted for, even with high-level E&M with complexity, as well as ongoing care furnished by the multidisciplinary palliative care team over the course of patients' serious illness.

Time is a key factor in providing high-quality palliative care services. It takes time to have in-depth conversations with patients and families about their pain and symptoms, their treatment options, and their fears and worries. For providers seeing patients in the community, it takes a good deal of time to get to each patient ("windshield time."). To meet needs holistically, it requires time for professionals to meet and discuss cases, and it takes the promise of time for patients to have access to 24/7 care. A solution which values this time-intensity and multiprofessional processes is required, through significant wRVU valuation.

Some palliative care services can also be furnished under the Medicare home health benefit, although this is not formally acknowledged by CMS in regulation or in sub regulatory guidance. Medicare home health services are interdisciplinary in nature and often focus on relieving symptoms, managing pain, improving comfort, and supporting quality of life for individuals with serious or chronic illnesses while they continue to receive medical care at home. In fact, a substantial proportion of seriously ill individuals utilize home health services during the last year of life.¹

We recommend, as a first step, that CMS revise its regulations and guidance to formally acknowledge that the provision of home health services (skilled nursing, home health aide,

¹ Jones T, Morrison S. Medicare Home Health Care Is the Ideal Platform for Home-Based Palliative Care at the End of Life. *Journal of Palliative Medicine*. 2025;28(7):862-864

medical social services, and therapy) can be for palliative purposes. A further recommendation is to modify existing documentation and quality measures so that providers and patients are not unintentionally penalized for using home health services for palliative needs.

ACP codes 99497 and 99498 are a positive step toward encouraging advance care planning and addressing patients' values, preferences, and goals. However, there is a mismatch between who manages these conversations and who can bill for them. Social workers play a key role in leading goals of care conversations and coordinating care plans with the treating clinicians, but social workers cannot bill these codes. The Coalition recommends that social workers' contributions to advance care planning be captured by ACP codes to foster greater access to advance care planning for patients and improved sustainability for palliative care programs.

Spiritual care also plays a key role in palliative care and advance care planning, and a lack of reimbursement and billing options create barriers to access. The HCPCS codes for chaplaincy recently approved by CMS are a helpful first step in overcoming these barriers. Patients and families have substantial need for spiritual care, and in a study of cancer patients, 79% reported at least one spiritual need.² Highly trained chaplains are well-equipped to engage in advance care planning and end-of-life discussions. Survey research shows that 70% of health care chaplains help patients complete health care directives and 90% report discussing treatment preferences at end of life with patients.³

A current information gap exists as it relates to tracking the delivery of specialty palliative care based on claims data. The current ICD-10 diagnosis code is not a reliable measure because it is used in various ways by other clinicians and its use among specialty palliative care providers is not widespread or consistent. The Coalition believes the ICD-10 diagnosis code has limited use for the purpose of improving access to specialty palliative care. A better solution would be to create a procedure code for palliative care, specifically a G-code for the essential comprehensive interprofessional assessment and care planning. There is precedence for an assessment and care planning code in the cognitive code 99483, as well as in HCPCS codes S0280 and S0281 used in Hawaii's new palliative care Medicaid benefit, and also in the Seriously Ill Population option under the CMMI Primary Care First model.

Telehealth is also a critical component of community-based palliative care delivery, particularly for patients with serious illness who face mobility challenges, caregiver dependence, or limited access to specialty care (i.e., rural or under-resourced locations). Hybrid care models, combining in-person and virtual visits, improve access, timeliness of symptom management, and caregiver engagement.

² https://bioethics.hms.harvard.edu/journal/spirituality-medicine#_edn10

³ Kwak J, Bang S, Rajagopal S, Dranamraju N, Handzo GF, Hughes B. (2022) Patients; spiritual concerns and needs and how to address them during advance care planning conversations: Healthcare chaplains' perspective. *Palliative and Supportive Care*: 1-8

To enhance the provision of palliative care outside of hospice care, the Coalition recommends the following:

- Create a G-code for a comprehensive palliative care assessment and care plan. The code must adequately account for the time it takes to provide key palliative care services. We recommend input and consideration by a minimum of three disciplines and consider professional time of no less than 90 minutes.
- Create additional G-codes to provide coverage and payment of an ongoing monthly case rate payment for the delivery of comprehensive, team-based community-based palliative care services, with payments tiered based on patient acuity.
- Use regulatory levers to explicitly accommodate palliative patients in Medicare home health services. Create a “palliative track” in Home Health Quality Reporting Program requiring coordination with a prescribing clinician, and more apt process requirements and quality measures.
- Allow social workers’ contributions to ACP be captured by the existing codes to bill the ACP codes.
- Issue guidance to palliative care specialists and other under-resourced clinicians on billing medical decision-making and using the complexity add-on code.

Medical Aid in Dying (MAID)

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.

The Coalition acknowledges the complexity that MAID represents to hospice programs, which aim to maximize patients’ end-of-life care. We recognize 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, the Coalition maintains that any hospice interface with MAID processes should be conducted in a manner consistent with state and federal laws and regulations.

The Coalition 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.

We contend 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 hospice policies and procedures that delineate the limitations on hospice staff involvement in MAID.

CONCLUSION

The Coalition shares CMS's commitment to protecting beneficiaries, promoting high-quality hospice care, and addressing fraud and abuse within the Medicare Hospice Benefit. The proposed changes to the addendum, SSVI and non-hospice spending analyses, MAID policy guardrails, Care Compare icon, and HCI re-specification will have significant implications for patients, families and providers.

The Coalition looks forward to working with CMS to refine these proposals in ways that strengthen oversight while preserving access to compassionate, interdisciplinary, and person-centered palliative care and hospice.

Sincerely,
Jessica Hausauer, PhD
Chief Executive Officer
National Coalition for Hospice and Palliative Care