May 26, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20543

RE: Request for Information on Ways to Enhance the Provision of Palliative Care Outside of Hospice Care

Dear Administrator Oz:

Thank you for the opportunity to submit comments on opportunities within Medicare to enhance access to, and quality of, specialty palliative care services.

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to improving quality of life, advancing health equity, and strengthening care delivery for people living with serious illness, and their caregivers. We provide health care professionals and organizations with the tools, training, and insights necessary to make health care work better for everyone.

A strong and consistent evidence base shows that palliative care improves quality of life, reduces caregiver and clinician burden, and in so doing, avoids preventable spending across all settings. Yet despite this clear value case, access to specialty palliative care services remains uneven, dependent on geography, provider tax-status, clinician knowledge, and other factors.

Medicare beneficiaries represent the majority of the population living with serious illness and in need of palliative care. We applaud CMS for recognizing this, and we offer the following insights and recommendations to strengthen palliative care services for these beneficiaries.

Current Palliative Care Medicare Billing Overview and Challenges

As noted in the RFI, most palliative care programs bill Medicare Part B; Evaluation & Management (E&M) codes, by setting, are billed most frequently. In addition, ambulatory and home-based programs sometimes bill the care management codes (e.g., CCM, CCCM, PCM, and PIN) and commonly use advanced care planning (ACP) and G2211 as add-ons to their encounters. The most relevant billed codes are in the CAPC summary guide, attached.

The existing Medicare Physician Fee Schedule can cover a good deal of palliative care program expenses but not all. Many palliative care leaders have noted the revenue improvements from the G2211 code, the principal care management codes that can be used by multiple providers

each month, and other recent changes. However, the ability to cover a full interprofessional team's salaries varies significantly, depending on:

1. *Team composition*. High-quality teams with strong social services and spiritual care are usually unable to cover their full salary costs on Medicare billing. National guidelines and emerging palliative care program standards require at least three disciplines on a palliative care team. With nurses unable to bill the Medicare fee schedule and social workers unable to bill outside of diagnosing and treating mental illness, these **interprofessional teams ncanot be sustained by fee-for-service billing alone**.

2. *Time requirements.* Palliative care's mechanism of intervention requires intense conversations with patients, caregivers, and members of the treating clinical team. In addition, high-quality home-based palliative care programs must include in-person visits, but this introduces a great deal of unreimbursable "windshield time," particularly for those serving rural areas. The **most productive home-based palliative care programs, using both in-person and telehealth encounters, accommodate 7-8 patients in a day** – roughly a quarter to a third of what a productive primary care office-based practice can accommodate.

3. *Coding competency of the palliative care clinicians*. Unlike many other specialties, palliative care clinicians rarely have professional coding support and must make their own decisions on documentation and coding. As a result, **palliative care is less likely to optimize their Medicare fee-for-service billing revenue**.

CAPC estimates that, with great variability, 65-75% of total annual expenses for a home-based team with at least three disciplines can be covered with *optimal* Part B billing. A few programs may fully cover their costs, but our surveys show that the vast majority of community-based palliative care programs rely on organizational subsidy and philanthropy to sustain their services.

Challenges of using ACP codes 99497 and 99498

CAPC greatly appreciates CMS's work to provide billing codes that recognize the unique clinical act of advanced care planning/goals of care conversations. Unfortunately, there are several obstacles to utilizing the ACP codes, especially: the need to document the ACP conversation separately; the need to separate the time spent (if billing on time); and the cost-sharing for the beneficiary. In addition, in many strong palliative care programs, goals of care conversations are primarily managed by the social worker or nurse, who coordinate with the medical provider(s) to adapt care plans but cannot bill for ACP services. **Adding the ability for social workers to bill these codes – and waiving the copayments wherever possible** – should better align the advance care planning codes with their original intent.

Challenges of the ICD-10 Z51.5 Diagnosis Code

Several years ago, CAPC investigated the use of the "palliative care encounter code" with program leaders across settings and with the Association of Clinical Documentation Integrity Specialists (ACDIS). Because that code is used by other clinicians to indicate that a patient is approaching end of life or that the treatment plan involves 'comfort measures' only, the positive predictive value to identify specialty palliative care team encounters with Z51.5 is only 67%, and the sensitivity is very low. In fact, some organizations encourage the use of Z51.5 to improve their quality metrics, even those organizations that provide no specialty palliative care. Further, because there are no financial consequences to using or omitting this code, its utilization among palliative care specialists varies widely.

Given all this, **CAPC strongly recommends that ICD-10 diagnosis codes not be considered as any part of the solution to expand access to specialty palliative care**.

Unfortunately, there is no reliable mechanism today to identify the provision of specialty palliative care services in claims data. There are two options that might improve this but the first would take concerted effort across palliative care programs, and the second would require CMS regulatory action:

- Edit existing certified Medicare providers working as palliative care specialists in the Medicare Provider Enrollment, Chain, and Ownership System (**PECOS**). Because palliative care is a sub-specialty and because advanced practice providers have limited options in the system, very few palliative care specialists are aware of the opportunity to select additional specialties, including specialty code 17. If the Medicare practitioners are correctly tagged as palliative care, utilization of specialty palliative care services can be more easily and accurately identified.

  However, this is not a comprehensive solution, as some palliative care specialists do not practice palliative care exclusively, so sensitivity may continue to be an issue. The coordinated effort required for this solution may also make this infeasible, but it is worth exploration.

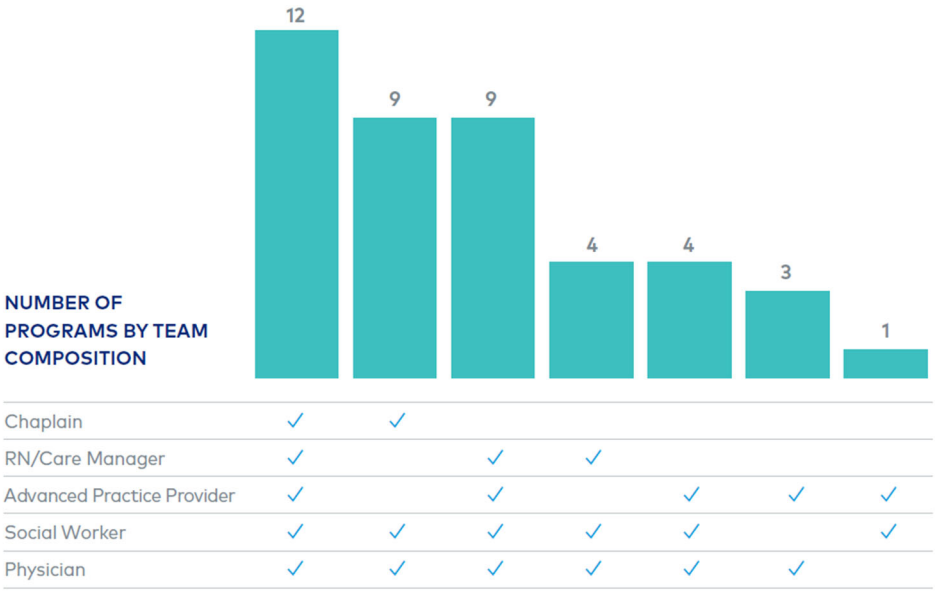
- A solution to both the problem of identifying palliative care provision and reimbursing the work of interprofessional palliative care teams is to introduce a **comprehensive specialty palliative care assessment HCPCS G-code**. Quality palliative care episodes begin with an interprofessional comprehensive assessment across physical, psychological, emotional, social, and spiritual domains, which in turn leads to a care plan or care plan adjustments. Patients who receive this service, documented through such a HCPCS code, can be said to have had a true specialty palliative care encounter, and a HCPCS code is a better fit than a diagnosis code.

Moreover, similar HCPCS coding is being used in new state Medicaid palliative care benefits (S0280) and can address many of the challenges asked about in the RFI. Please see our recommendations section below for more information.

Challenges in Covering 'Non-Billable' Team Members

As noted above, Part B billing is dependent on the time available from eligible clinicians, and some services when provided by non-billable team members cannot be billed, even if delivered "incident to." Recent fee schedule updates such as the community integration or principal illness navigation codes can support some non-billable staff in community-based programs but still leave professional services such as social service assistance or spiritual counseling uncovered.

In 2024, CAPC and the Palliative Care Quality Collaborative analyzed the team composition of 72 home-based specialty palliative care programs together serving over 35,000 patients annually; **84% of those reporting operate with "non-billable" staff**:



It should also be noted that many community-based palliative care social workers are not licensed at the level required to bill psychotherapy codes, or focus on tasks outside of psychotherapy, and thus cannot generate revenue.

Lastly, the **Medicare physician fee schedule does not account for the time and effort necessary to work as an interprofessional team**, discussing cases holistically and sharing opinions on treatments and conversations based on collegial input.

Non-Medical Services in Need of Reimbursement

The largest gaps in revenue for palliative care remain social services and spiritual care. As demonstrated by the palliative care team staffing figure above, almost all programs rely on social workers for assessing and addressing barriers to care, including financial resources, transportation, and family responsibilities, and more. As one palliative care physician leader recently noted:

> *"We are helping patients and families tremendously, but that's not me – social work is absolutely essential for these highly-emotional situations and complex social needs."*

While the newer care management codes begin to address this need in outpatient settings, the low wRVUs assigned to those codes are not aligned with the critical skills applied, nor with the time intensity given by professional palliative care social workers. And, as noted, the time a palliative care social worker spends clarifying goals of care may not always align with the incident-to requirements since many of these conversations occur in inpatient settings.

Spiritual care is another significant gap in Medicare billing. Many people in the United States consider spirituality and religion integral to their lives and their health care. In the face of serious illness, those spiritual needs become more frequent and intense, with as many as 79% reporting unmet spiritual needs. Yet despite the enormous need, chaplaincy services are reported at fewer than half of palliative care programs, with as few as one in four providing spiritual care in the ambulatory care setting (PCQC Quality Matters 2022). When investigated, most palliative care program leaders cite lack of sufficient revenue to support an employed chaplain. Early conversations reveal that, in anticipation of revenue losses for 2027, more chaplain positions are being eliminated than are being added.

Finally, please note that about 20% of home-based programs report additional "non-billable" staff, commonly including pharmacists and arts/recreational therapists.

Other Challenges: Preventing Costly Crises through Unreimbursed Time

As noted, palliative care field guidelines and emerging program operation standards **require 24/7 access to a knowledgeable clinician** with access to the medical record. Health care crises commonly occur among unstable, high-needs patients in the community; those patients and families in crisis must have appropriate medical advice to reduce suffering and avoid unnecessary emergency department visits and admissions. While the actual visit may be reimbursable under Part B, the significant additional expenses and compensation for on-call coverage is financially unsustainable with just fee-for-service billing.

The Intersection of Home Health and Palliative Care

As CMS correctly notes, certified home health services can contribute significantly to holistic, interprofessional specialty palliative care. In speaking with home health providers about

palliative care delivery, there is consensus that palliative care needs are skilled needs (e.g., assessment, teaching, managing medications and therapies) and that roughly 80-90% of their palliative care patients meet continual home-bound status.

However, home health as currently regulated cannot be a complete solution for three key reasons:

- Interprofessional specialty palliative care requires medical care from a trained physician or advanced practice provider coordinating closely with the other disciplines. Because these are separate licensure categories at the state level and separate certifications in Medicare, deployed responsibilities and communication mechanisms must be articulated between the two before the combination can deliver effective palliative care; however, such medical agreements are currently not required by Medicare.

- In some states, social work is carved out of the Medicare home health benefits for dual-eligible individuals, and as noted above, social work is essential to quality, effective palliative care.
    - Even in those states where social work services may be delivered within a home health episode, spiritual care remains a gap.

- The existing measurement and quality management for Medicare certified home health services are a poor match for palliative care patients. The OASIS over-burdens patients and staff with some assessments that are often not relevant to the care plan, and the quality incentives unfairly penalize agencies when a palliative care patient's expected functional decline indeed occurs. Many seriously ill and deteriorating patients benefit from maintenance therapy and nursing care, but the home health quality reporting program leaves little room to accommodate these patients, even with the adjustments made in the wake of *Jimmo v Sebelius*.

If a **new maintenance/palliative track within the certified home health infrastructure can be created**, many of these issues can be addressed. A coordinated care plan with medical practitioners can be required, guidance for states on social work services within the track can be issued, some OASIS sections may be deemed optional, and a more tailored or reduced set of quality measures can be required.

Recommendations for Non-Legislative Solutions

CAPC spoke with community-based palliative care programs leaders and palliative care billing experts to prepare feasible recommendations that can make a meaningful difference in revenue-generation and support of true multi-disciplinary palliative care delivered in home and office settings. Based on these conversations, we recommend the following:

- **Create a G-code for a Comprehensive Palliative Care Assessment and Care Plan**. The availability of such a code would be consistent with both Hawai'i and New Jersey Medicaid benefits, using the HCPCS S0280, and is also consistent with the design of the CMMI Seriously Ill Population (SIP) option that was proposed in 2019, and the existing CPT code 99483 for a comprehensive cognitive assessment and care plan.

  This assessment and care plan code must carry a wRVU that reflects the extensive time for palliative care introduction and assessment activities, across physical, psychological, social, and spiritual domains. It must require input and consideration by a minimum of three disciplines and consider professional time of no less than 90 minutes, thus earning a minimum of 4.0 wRVUs. (By way of comparison, a gastroenterologist performing a screening colonoscopy, CPT 45378, on an otherwise well person receives 3.18 work RVUs for 67 minutes of pre-, intra-, and post-service time). With sufficient compensation for the initial enrollment work required across the multi-member team, the existing E&M codes with the outpatient complexity add-on and ACP codes, combined with the principal care management/principal illness navigation codes, should be able to sustain ongoing longitudinal care for patients. When comprehensive re-assessments are needed, a template for coding that work exists in S0281.

  An additional advantage of introducing a palliative care assessment and care planning code is the ability to identify patients receiving specialty palliative care services, eliminating the need to rely on the faulty Z51.5 diagnosis code.

- **Create a "palliative track" in the Home Health Quality Reporting Program**. As noted, home health agencies can form a strong basis for quality home-based palliative care, but current quality measures discourage this. CMS should create a mechanism for agencies to distinguish between traditional home health patients and those who are receiving nursing and therapy as part of a palliative care plan. For patients on this track, there should be a written "coordination agreement" between a palliative care physician or advanced practice provider and the home health agency.

  The quality measures for patients on this track might consider: the proportion of patients with a symptom assessment, a psychosocial assessment, and a spiritual assessment; MIPS measure #495 patients' experience of feeling heard and understood; and some measured improvement of distress burden from intake to discharge. We urge against using the proportion of patients transitioning to hospice, as acceptance of hospice varies greatly by population served, and does not always reflect goal-concordant care.

Other regulatory actions that CMS can take to improve palliative care payment include:

- Adding social workers as certified providers allowed to bill the advanced care planning codes;
- Issuing guidance for palliative care specialists on billing medical complexity, adding relevant codes in the PECOS system, and how to use certain codes including G2211 and principal care management 99426 and 99427;
- Waive co-pays for advanced care planning in any program that CMS has authority, including for those attributed/participating in CMMI models. To facilitate this across all programs, advanced care planning should be categorized as a preventive service;
- Maintain monthly complex chronic care management and primary care management billing capabilities, particularly allowing non-physician billing for those codes; and
- Maintain (to the full extent of CMS authority) Medicare payment for palliative care services delivered via telehealth.

These actions should have a strong, positive impact on Medicare fee-for-service opportunities to support high-quality specialty palliative care services in community settings. In addition, we look forward to the continued drive towards value and we urge CMS to include specialty palliative care explicitly in all relevant alternative payment models.

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Thank you for the opportunity to submit these comments and for your genuine interest in enhancing access to palliative care. CAPC would welcome continuing the conversation on these issues and recommendations; please contact me at allison.silvers@mssm.edu to further this dialog.

Sincerely,

Allison Silvers
Chief, Health Care Transformation
Center to Advance Palliative Care

Attachments:

- Common palliative care codes by setting
- Spotlight on Home-Based Palliative Care: Insights and Recommendations from CAPC and PCQC