September 11, 2026

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

RE: CY 2027 Physician Fee Schedule Proposed Rule (CMS-1848-P), 91 FR 43842 — Request for Information on Community-Based Palliative Care (Section II.G.2)

Dear Administrator Oz:

The Center to Advance Palliative Care (CAPC) appreciates this opportunity to respond to CMS's Request for Information (RFI) on community-based palliative care.

We are grateful for CMS's focus on the needs of people living with serious illness, as demonstrated by recent RFIs and proposals in rulemaking across settings, care programs, and payment mechanisms. We refer you to our previously submitted comments on the Hospice proposed rule (CMS-1851-P); the ESRD proposed rule (CMS-1846-P); and the Home Health proposed rule (CMS-1844-P) for additional context.

A large body of evidence demonstrates that when patients' palliative care needs are met, their quality of life improves and acute care utilization is reduced. We urge CMS to approach this work through the lens of **one population with a shared set of needs**, rather than parsing it into categories, i.e., "serious illness care," vs. "palliative care." Separating the population in this way creates siloed eligibility rules and payment mechanisms, resulting in costly fragmentation and unnecessary complexity. By defining a single population, CMS can use existing mechanisms to support the work of palliative care teams to meet those needs as they change. Using the fee schedule as the baseline, CMS can then fill discrete gaps to ensure that high-quality, interprofessional palliative care is accessible for all high-risk Medicare beneficiaries with serious illness. This approach avoids duplicative new constructs, provides better flexibility to meet the complex needs of people with serious illness, and reflects how care is actually delivered.

In this letter, we offer what can be a comprehensive Medicare strategy for meeting the needs of beneficiaries with serious illness:

- Utilize both a claims-based process for identifying beneficiaries with palliative care needs, while maintaining a pathway for clinician referral to palliative care based on clinical assessment.
- Upon identification/referral, we recommend reimbursement for a comprehensive palliative care assessment and care plan to determine whether longitudinal palliative care services are needed
- For patients who require longitudinal support from a community-based palliative care team, utilize a new palliative care management code tiered to the level of patient need. The care management would exclude visits for the billable clinician on the team, who would continue to bill for those encounters.

Please see our responses to the specific questions in Section II.G.2 in the order that CMS presented them. The evidence we cite is in the hyperlinks.

Where should CMS focus on potential fraud, waste, and abuse in community-based palliative care? Please support your statements with peer-reviewed evidence or evidence from your institution with sufficient detail for review.

We are unaware of any palliative care program involved in fraud or abuse, because gaps in reimbursement for interprofessional palliative care services have historically made palliative care unattractive to "bad actors." And, we share CMS's concern for quality care for Medicare beneficiaries living with serious illness. To this end, by mid-2027 CAPC will release palliative care program standards – detailed, consensus-driven definitions of the required structure and capacities for palliative care teams, including staff composition and training, minimum services, and care model elements that have evidence of significant impact on outcomes. We will share the standards with CMS and others to guide accountability for quality palliative care.

b. Eligibility for Serious Illness Care

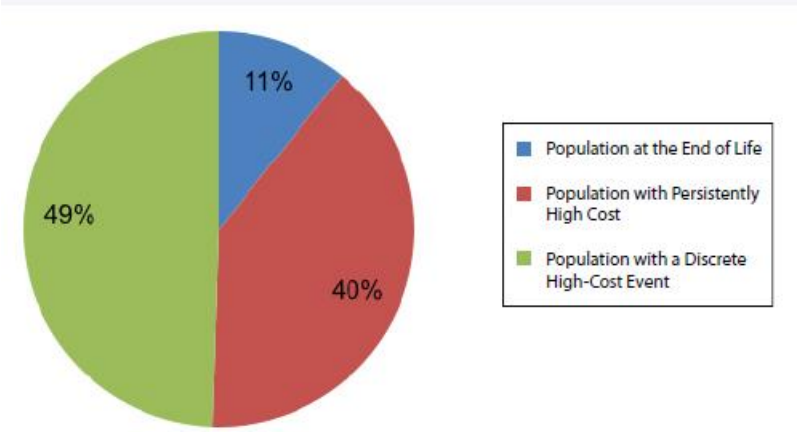
- *For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?*

(Again, we are answering this with the understanding that "serious illness care" means "palliative care.")

First, **CAPC strongly urges CMS not to use prognosis to determine eligibility for services**. Despite a large number of attempts at predictive algorithms, death remains

highly unpredictable, and clinician prognostic accuracy is weak when death is not imminent. Moreover, the benefits of palliative care – to both patients and the health system – accrue when access is based on need, not prognosis. Use of prognosis-based eligibility criteria will only perpetuate inaccuracies, over-payments, and barriers to access.

The palliative care specialty has always targeted those with high needs (and often high spend). Among Medicare beneficiaries, only 11% of high-spend individuals, here analyzed for the top 5% of spenders, die within the next twelve months. Nearly half of the top 5% are one-time high-cost, and a full 40% maintain year-after-year of high spending, as shown in this analysis from the National Academy of Medicine:



By linking eligibility to life expectancy, CMS would eliminate access to palliative care to the largest proportion of high-spend Medicare beneficiaries who could benefit.

Finally, there are many Medicare beneficiaries who recover from their serious illness and go on to live healthy lives. This population can benefit tremendously from palliative care ***during treatment***; in fact, studies suggest that adherence to treatment, particularly in cancer, is enhanced when concurrent palliative care is delivered.

Given all this, we encourage CMS to consider alternative means to determine eligibility, which we detail below.

- *If eligibility is restricted to those beneficiaries with a terminal prognosis, is there evidence to suggest a reasonable interval (that is, less than 1 year of life expectancy as in some States' Medicaid programs)?*

A two-step approach that combines a life-limiting diagnosis (as identified through a discrete list of ICD-10 codes) **with a second indicator of need** (as identified through past

utilization) would allow CMS to identify eligible beneficiaries based on existing claims data, as illustrated in the table below:

Two-Step Data Screening	
Diagnoses	→ advanced cancer (locally advanced or metastatic); leukemia or lymphoma → Heart failure or advanced heart disease → Advanced lung disease, oxygen-dependent → Advanced dementia or Alzheimer's disease → Advanced kidney disease → Advanced lung disease with home oxygen or hospitalized for the condition → Frailty syndrome (weakness, slowness, low level of physical activity, fatigue, unintentional weight loss)
--AND--	
One or more of these indicators of unmet need, impaired function, or high symptom burden	→ One or more ED visits within past three months → One or more hospital admissions within the past three or six months → Home health episode from community referral → Sequential home health episodes → Durable medical equipment claims consistent with impaired function or high symptom burden → Discharge from post-acute care with low functional score

This combination of a **specific diagnosis combined with past health services utilization** aligns with a higher risk of Medicare expenditures and death. Past utilization may include emergency department visits, hospital admission, repeated home health episodes, or specific durable medical equipment. This two-step approach to eligibility mirrors what had been implemented successfully in the Independence at Home program as well.

However, claims-based identification processes will generate false positives and false negatives, and some areas of palliative care needs – such as caregiver distress or declining function without health services utilization – should also be accommodated to determine eligibility for palliative care services. We offer a secondary process for identifying patients below.

c. Eligibility for Palliative Services

For any future supportive or palliative care service for Medicare beneficiaries, how could we consider impact on the daily functions of life or activities of daily living as part of who is eligible for the service?

CAPC has worked with dozens of payers and population health managers to identify patients who would benefit from palliative care and has consistently found that **processes which require screening for function prior to any referral are not only labor-intensive but also are difficult to assess reliably because function changes over time.**

That said, a comprehensive assessment of palliative care needs – spanning symptom burden, psychological distress, caregiver burden, functional status, spiritual or existential needs, and social risk factors – allows the palliative care team to identify and address unmet needs that could otherwise lead to distressing and costly emergencies. There is also some evidence that a palliative care symptom assessment itself results in reduced risk of emergency department visits.

Therefore, CAPC recommends that rather than using functional status to determine referral for palliative care services, **CMS create a comprehensive specialty palliative care assessment HCPCS G-code.** This would enable a broader range of Medicare beneficiaries to receive a holistic needs assessment that would, like the OASIS in home health, define services to be delivered to reduce patient suffering and improve outcomes. Further, this HCPCS code would be a powerful solution to enable both Medicare and private payers to identify patients who receive subsequent services from a specialty palliative care team.

As CAPC described in our response to the palliative care RFI in the 2027 hospice proposed rule, HCPCS S0280 is currently used in both the Hawai'i and New Jersey Medicaid plans and is also consistent with the design of the CMMI Seriously Ill Population (SIP) option that was proposed in 2019, as well as the existing CPT code 99483 for a comprehensive cognitive assessment and care plan. We further recommend that a palliative care assessment and care plan code require input and consideration by a minimum of three clinical disciplines – reflecting the multifactorial needs of Medicare beneficiaries with serious illness – and consider professional time of no less than 90 minutes, thus earning a minimum of 4.0 wRVUs.

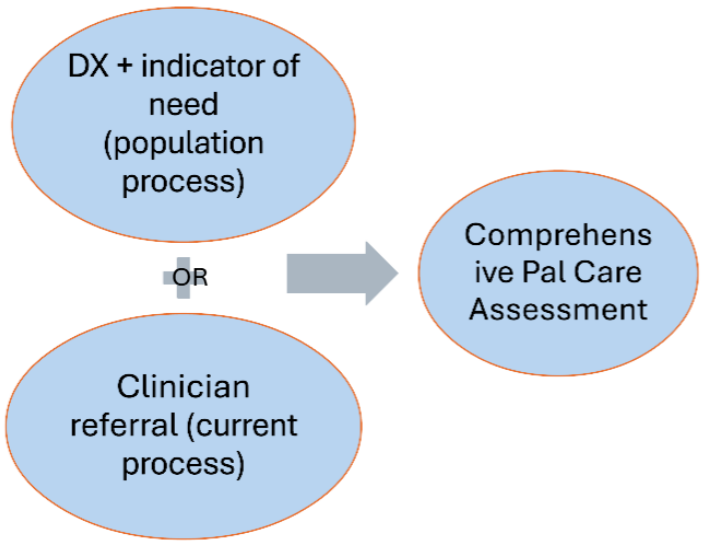
Would eligibility best be based on impact on daily function, on caregiver strain, or both? How can we avoid overly burdensome requirements for defining eligibility for services?

The research on Americans living with serious illness shows the symptoms and stressors of serious illness impact function, caregiver well-being, and quality of life – and so selecting one or the other for an eligibility threshold does not serve the Medicare population in need. It is also important to note that patients under-report their functional impairment and caregivers often minimize their distress when speaking with clinicians – making it less likely that this approach will correctly identify the population in need.

Instead, **we strongly recommend using two proven approaches** to define eligibility for interdisciplinary specialty palliative care services:

1. **Use claims to identify beneficiaries with a serious health condition AND past utilization of health care services** (which indicate unmet need)**.**
2. **Create a new HCPCS code to pay for a comprehensive, interdisciplinary palliative care assessment (including caregiver burden) triggered by clinician referral,** and require that use of the assessment results in a palliative care plan.

Note that both approaches can be used simultaneously to optimize timely access to appropriate palliative care services for high-need beneficiaries with serious illness:



While proactive identification through available data is important, there will continue to be many patients in dynamic treatment situations where the treating clinician recognizes that specialty palliative care consultation is required, and where the data-driven approach falls short. Thus, CAPC **strongly urges an approach that enables any Medicare beneficiary with serious illness to have access to a comprehensive palliative care assessment**

and care plan. This assessment process will not only help the patient's treating clinician to address palliative care needs, but also will identify patients who would benefit from ongoing specialty palliative care.

d. The Future of the Care Management Services

How should we differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?

A good number of community-based palliative care programs use the existing CCM, CCCM, and PCM codes for longitudinal care, combined with E&M visits. That said, if CMS is considering the use of a new, distinct care management code for beneficiaries living with serious illness as a mechanism to support specialty palliative care services exclusively, **CAPC urges strict provider eligibility criteria** to use that code, ideally aligned with the field's program standards currently under development (and mentioned above). Whereas currently any eligible clinician can bill the existing care management codes for appropriate beneficiaries, a care management service exclusive for "serious illness care" must be limited to interdisciplinary care by qualifying programs.

It is worth noting that there is precedent within the Physician Fee Schedule for requiring an interdisciplinary team in order to bill. For instance, CPT 99492/99493/99494 (Psychiatric Collaborative Care – first and subsequent months) can only be billed when care is delivered through a defined three-role team: the billing treating practitioner, a behavioral health care manager, and a psychiatric consultant. As such, we encourage CMS to use this as a model for a new serious illness care management code with required disciplines participating.

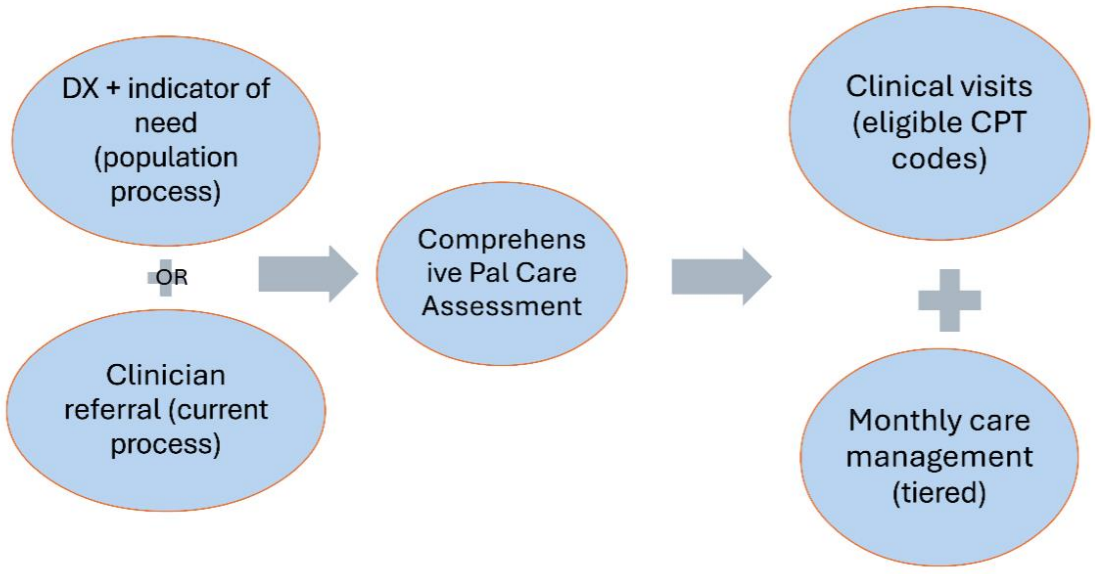
If a serious illness care management code is limited for use by qualified palliative care programs, the additional code can help to fill existing gaps in funding for holistic care of beneficiaries living with serious illness. Again, states like Hawai'i and New Jersey are using a similar code, S0311, to cover comprehensive management and care coordination for advanced illness, per calendar month. In those cases, the care management code is intended as a bundled payment for all services, but **CAPC recommends that Medicare align more closely with existing reimbursement practices and pay both the monthly care management code and existing clinician visits** (such as evaluation & management, health and behavioral assessment and intervention, caregiver training, etc.) just as is done with CCCM and PCM currently. This can minimize opportunities for fraud and abuse while encouraging meaningful contact with an interprofessional palliative care team that is

equipped to address the multifactorial needs of people with serious illness that result in preventable utilization.

Lastly, **we recommend that CMS test a tiered model of serious illness care management**, much like the two sets of codes for chronic care management and complex chronic care management, or the tiered dementia care management payments in the CMMI GUIDE Model. Like function, palliative care needs are dynamic and change over time, requiring varying levels of service intensity from the palliative care team. Location of service also impacts the intensity of care management required, particularly whether the beneficiary is homebound or not. Caregiver circumstances also vary significantly and that has an enormous impact on clinical care management activities. A tiered care management payment would better reflect actual care delivery.

Consolidated Recommendation

CAPC has done a great deal of investigation into the questions of eligibility for specialty palliative care services and the reimbursement needed to ensure high-quality, interprofessional care for complex patients. Combining both sets of questions, we envision an eligibility and longitudinal payment model that works as follows:



e. Advanced Primary Care Management MIPS Value Pathway

Should care management services for seriously ill beneficiaries also require reporting to a MIPS Value Pathway? Which quality measures should be reasonably included? If no viable MIPS Value Pathway reporting mechanism is found, what are the essential quality elements required for palliative care management? Is sole reporting of ambulatory palliative care patients feeling heard and understood (CBE 3665) sufficient? Should other measures be considered?

Palliative care programs have often struggled with appropriate quality measures the reflect the clinical reality of serious illness, because many validated measures concern patient improvement, metabolic control, or screenings that are inappropriate for this population. Nonetheless, subject matter experts in the field of palliative care have convened around this measure set in the past:

Concept	Measure	Comments
Patient-reported experience of care delivery	Ambulatory palliative care patients' experience of feeling heard and understood	MIPS #495 Expand to ambulatory and home-based
Documentation of advance care planning (ACP) or surrogate decision-maker	Proportion of patients who have an advance care plan or surrogate decision-maker documented in the medical record	MIPS #047
Prevention and treatment of symptoms	Palliative care patients' getting the help wanted for pain	Stewarded by the American Academy for Hospice and Palliative Medicine
Timely and appropriate use of Hospice care	Proportion of patients who died admitted to hospice for less than three days	MIPS #457 Currently validated for cancer patients only; expand to all patients and consider a longer time period

There are additional quality measure concepts that would be appropriate to include in such a MIPS Pathway, especially: the proportion of patients who have completed symptom assessments; and the proportion of patients who have a family caregiver documented in the medical record with a completed burden assessment. However, there are not yet quality measures that have been tested, validated, and approved for these concepts.

* * * * *

Thank you for the opportunity to submit these comments and for your 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