September 14, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
US Department of Health & Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program [CMS-1848-P]

Dear Administrator Oz:

On behalf of the Patient Quality of Life Coalition (PQLC), thank you for the opportunity to provide our feedback regarding the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Medicare Physician Fee Schedule proposed rule (hereinafter "the CY27 Proposed Rule"). PQLC is a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, and our members represent patients and their caregivers, health professionals, and health care systems with the overarching goal of providing these patients with greater access to palliative care services. Herein we provide background on palliative care and recommendations concerning the following proposals:

- CY 2027 Conversion Factor
- Caregiver Training Services
- RFI: Community-Based Palliative Care
- Care Management Coding
- Evaluation & Management (E&M) Complexity Add-On
- Advance Care Planning

Palliative Care

One of the key priorities of the PQLC is to improve patient access to palliative care. Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis) and can be provided along with curative treatment. The goal is to improve quality of life for both the patient and the family.

Studies show that palliative care interventions are associated with improvements in patient quality of life and symptom burden.[1] Without palliative care, patients with serious illnesses and their families are

[1] Kavalieratos D, Corbelli J, Zhang D, Dionne-Odom JN, Ernecoff NC, Hanmer J, Hoydich ZP, Ikejiani DZ, Klein-Fedyshin M, Zimmermann C, Morton SC, Arnold RM, Heller L, Schenker Y. Association Between Palliative Care and

at risk of poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other caregivers.[2,3] In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.[4] Another study found that the receipt of a palliative care consultation within two days of hospital admission was associated with 22 percent lower costs for patients with certain comorbid conditions, saving an average of $3,200 on every admission, with savings climbing to $4,200 for patients with cancer.[5] The American Heart Association has stated that palliative care can be a helpful complement to current care practices and can improve quality of life for stroke patients, caregivers, and providers.[6]

Yet, despite the demonstrated benefits of palliative care, millions of Americans remain unable to access such services. It is estimated that between 5-12 percent of adults and up to 1 percent of children require palliative care, but access remains uneven, particularly in public and rural health care systems.[7]

CY 2027 Conversion Factor

Like in CY 2026, CMS continues to implement two separate conversion factors for CY 2027: one for qualifying alternative payment model (APM) participants (QPs), and one for providers who are not QPs. The CY27 Proposed Rule updates the conversion factor for QPs by +0.75% and updates the conversion factor for non-QPs by +0.25%. Changes to the conversion factors also include a +0.53% adjustment to account for adjustments in work relative value units (RVUs). Additionally, the CY27 Proposed Rule includes a reduction to both conversion factors due to the expiration of a 2.5% increase to fee schedule payments for 2026 specified by Public Law 119-21, the Working Families Tax Cut (WFTC). In sum, the conversion factor for QPs will decrease by $0.40 (-1.19%), and the conversion factor for non-QPs will decrease by $0.56 (-1.68%).

Comment: As WFTC relief expires, we continue to urge the Agency to work with Congress on long term payment reform and recognize the value of palliative care. Payment certainty for providers allows the healthcare system to work better for patients. Even in times of payment uncertainty, palliative care providers have supported patients in need of specialized care. These providers relieve patient suffering and coordinate care across multiple specialties. Access to palliative care continues to pose a challenge to the U.S. healthcare system, and we urge CMS to recognize how its payment

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Patient and Caregiver Outcomes: A Systematic Review and Meta-analysis. JAMA. 2016 Nov 22;316(20):2104-2114. doi: 10.1001/jama.2016.16840. PMID: 27893131; PMCID: PMC5226373.

[2] Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. JAMA. 2004 Jan 7; 291(1):88-93.

[3] Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. The Milbank Quarterly. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

[4] Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med. 2010;363:733-742.

[5] May P, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. Health Affairs. January 2016.

[6] Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association / American Stroke Association.

[7] America's Readiness to Meet the Needs of People with Serious Illness: 2024 Serious Illness Scorecard. Center to Advance Palliative Care. August 2024.

systems drive patients' ability to access high-quality, life enriching palliative care and recognize the cost-savings this care provides to both CMS and Medicare beneficiaries.

Caregiver Training Services

CMS seeks comment on whether the resource costs associated with Caregiver Training Services (CTS) are well reflected through current Healthcare Common Procedure Coding System (HCPCS) G-codes, or if these costs are reflected in the valuation of other codes paid under the PFS, such as evaluation and management (E/M) visits. In CY 2025, CMS finalized new HCPCS G-Codes (G0541, G0542, and G0543) which provided payment for direct care CTS, a policy strongly supported by PQLC.[8]

Comment: We urge CMS to maintain separate payment for CTS and avoid payment reductions to this vital service. The resource costs associated with CTS are best reflected through the existing, standalone G-codes. Please see the table below to illustrate distinctions between the codes:

CTS Service Category	Typical Providers	Training Location
Functional Performance Training	Rehabilitation therapists (occupational therapists, physical therapists, speech-language pathologists), physicians, nurses	Private practices, patient's home, facilities, remote (telehealth)
Direct Care Strategies	Nurses, Physicians	Private practices
Behavior Management	Social workers, psychologists	Private Practices, patient's home

These services require distinct provider resources and time to train caregivers in skills necessary to support care and reduce complications. The necessary time to educate and train caregivers is not adequately reflected in the typical E/M visit, even at the higher complexity levels, as disease treatment itself requires extensive time and decision-making, quite separate from the training caregivers receive once a course is decided upon. Additionally, by design, this training is provided without a patient present and serves a "fundamentally different purpose" than E/M visits, which focus on patient evaluation and management. Many of the allied professionals who can bill for CTS codes under the existing program, such as OTs, cannot bill for E/M services. We urge CMS to continue its support of caregivers and patients by maintaining distinct CTS payment codes for all types of caregiver training needed.

[8] Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, 89 Fed. Reg. 97710, 97817-21 (December 9, 2024).

Community Based Palliative Care

CMS requests information on appropriate requirements the agency should consider for the administration of community-based palliative care. Community-based palliative care services are delivered outside the hospital and across a variety of care settings including outpatient facilities, physician offices, a patient's home, skilled nursing facilities and supportive residences, and other settings.

Comment: We appreciate CMS' attention to the needs of patients living with serious illnesses that require palliative care services and urge CMS to avoid overly burdensome requirements that complicate care delivery or reduce access to palliative care. In its request for information (RFI), CMS rightly recognizes the benefits of a comprehensive approach to palliative care for patients.

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?*
- *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)?*

We urge CMS not to restrict palliative care services based on life expectancy duration. Some of the patients who benefit from palliative care eventually recover from their illnesses, while others manage their condition for many years as a chronic illness. Indeed, randomized controlled trials[9] and systematic reviews[10] have shown that patients benefit when they receive palliative care in conjunction with curative treatment – this is one factor distinguishing palliative care from hospice care.[11] Determinations of which patients may benefit from palliative care are best made by the treating physician, and not constrained by arbitrary timelines. In fact, we have sufficient evidence to conclude that clinicians are poor prognosticators,[12] and predictive models[13] do not fare much better.[14] We urge

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[9] Temel JS, Greer JA, El-Jawahri A, et al. Effects of Early Integrated Palliative Care in Patients With Lung and GI Cancer: A Randomized Clinical Trial. *J Clin Oncol*. 2017;35(8):834-841. doi:10.1200/JCO.2016.70.5046

[10] Haun MW, Estel S, Rücker G, et al. Early palliative care for adults with advanced cancer. *Cochrane Database Syst Rev*. 2017;6(6):CD011129. Published 2017 Jun 12. doi:10.1002/14651858.CD011129.pub2

[11] Temel JS, Greer JA, El-Jawahri A, et al. Effects of Early Integrated Palliative Care in Patients With Lung and GI Cancer: A Randomized Clinical Trial. *J Clin Oncol*. 2017;35(8):834-841. doi:10.1200/JCO.2016.70.5046; Haun MW, Estel S, Rücker G, et al. Early palliative care for adults with advanced cancer. Cochrane Database Syst Rev. 2017;6(6):CD011129. Published 2017 Jun 12. doi:10.1002/14651858.CD011129.pub2

[12] Orlovic, M., Droney, J., Vickerstaff, V., Rosling, J., Bearne, A., Powell, M., Riley, J., McFarlane, P., Koffman, J., & Stone, P. (2023). Accuracy of clinical predictions of prognosis at the end-of-life: evidence from routinely collected data in urgent care records. *BMC palliative care*, *22*(1), 51. https://doi.org/10.1186/s12904-023-01155-y

[13] Einav L, Finkelstein A, Mullainathan S, Obermeyer Z. Predictive modeling of U.S. health care spending in late life. *Science*. 2018;360(6396):1462-1465. doi:10.1126/science.aar5045

[14] Orlovic, M., Droney, J., Vickerstaff, V., Rosling, J., Bearne, A., Powell, M., Riley, J., McFarlane, P., Koffman, J., & Stone, P. (2023). Accuracy of clinical predictions of prognosis at the end-of-life: evidence from routinely collected data in urgent care records. *BMC palliative care*, *22*(1), 51. https://doi.org/10.1186/s12904-023-01155-y; Einav L, Finkelstein A, Mullainathan S, Obermeyer Z. Predictive modeling of U.S. health care spending in late life. *Science*. 2018;360(6396):1462-1465. doi:10.1126/science.aar5045

CMS to not complicate these determinations by enacting overly burdensome restrictions on palliative care delivery.

C. Eligibility for Palliative Services

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

We urge CMS to implement a palliative care assessment HCPCS G-code to determine eligibility for palliative care services. Screening patients for daily functions of life requires significant provider resources and is unlikely to be done unless there is sufficient compensation. Unfortunately, the impact on quality of life, function, and caregiver burden can only be determined through careful conversation, and sometimes home observation. A palliative care assessment that weighs several risk factors across multiple areas of need – physical, social, psychological, and spiritual – would provide Medicare beneficiaries with an adequate understanding of care needs. Clinician time for that assessment should be separately and appropriately valued so that patients have access to this care.

- *Would eligibility best be based on impact on daily function, on caregiver strain, or both?*

The Coalition supports a multifaceted approach to palliative care eligibility determinations. Symptom burden impacts both daily function and causes caregiver stain. Both are ever-present concerns for patients in need of palliative care, but individual circumstances vary widely. An approach that emphasizes either daily function or caregiver strain would inappropriately minimize the other. CMS' approach should recognize multiple factors, including but not limited to daily function, caregiver strain, diagnosis, and unmet patient need to encompass a wholistic approach to eligibility.

- *How can we avoid overly burdensome requirements for defining eligibility for services?*

CMS should avoid eligibility criteria that require extensive additional resources by providers without adequate reimbursement. Treating clinicians already utilize existing code sets and information gathered in the ordinary course of care to provide palliative care services. Incorporating palliative care in a treatment plan is a highly personalized clinical decision, and CMS should allow providers to exercise clinical judgment when weighing the individual circumstance of the patient and caregivers.

D. The Future of Care Management Services

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

We urge CMS to recognize the special needs of patients with serious, potentially life-limiting illness. Many palliative care providers already utilize existing Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), and Principal Care Management (PCM) codes to provide ongoing care. If CMS were to implement specific palliative care management codes, we urge it to incorporate extensive stakeholder feedback. Case management for Medicare beneficiaries with serious illnesses should reflect the greater complexity, symptom burden, diversity of information, and care coordination needs associated with these diseases.

E&M Visit Complexity Add-On

In the CY27 Proposed Rule, CMS proposes to convert the E/M visit complexity add-on, HCPCS code G2211, into a modifier on the base E/M service. Since CMS began paying for G2211 in CY 2024, this add-on has been used by palliative care providers to support the inherent complexity in longitudinal care for serious illness that the base E/M codes do not fully capture.

Comment: The Coalition supports CMS efforts to convert G2211 into a modifier on the base E/M service. Tying payment for visit complexity to the value of the base E/M service (16 percent) rather than a flat add-on amount provides a more appropriate means to recognize the variable complexity across E/M services.

CMS's analysis demonstrates that the flat add-on payment increases reimbursement for a lower-level established patient visit by about 29 percent. For a higher-level visit, this payment increases reimbursement only by approximately 9 percent. The new, proportional approach better recognizes the additional work required by high-level visits.

Lastly, the proposed change would better align reimbursement and provide additional resources required to provide longitudinal care to complex, seriously ill patients. This population has not always been adequately reflected in the Physician Fee Schedule, and we appreciate CMS' evident goal to support upstream care for these patients. For these reasons, the Coalition strongly supports converting G2211 from a standalone HCPCS add-on code to a modifier of an underlying E/M service.

Advance Care Planning

CMS proposes to create two new HCPCS codes for advance care planning (ACP). Specifically, CMS proposes HCPCS G-codes:

- GACP1 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), surrogate directed by a treating physician or other treating qualified health care professional); and
- GACP2 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), surrogate directed by a treating physician or other treating qualified health care professional).

Comment: The PQLC generally supports CMS' proposal to establish new ACP HCPCS codes, while recognizing that this approach may present challenges that should be carefully monitored by CMS. ACP is often an iterative and interdisciplinary process among different members of a palliative care team and involves engaging patients and their families at different points during care. The addition of GACP1 and GACP2 would allow providers to receive reimbursement when these conversations are conducted by a nurse or social worker and may be particularly valuable in the inpatient setting.

While new HCPCS codes have the potential to make ACP more flexible and accessible, there is uncertainty regarding how they will interact with existing billing practices (e.g. incident-to rules). Accordingly, we recommend that CMS utilize a pilot program for the new ACP HCPCS codes to monitor whether implementation results in an increase in ACP service utilization. If utilization does not

meaningfully increase, CMS should refine ACP reimbursement policies to reflect the iterative and interdisciplinary nature of ACP.

Conclusion

On behalf of the PQLC, we thank you for the opportunity to comment on the proposed CY 2027 updates to the PFS. If you have any questions, please contact Dan Smith, Chair of the PQLC, at dan.smith@advocacysmiths.com.

Sincerely,

American Academy of Hospice and Palliative Medicine
American Cancer Society Cancer Action Network
The Association of Pediatric Hematology/Oncology Nurses
The Catholic Health Association of the US
Center to Advance Palliative Care
National Alliance for Caregiving
National Brain Tumor Society
National Coalition for Hospice & Palliative Care
Pediatric Palliative Care Coalition