September 12, 2025

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 2026 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-1832-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) 2026 Medicare Physician Fee Schedule 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 2026 Conversion Factors
- Efficiency Adjustment
- Telehealth
- Enhanced Care Management

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 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

[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 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.

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 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 2026 Conversion Factor

As CMS outlines in the proposed rule, beginning in CY 2026, there will be two separate conversion factors: one for qualifying alternative payment model (APM) participants (QPs) who receive a base payment update of +0.75 percent, and one for physicians and practitioners who are not QPs who receive a base payment update of +0.25 percent. The proposed conversion factor of $33.59 for QPs represents a projected increase of $1.24 (+3.8%) from the current conversion factor of $32.35, and the proposed conversion factor of $33.42 for non-QPs represents a projected increase of $1.07 (+3.3%) from the current conversion factor of $32.35.

Comment: As CMS implements the statutorily-mandated 2 conversion factors based on QP status, we urge the Agency to work with Congress on long term payment reform and recognize the value of palliative care. During prior years of payment uncertainty, palliative care providers have stepped up to care for those Medicare beneficiaries who are most in need of specialized care, to relieve patient suffering, and to provide coordination among the healthcare team. Access to palliative care continues to be a stumbling block across our healthcare system, and as CMS implements the QP and non-QP conversion factors, we urge CMS to recognize how its payment systems support patients' ability to access life-enriching palliative care and recognize the cost-savings this care can provide.

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[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 http://circ.ahajournals.org/content/early/2016/08/08/CIR.0000000000000438 Aug 16.

[7] 10 *America's Readiness to Meet the Needs of People with Serious Illness: 2024 Serious Illness Scorecard*. Center to Advance Palliative Care. August 2024.

Efficiency Adjustment

CMS proposes to apply an efficiency adjustment to the majority of codes under the fee schedule. Under this proposal, CMS would reduce the work relative value units (RVUs) and intraservice portion of physician time for applicable services by 2.5 percent. Certain services, including evaluation and management (E/M) and care management services, would be excluded from the policy.

Comment: We urge CMS to consider the potential for unintended impacts of the efficiency adjustment. While most palliative care specialist bill evaluation & management codes and care management codes—which are often time-based and proposed to be exempted—there are palliative care clinicians working in all settings with all types of Medicare beneficiaries, and as these clinicians coordinate with their other colleagues, there may be additional claims that support palliative care services that still require significant time and effort. We request that CMS consider the impact on already under-funded high-value services such as palliative care, and include opportunities to appeal or to fully exempt services delivered to complex patients with serious illness.

Telehealth

CMS proposes a number of new telehealth policies for CY 2025, including:

- Simplification of the process to add services to the annual Medicare Telehealth Services List;
- Removal of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations; and
- Adoption of a permanent definition of direct supervision that would allow a physician or supervising practitioner to provide direct supervision through real time audio and visual interactive telecommunications (excluding audio-only) for most services.

Comment: The Coalition supports CMS' telehealth proposals detailed above and urges CMS to work with Congress to make permanent existing telehealth geographic location and originating site flexibilities. In particular, we appreciate CMS' efforts to make the process for inclusion in the telehealth list more streamlined, and to adopt permanent policies around telehealth that enable consistency for patients and providers.

Enhanced Care Management

In its CY 2025 final Medicare Physician Fee Schedule, CMS established coding and payment for a new set of Advanced Primary Care Management (APCM) services, building upon CMS' Principal Care Management, Transitional Care Management, and Chronic Care Management initiatives. In its CY 2026 proposed rule, CMS queries stakeholders concerning other services, such as behavioral health, that could be integrated into APCM services.

Comment: The Coalition supports CMS efforts around APCM and requests that CMS recognize palliative care programs that meet the criteria. While palliative care may be thought of as applicable for patients with late-stage illness, oftentimes its benefits are realized early on in disease or illness onset. Some patients who have a serious illness rely upon community-based palliative care programs to manage their entire health care journey. Therefore, we request that CMS clarify that the APCM

services may be used by practices like palliative care programs that would not traditionally be considered primary care.

Conclusion

On behalf of the PQLC, we thank you for the opportunity to comment on the proposed CY 2026 updates to the PFS. If you have any questions, please contact Dan Smith, acting 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
Center to Advance Palliative Care
Children's National Hospital
Hospice and Palliative Nurses Association
National Alliance for Care at Home
National Palliative Care Research Center
Oncology Nursing Society
Pediatric Palliative Care Coalition
Physician Associates in Hospice and Palliative Medicine