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Pierre M. Désy, MPH CAE

September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Oz:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below.

Physician Fee Schedule Payment Provisions

- **CY 2027 Conversion Factor (CF).** AAHPM urges CMS to work with Congress to avert a CF reduction for 2027 and to achieve long-term reforms that provide positive payment updates consistent with increases in the Medicare Economic Index (MEI).
- **Specialty Impacts and HPM Designation.** CMS should include specialty code 17, Hospice and Palliative Care, in its specialty impact tables in the MPFS final rule and all future proposed and final rules going forward. CMS should also update the specialty code description to read “Hospice and Palliative Medicine” rather than “Hospice and Palliative Care.”
- **Request for Information (RFI) on Community-based Palliative Care.**
 - AAHPM would be pleased to work with CMS and other policymakers and stakeholders to effectuate payment reforms in the Medicare program to best support delivery of comprehensive, interdisciplinary team-based palliative care to patients with serious illness.
 - AAHPM strongly recommends that CMS determine patient eligibility for community-based palliative care services based on patient need and not on prognosis.
 - AAHPM offers recommendations for considering eligibility criteria and essential service elements for community-based palliative care services, including to require specialized expertise in palliative care delivery as a prerequisite for billing new palliative care management codes. We also offer recommendations regarding a quality accountability framework.
- **Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2).** AAHPM is generally supportive of the idea of creating new ACP codes to describe services furnished by clinical staff, but we request clarification on several questions related to the billing of the new codes. We also recommend that CMS revisit the valuation of the proposed codes to support higher payment.
- **Nursing Facility Practice Expense (PE) Relative Value Units (RVUs).** AAHPM supports CMS’s proposal to increase the facility PE RVUs for nursing facility services to match the non-facility PE RVUs for these services.
- **Site-of-Service Differential PE Policy.** AAHPM recommends that CMS rescind the currently effective site-of-service differential PE policy and instead consider alternative approaches for better addressing potentially duplicative payment when physicians are employed by hospitals and health systems.
- **Teaching Physician Billing with Virtual Presence.** AAHPM supports CMS’ proposal to allow teaching physician billing for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary.
- **Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS G2211).** AAHPM supports CMS’ proposal to replace HCPCS code G2211 with modifier MOD1 that would increase payment for the associated base E/M code by 16 percent.
- **Health Coaching Services.** While AAHPM recognizes the value of health coaching when conducted by appropriately trained and skilled professionals, AAHPM raises concerns about the program integrity risks that CMS’ proposal to pay for health coaching services would pose.
- **Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods.** AAHPM urges CMS not to finalize its policy to apply payment reductions when global services are furnished on the same day as separately identifiable E/M visits.
- **Caregiver Training Services (CTS).** AAHPM urges CMS to maintain separate coding and payment for direct care CTS, and we caution against any future payment reductions that would limit delivery of these services.

- **Current Procedural Terminology (CPT) RFI.** AAHPM disagrees with any consideration of an alternative code set besides CPT to describe physician services, but we acknowledge that opportunities exist to modernize processes for service valuation.

Ambulatory Specialty Model (ASM) Provisions

- **Recommended Rescission of ASM.** AAHPM continues to object to CMS' planned implementation of the ASM given the problematic precedents it would set for physician-focused payment models, and we therefore urge CMS to rescind the model.

Quality Payment Program (QPP) Provisions

- **MIPS Value Pathways (MVPs) General.** CMS should maintain MVPs as a voluntary reporting option and prioritize the development of population-based MVPs that focus on specific patient populations rather than relying on a specialty-specific frameworks.
- **Addition and Modifications of MVPs.** CMS should add the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (*Heard and Understood*) measure to the (1) Vascular Surgery, (2) Neuropsychology, (3) Value in Primary Care, and (4) Pulmonology Care MVPs.
- **MIPS Quality Performance Category.** CMS should work with specialty societies to identify and add more meaningful measures to both MIPS and MVPs. Additionally, CMS should add the Receiving Desired Help for Pain measure (*Help Wanted for Pain*) to the MIPS measure inventory.
- **MIPS Core Measures.** CMS should finalize its proposal to designate the *Heard and Understood* measure as a core measure under traditional MIPS and within both the Advancing Cancer Care MVP and the Quality Care for Patients with Neurological Conditions MVP. CMS should also designate the *Heard and Understood* measure as a core measure in all MVPs in which it is currently included, as well as in any MVPs it is added to in the future. At the same time, CMS should preserve clinicians' flexibility to select the measures most relevant to their patients and practices by maintaining core measures within MVPs on an optional basis.
- **Proposed measure changes.** CMS should explore extending the measurement periods for both the *Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life* measure and the *Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days* measure to better incentivize more timely enrollment in palliative care and earlier referral to hospice care.
- **Topped Out Measures.** CMS should extend its recently finalized topped out measure policy to all clinicians impacted by limited measure choice and the scoring cap policy.
- **Fast Healthcare Interoperability Resources (FHIR) – RFI.** CMS should adopt a thoughtful, long-term transition to digital quality measurement that recognizes the burden and operational challenges providers experience in adopting and updating electronic health record (EHR) systems that support interoperable data exchange.
- **MIPS Improvement Activities.** CMS should finalize its proposal to add the Advance Care Planning (ACP) Conversations activity to the MIPS Improvement Activities Inventory. Additionally, CMS should work with stakeholders like AAHPM to explore ways to further support high-quality ACP discussions.

Physician Fee Schedule Payment Provisions

CY 2027 Conversion Factor

For CY 2027, CMS proposes a conversion factor (CF) of \$33.1693 for items and services furnished by Qualifying Alternative Payment Model (APM) Participants, or QPs, and a CF of \$32.8409 for all other items and services. These reflect decreases of 1.19 percent and 1.68 percent, respectively, relative to the CF for CY 2026.

As predicted, physicians are once again facing a reduction in the CF after a temporary reprieve for 2026 – meaning that physician payments will have decreased 6 out of the 7 years from 2021 through 2027. This state of affairs is not sustainable for physician practices, which rely on Medicare payments to operate their practices and furnish the care Medicare beneficiaries need. Physicians require consistent, predictable payment updates that provide adequate compensation for the costs they incur to run their practices. Instead, they have faced reductions year-after-year, despite nominal base payment increases required under the Medicare Access and CHIP Reauthorization Act.

AAHPM continues to be deeply troubled by this ongoing erosion of payment for Medicare physician services – a trend that devalues the role that physicians play in promoting the health and well-being of Medicare beneficiaries. It also fails to adequately compensate physicians for the costs that they incur, as annual payment updates do not account for inflation in practice expense costs, including increased costs for clinical staffing wages and benefits, office space, information technology and cybersecurity, and more. To illustrate, between 2020 and 2027, the conversion factor will have decreased by 9 percent under CMS' current estimate, while the Medicare Economic Index (MEI) – which reflects physician practice cost inflation – will have increased by 22 percent. This disparity between changes in physician costs versus changes in payment is inexcusable and unsustainable.

AAHPM recognizes that structural problems with the statutory formulas for updating payments under the MPFS are responsible for the payment challenges that exist under the MPFS, including the fact that payment updates are not tied to any indicators of inflation – unlike updates received for almost every other Medicare payment system – and that changes in relative value units (RVUs) are subject to budget neutrality adjustments. And while these structural challenges have been longstanding, Congress has only offered temporary, superficial patches that have failed to provide necessary relief.

AAHPM continues to believe that major reforms are needed in how Medicare physician payment updates are made. In particular, AAHPM believes annual MPFS conversion factor increases tied to changes in the Medicare Economic Index (MEI) are critical for ensuring that payments keep pace with costs. ***AAHPM therefore urges CMS to work with Congress to avert a CF reduction for 2027 and to achieve long-term reforms that provide positive MPFS payment updates consistent with increases in the MEI.*** We believe such changes are necessary to protect the sustainability of physician practices and ongoing access for Medicare beneficiaries.

Additionally, as we have repeatedly requested, ***we again urge CMS to include specialty code 17, Hospice and Palliative Care, in its Regulatory Impact Analysis (e.g., Table 92, Table 108) for the final rule, and for all future MPFS proposed and final rules going forward. We also request that CMS update the specialty code description to read “Hospice and Palliative Medicine” rather than “Hospice and Palliative Care;”*** such a change would align the physician specialty code description with the physician subspecialty recognized by the [American Board of Medical Specialties](#).

Request for Information (RFI) on Community-Based Palliative Care

In coordination with RFIs included in the fiscal year (FY) 2027 Medicare Hospice Wage Index and Rate Update proposed rule and the CY 2027 Medicare End-Stage Renal Disease Prospective Payment System proposed rule, CMS seeks additional comment on specific requirements it should consider as it contemplates future supportive or palliative care services for Medicare beneficiaries that could be furnished under the MPFS.

AAHPM greatly appreciates this focus on improving access to community-based palliative care services, which closely aligns with longstanding Academy efforts. AAHPM has long promoted the value of palliative care in managing the debilitating effects of serious illness in a patient- and family-centered manner that focuses on matching treatment to achievable patient goals to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients traverse throughout the course of a serious illness. High-quality palliative care also supports caregivers by offering education and information, emotional support, tools and strategies for supporting loved ones, social work assistance, and more. Notably, the [National Consensus Project Clinical Practice Guidelines for Quality Palliative Care](#) (NCP Guidelines) describes the core concepts, structures, and processes necessary for the delivery of high-quality palliative care by interdisciplinary care teams across care settings.

As we have previously noted, however, current policies and payment systems continue to pose numerous barriers that limit palliative care teams' ability to receive adequate reimbursement for providing comprehensive palliative care services consistent with the NCP Guidelines, and therefore limit patients' ability to receive high-quality palliative care. We are therefore pleased that CMS is now contemplating improvements to payment under MPFS that – paired with broader regulatory and legislative reforms to bolster the palliative care workforce, increase funding for palliative care research, and protect access to multimodal pain management therapies – would expand access to palliative care services nationwide.

AAHPM would be pleased to work with CMS and other policymakers and stakeholders to effectuate such payment reforms in the Medicare program to best support delivery of comprehensive, interdisciplinary team-based palliative care to patients with serious illness. As a starting point for this engagement, we offer preliminary recommendations and feedback below in response to CMS questions.

Eligibility for Serious Illness Care and Care Management Services

CMS asks if any future supportive or palliative care service for Medicare beneficiaries should be restricted to beneficiaries who have a certification of a likely life expectancy duration. ***AAHPM strongly recommends that CMS determine patient eligibility for community-based palliative care services based on patient need and not on prognosis.***

Prognostication is not an exact science, and extensive evidence demonstrates that physicians' ability to make accurate predictions regarding life expectancy is imperfect.^{1,2,3,4,5} Relying on prognostication could therefore inappropriately restrict patients from receiving medically necessary palliative care based on inaccurate predictions of life expectancy. In fact, we believe such a pattern exists with hospice care: while patients are eligible to elect hospice if they have a prognosis of six months or less, hospice utilization data show that for FY 2024, 20 percent of hospice beneficiaries were enrolled in hospice for 4 or fewer days, and 56 percent of beneficiaries were enrolled in hospice for 30 or fewer days.⁶ Uncertainty regarding prognosis is likely to play a key role in keeping hospice utilization low.^{7,8}

Rather than eligibility based on inaccurate and imprecise prognoses, need-based eligibility for palliative care services is more objective, reliable, and patient-centered.^{9,10,11} CMS should therefore prioritize availability of palliative care services to patients demonstrating need for such services, without applying an arbitrary prognosis requirement.

Eligibility for Palliative Services

CMS asks for information on potential factors it should consider in determining eligibility for future supportive or palliative care services, including daily function, activities of daily living, and caregiver strain. AAHPM, working together with the National Coalition for Hospice and Palliative Care (NCHPC), has previously recommended an [approach](#) for identifying the population of patients with serious illness in the

¹ Amano K, Maeda I, Shimoyama S, et al. The Accuracy of Physicians' Clinical Predictions of Survival in Patients with Advanced Cancer. *J Pain Symptom Management*. 2015; 50(2):139-146.

² Gupta A, Burgess R, Drozd M, Gierula J, Witte K, Straw S. The Surprise Question and clinician-predicted prognosis: systematic review and meta-analysis. *BMJ Support Palliat Care*. 2025;15(1):12-22. doi:10.1136/spcare-2024-004879.

³ Coulon A, Bourmorck D, Steenebruggen F, Knoops L, De Brauwier I, on behalf of the COPE Project. Accuracy of the "Surprise Question" in predicting long-term mortality among older patients admitted to the emergency department: comparison between emergency physicians and nurses in a multicenter longitudinal study. *Palliat Med Rep*. 2024;5(1):387-395. doi:10.1089/pmr.2024.0010.

⁴ Hui D, Palva CE, Del Fabbro EG, et al. Prognostication in Advanced Cancer: Update and Directions for Future Research. *Supportive Care in Cancer*. 2019;27:1973-1984. doi.org/10.1007/s00520-019-04727-y

⁵ White N, Reid F, Harris A, et al. A Systematic Review of Predictions of Survival in Palliative Care: How Accurate are Clinicians and Who are the Experts? *PLoS One*. 2016; 11(8): e0161407. doi: 10.1371/journal.pone.0161407.

⁶ Centers for Medicare & Medicaid Services. *Hospice Monitoring Report*. CMS; April 2025. Accessed September 3, 2026. <https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf>.

⁷ Aamodt WW, Sun C, Dahodwala N, et al. End-of-Life Health Care Service Use and Cost Among Medicare Decedents with Neurodegenerative Diseases. *Neurology*. 2024;103:3209925. Doi:10.1212/WNL.0000000000209925.

⁸ Fine PG. Hospice Underutilization in the U.S.: The Misalignment of Regulatory Policy and Clinical Reality. *J Pain Symptom Management*. 2018; 56(5):808-815. doi: [10.1016/j.jpainsymman.2018.08.005](https://doi.org/10.1016/j.jpainsymman.2018.08.005)

⁹ Cataneo-Piña DJ, Navarrete-Reyes AP, Mondragon-Posada LA, et al. Geriatric Vulnerability and Symptom Burden as Determinants of Palliative Care in Respiratory Disease. *J Pain Symptom Manage*. 2026; 71(6):753-761.e3. doi: [10.1016/j.jpainsymman.2026.02.019](https://doi.org/10.1016/j.jpainsymman.2026.02.019).

¹⁰ Hui D, Anderson L, Tang M, et al. Examination of Referral Criteria for Outpatient Palliative Care Among Patients with Advanced Cancer. *Support Care Cancer*. 2020; 28(1):295-391. doi: [10.1007/s00520-019-04811-3](https://doi.org/10.1007/s00520-019-04811-3).

¹¹ Chang YK, Allen LA, McClung JA, et al. Criteria for Referral of Patients with Advanced Heart Failure for Specialized Palliative Care. *J Am Coll Cardiol*. 2022; 80(4):332-344. doi: [10.1016/j.jacc.2022.04.057](https://doi.org/10.1016/j.jacc.2022.04.057)

context of alternative payment models (APMs). This approach was based on peer-reviewed evidence¹² and required both (1) a qualifying patient diagnosis(es) and (2) an indicator of unmet need, impaired function, and/or high symptom burden.

AAHPM continues to believe that this approach generally provides a sound, evidence-based way to identify patients with serious illness who should be eligible for community-based palliative care services. However, we recognize that the field of palliative care is evolving and that – as our knowledge and experience grows – the basis for determining eligibility may change. For example, we offer the following modification to our previous recommendations: we believe that significant feeding intolerance or gastrointestinal failure should be included as an additional indicator of impaired function in order to account for the fact that intestinal failure results at the end stages of disease progression for many rare diseases. We also recognize that additional changes to eligibility criteria may be warranted in the future.

We therefore recommend that CMS consider the following framework as a starting point for determining eligibility for any future palliative care services. The recommended diagnoses and indicators (revised as noted above) are as follows:

	Population for Evaluation
First, a qualifying diagnosis(es): at least one of these	• Advanced cancer (locally advanced or metastatic) • End stage or stage 5 renal disease • Advanced dementia • Advanced lung disease with home oxygen or hospitalized for the condition • Advanced heart failure with home oxygen or hospitalized for the condition • Advanced liver disease • Diabetes with severe complications • Advanced Parkinson’s disease • Amyotrophic Lateral Sclerosis, Huntington’s, progressive supranuclear palsy or other neurodegenerative diseases • Hip fracture, over age 70 • Stroke requiring hospital admission • Human Immunodeficiency Virus (HIV) with complications of Acquired Immunodeficiency Syndrome (AIDS)
---AND---	
At least one of these indicators of unmet need, impaired function, and/or high symptom burden	• One or more emergency department visits within past six months • One or more hospital admissions within the past six months • Home health episode with date of admission not following a hospital discharge (e.g., community referral) • Sequential home health episodes

¹² Kelley AS, Ferreira KB, Bollens-Lund E, Mather H, Hanson LC, Ritchie CS. Identifying Older Adults With Serious Illness: Transitioning From ICD-9 to ICD-10. *J Pain Symptom Manage*. 2019; 57(6):1137-1142. doi: 10.1016/j.jpainsymman.2019.03.006. Epub 2019 Mar 12. PMID: 30876955.

	• Durable medical equipment claims consistent with impaired function or high symptom burden • Documented difficulty with activities of daily living captured in ICD-10 codes, or documented in post-acute discharge data • Documented social needs (e.g., unsafe housing, food insecurity) captured in ICD-10 codes, or documented in a social needs screen such as in the Accountable Health Communities program • Documented significant feeding intolerance or gastrointestinal failure
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Additionally, we support consideration of factors that may not be identified through claims data, including declining functional status, patient frailty, and caregiver strain. We expect that caregiver strain will be pervasive for patients who require palliative care services, and we highlight the importance and value of interdisciplinary palliative care teams in supporting caregivers and alleviating strain.

The Future of Care Management Services

CMS asks how it should differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries, and what essential service elements should be included.

Consistent with our comments in response to the FY 2027 Medicare Hospice proposed rule, AAHPM recommends that CMS develop codes for comprehensive palliative care services furnished by an interdisciplinary care team across facility and non-facility settings. This could include a code for an initial comprehensive palliative care assessment and care plan development, which would require multidisciplinary assessment across physical, psychological, social, and spiritual domains, along with a resulting care plan that addresses patients' needs and goals across the domains. CMS could also develop additional codes that would allow for ongoing delivery of palliative care services pursuant to the care plan under a monthly case rate that would cover comprehensive palliative care furnished in a manner consistent with NCP Guidelines. Eligibility for these payments should require palliative care teams to meet interdisciplinary staffing and quality standards consistent with the NCP Guidelines. Additionally, the monthly case rate codes should include tiered case rates that would cover applicable services based on patient need or service intensity. ***AAHPM strongly recommends that CMS work to establish such codes and provide Medicare coverage through the MPFS, in order to support comprehensive, team-based palliative care; reduce administrative burden; and facilitate care consistent with patients' goals and preferences.*** AAHPM provides additional input on how these services may be structured in our comments below.

Notably, however, we believe it will be important to ensure that provision of these palliative care services includes specialized expertise in palliative care. We believe such expertise is necessary to ensure the quality and integrity of the palliative care services furnished, as well as to minimize risk of improper or fraudulent billing and payment. More specifically, we believe that – in an ideal world – the interdisciplinary care team should be led by a physician who is either board certified in Hospice and Palliative Medicine through the [American Board of Internal Medicine](#) or the [American Osteopathic Association](#). However, AAHPM recognizes that there is a shortage of HPM physicians in the country, and that such shortages are exacerbated in rural and underserved areas, such that strict enforcement of such a policy, especially during the first several years that new palliative care codes would be available, could drastically reduce beneficiary access. ***We therefore recommend that CMS implement a specialized***

expertise requirement for billing for any new specialized palliative care services, but that CMS provide enforcement discretion on this requirement during a ramp-up period.

Initial Comprehensive Palliative Care Assessment and Care Plan Development

An initial comprehensive assessment is necessary to identify patients' current status, as well as their needs, preferences, and goals. The assessment should involve interdisciplinary assessment across physical, psychological, social, and spiritual domains, and should be led by a physician with specialized expertise in palliative care. The assessment should result in the development of a coordinated care plan that is informed by input from all of the patient's physicians and providers and that addresses the patient's needs in a manner that is consistent with their care goals.

Advanced Palliative Care Management Services

For the ongoing monthly palliative care services that we envision, we believe that CMS could adopt Advanced Palliative Care Management Services that are modeled on CMS' recently established Advanced Primary Care Management (APCM) Services. This could include three tiers of service, which would reflect increasing levels of service intensity based on location:

- Office/telemedicine-based palliative care practice
- Skilled nursing facility-based practice
- Home-based practice

As with APCM services, Advanced Palliative Care Management Services would cover clinical staff time, not billing physician time, and physicians would continue to be able to furnish separately billable physician services, including evaluation and management (E/M) visits. And as noted above, interdisciplinary care team staffing would have to be consistent with the NCP Guidelines, meaning that the team should include a nurse, social worker, and a chaplain or spiritual care professional, and it should be led by a physician with specialized palliative care expertise. Ideally, the team would also include a pharmacist to support safe symptom management, particularly with respect to safe opioid use, methadone dosing, and polypharmacy reconciliation. Time spent by each of these disciplines would be expressly covered under these codes.

Notably, many of the required service elements would overlap between APCM services and Advanced Palliative Care Management Services, including, for example, consent, 24/7 access; continuity of care. However, the Advanced Palliative Care Management services would focus on the delivery of palliative care, including palliative assessment, symptom management, and interdisciplinary team care. To illustrate our current thinking, we have provided suggested line edits to the APCM code descriptors to illustrate how those codes could be modified to shift the emphasis to palliative care in the text box below.

Advanced Palliative Care Services Code Descriptors (Reflecting Line Edits from APCM Descriptors)

- GXXX1 (Office and telehealth-based ~~Advanced~~ advanced ~~primary~~ palliative care management services provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all ~~primary~~ palliative care and serves as the continuing focal point for all ~~needed health care services~~ symptom management related to the patient's serious illness, per calendar month, with the following elements, as appropriate:
 - Consent;

++ Inform the patient of the availability of the service; that only one practitioner can furnish and be paid for the service during a calendar month; of the right to stop the services at any time (effective at the end of the calendar month); and that cost sharing may apply.

++ Document in patient's medical record that consent was obtained.

- Initiation ~~during a qualifying visit for new patients or patients not seen within 3 years~~ following an initial comprehensive palliative care assessment performed by a physician-led interdisciplinary palliative care team;
- Provide 24/7 access for urgent needs to care team/practitioner, including providing patients/caregivers with a way to contact health care professionals in the practice to discuss urgent needs regardless of the time of day or day of week;
- Continuity of care with a designated member of the care team with whom the patient is able to schedule successive routine appointments;
- Deliver care in alternative ways to traditional office visits to best meet the patient's needs, such as ~~home visits and/or~~ expanded hours ~~and/or virtual care~~;
- Overall comprehensive care management;
 - ++ Systematic needs assessment (medical, ~~and~~ psychosocial, ~~and~~ spiritual).
 - ++ System-based approaches to ensure ~~receipt of preventive services~~ anticipatory symptom management and advance care planning.
 - ++ Medication reconciliation, ~~prescription of pain and symptom~~ management ~~interventions~~, and oversight of self-management.
- Development, implementation, revision, and maintenance of an electronic patient-centered ~~comprehensive symptom management~~ care plan;
 - ++ Care plan is available timely within and outside the billing practice as appropriate to individuals involved in the beneficiary's care; ~~and~~ can be routinely accessed and updated by care team/practitioner; ~~and copy of care plan to patient/caregiver;~~
 - ++ Care plan is translated into patient-friendly language and provided to patient/caregiver for use at home
- Coordination of care transitions between and among health care providers and settings, including referrals to other clinicians and follow-up after an emergency department visit and discharges from hospitals, skilled nursing facilities or other health care facilities as applicable;
 - ++ Ensure timely exchange of electronic health information with other practitioners and providers to support continuity of care.
 - ++ Ensure timely follow-up communication (direct contact, telephone, electronic) with the patient and/or caregiver after an emergency department visit and discharges from hospitals, skilled nursing facilities, or other health care facilities, within 7 calendar days of discharge, as clinically indicated.
- Ongoing communication and coordinating receipt of needed services from practitioners, home- and community-based service providers, community-based social service providers, hospitals, and skilled nursing facilities (or other health care facilities), and document communication regarding the patient's psychosocial strengths and needs, functional deficits, goals, preferences, and desired outcomes, including cultural and linguistic factors, in the patient's medical record;

- Enhanced opportunities for the beneficiary and any caregiver to communicate with the care team/practitioner regarding the beneficiary's care through the use of asynchronous non-face to-face consultation methods other than telephone, such as secure messaging, email, internet, or patient portal, and other communication-technology based services, including remote evaluation of pre-recorded patient information and interprofessional telephone/internet/EHR referral service(s), to maintain ongoing communication with patients, as appropriate;
 - ++ Ensure access to patient-initiated digital communications that require a clinical decision, such as virtual check-ins and digital online assessment and management and E/M visits (or e-visits).
 - Analyze patient-reported outcome population data to identify gaps in care and offer additional interventions, as appropriate quality and opportunities for improvement;
 - ~~○ Risk-stratify the practice population based on defined diagnoses, claims, or other electronic data to identify and target services to patients;~~
 - Be assessed through performance measurement of primary palliative care quality, total cost of care, and meaningful use of Certified EHR Technology.).
 - Furnished by a multidisciplinary care team that includes, at a minimum, a nurse, social worker, spiritual care provider, and pharmacist – all overseen by a physician with specialized palliative care expertise
- GXXX2 (Advanced palliative care management services provided by clinical staff to patients residing in skilled nursing facilities and directed by a physician or other qualified health care professional who is responsible for all palliative care and serves as the continuing focal point for all symptom management related to the patient's serious illness, per calendar month, with the same elements as GXXX1, except:
 - Deliver care primarily in-person in nursing facility settings, but also in alternative ways to best meet the patient's needs, including virtual care on a limited basis;
 - GXXX3 (Home-based advanced palliative care management services provided by clinical staff and directed by a physician or other qualified health care professional who is responsible for all palliative care and serves as the continuing focal point for symptom management related to the patient's serious illness, per calendar month, with the same elements as GXXX1, except:
 - Deliver care primarily in-person in the patient's home, but also in alternative ways to best meet the patient's needs, including virtual care on a limited basis;

Finally, we also request that CMS ensure that payment rates for palliative care services reflect the full range of resources required to furnish high-quality care and support the interdisciplinary palliative care team. Home-based palliative care services, in particular, are resource intensive, including because they may involve multiple visits to patients' homes each week – in some cases with multiple team members representing different disciplines. As a point of reference for valuing this care, we direct CMS to its discussion in the CY 2027 Medicare Home Health Prospective Payment System proposed rule on the use of home health care as an avenue for delivering palliative care services; CMS proposes to pay for home health services – including those used to furnish palliative care – at a rate of \$2,092.27 for a 30-day period in 2027.

But even for office and SNF-based palliative care services, patients with serious illness often require frequent clinical intervention; coordination of durable medical equipment, medications, and social services; communication and coordination with numerous other patient care teams; complex case management, and more. Adequate payment will be necessary to ensure that palliative care teams have the resources they need support this ongoing care delivery. To that end, we highlight that [Hawaii](#) offers \$900 per Medicaid patient per month (non-dual eligible) for community-based palliative care services. We believe this rate should serve as lower bounds for monthly case rates for Advanced Palliative Care Management Services furnished to Medicare beneficiaries, and we also highlight the need to monitor adequacy of the rate given the limited experience with these relatively new benefits.

Advanced Primary Care Management and MIPS Value Pathways (MVPs)

CMS asks questions on options for building quality accountability into the delivery of potential future palliative care services, including a potential MVP or other specified quality measures.

AAHPM supports CMS' interest in ensuring quality accountability in the delivery of care for patients with serious illness and believes that seriously ill patients should receive high-quality palliative care regardless of how their services are paid – whether that is through Medicare Advantage, an accountable care model, or fee-for-service. To that end, and through the same effort referenced above, AAHPM joined with NCHPC to develop [recommendations](#) for a standard set of high-priority quality measures that would apply under any payment arrangement that includes patients with serious illness. We believe these recommended cross-cutting quality measures are centered on what matters most to people with serious illness. These include measures that focus on:

- Patient-reported experience of serious illness care
- Prevention and treatment of symptoms
- Timely and appropriate use of hospice care, and
- Avoidance of potentially preventable hospital stays.

We continue to support the inclusion of these measures in quality accountability frameworks in order to promote high-quality care for patients with serious illness, including under potential future palliative care services furnished under the MPFS.

Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)

CMS proposes to create two new HCPCS codes, GACP1 and GACP2, to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner. Under this proposal, the existing CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner.

AAHPM is generally supportive of the idea of creating new ACP codes to describe services furnished by clinical staff and believes that separate billing for clinical staff time versus Qualified Health Professional (QHP) time could simplify coding and billing for ACP services. We particularly appreciate that CMS is seeking to leverage these codes to address underutilization of ACP services. However, ***we request clarification on the following questions related to the billing of the new codes:***

- **Concurrent care delivery.** If a physician and a clinical staff member are performing ACP concurrently with the same patient, would the physician be able to bill for the time spent by

both? That is, could the physician bill CPT code 99497 and GACP1 together for the concurrent time? We believe that allowing billing for concurrent participation would better reflect the resources utilized in furnishing care.

- **Incident to billing.** Would incident to rules apply for the billing of these codes, or would these codes be able to be billed by physicians practicing in hospital outpatient department settings? Under current rules, CPT codes 99497 and 99498 can only be billed on an incident to basis when they are furnished in the physician office setting, which limits the ability to use these codes in other settings. Approved use of GACP1 and GACP2 in outpatient settings would significantly enhance hospital-based palliative care teams' ability to engage with patients in meaningful ACP discussions.
- **Form completion.** Would billing of these codes require that an ACP form be completed during the session in order for the service to be billed? While we believe the parenthetical language "(with completion of such forms, *when performed*)" [emphasis added] suggests that form completion is not a requirement, consistent with current requirements for 99497 and 99498, we would appreciate clarification confirming our interpretation. Further, we ask that CMS clarify that, when performed, completion of many different document types would be permitted to bill these codes; that is, form completion should not be limited to an advance directive, living will, or health care power of attorney, but could encompass many other types of forms and medical orders that detail patient preferences in the receipt of care.
- **Required time.** Is it necessary for clinical staff to complete 20 full minutes of ACP discussions before these codes could be billed, or could these services be billed if the halfway point were reached?
- **Eligible clinical staff.** Are there any restrictions on the type of clinical staff that may perform these services? Likewise, could CMS clarify that social workers and chaplains would be among the clinical staff who could deliver this care?

In addition to our requests for clarification, we also raise concerns with the proposed valuation of these codes, which we worry would result in payment that is not sufficient to cover the cost of delivering care. This is particularly concerning given that these services occur in multiple discussions that take place over time, and insufficient payment would decrease practices' ability to undertake this iterative effort. ***We therefore recommend that CMS revisit the valuation of these codes to support higher payment.*** We note that CMS indicates a crosswalk to CPT 99490 and CPT 99439 for work RVUs, but CMS assigns 25 minutes of clinical labor time for those codes, as opposed to the 20 minutes of clinical labor time assigned for GACP1 and GACP2. At a minimum, we recommend that CMS update the clinical labor time to be consistent with 99490 and 99439, respectively.

Practice Expense Methodology – Site-of-Service Differential

In the CY 2026 MPFS final rule, CMS finalized a policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting relative to the indirect PE RVUs per work RVU for services furnished in the non-facility setting. In our comments last year, AAHPM raised numerous concerns about the policy, including that the resource costs incurred by independent practice physicians would not be adequately reimbursed when they furnished services in the facility setting.

This year, citing unintended but significant site-of-service differential payments for physician visits in nursing facility settings as a result of the above policy, CMS proposes to increase the facility PE RVUs to match the non-facility PE RVUs for nursing visit CPT codes 99304 – 99316, which cover initial nursing facility care, subsequent nursing facility care, and nursing facility discharge management. Notably, prior to the implementation of this policy, PE RVUs for these visits were the same across facility and non-facility services, reflecting the fact that the setting of care is the same regardless of the service's facility/non-facility status. This is because the facility/non-facility designation for a nursing facility resident is dependent on whether the patient is in a Part A versus Part B stay, even if the patient remains in the same room.

AAHPM supports this proposal, which we believe appropriately reflects that physician resources required are the same whether the patient is in a Part A or Part B stay. Our members routinely furnish care to seriously ill patients who are admitted to nursing facilities. Those who operate independently incur the full set of practice costs, including for rent and utilities, clinical and administrative staff, office equipment and supplies, and more, but the payment differential that applies for 2026 fails to cover these costs when the patient is in a Part A stay. Moreover, nursing facility residents are vulnerable patients with high care needs who require and deserve thoughtful medical care. The current site-of-service payment differential and inadequate payment rates decrease physicians' ability to visit patients in the nursing facility setting, which increases risks to patients.

Correcting this mismatch for nursing facility services is therefore a good first step in righting the harms that CMS' site-of-service differential PE policy imposed, but it is not enough. AAHPM continues to believe that the site-of-service differential PE policy fails to adequately reimburse costs for independent practice physicians across facility settings, as well as exposes Medicare providers and beneficiaries to further unintended consequences. We also understand the policy creates incentives for gaming, for example around ownership arrangements or site-of-care decisions. For all these reasons, ***we recommend that CMS rescind the currently effective site-of-service differential PE policy and instead consider alternative approaches for better addressing potentially duplicative payment when physicians are employed by hospitals and health systems.***

Teaching Physician Billing with Virtual Presence

CMS proposes that, rather than requiring the teaching physician, resident, and beneficiary to each be in a different location in order to allow virtual presence for teaching physician supervision, teaching physicians would be allowed to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. CMS would generally interpret physical presence to mean the teaching physician or resident is in the same room as the beneficiary but seeks comment on other scenarios.

AAHPM supports this proposal, which provides added flexibility to teaching physicians and expands the capacity of teaching programs, and urges CMS to finalize the policy as proposed. We also ask that CMS clarify that teaching physicians can continue to supervise residents via virtual presence when the teaching physicians, residents, and beneficiaries are all in different locations, consistent with the flexibilities that are in effect for 2026. While we believe that is consistent with CMS intent, we believe that a restatement of this policy would provide valuable clarification.

Valuation of Specific Codes

E/M Visit Complexity Add-On (HCPCS G2211)

CMS proposes to replace HCPCS code G2211 with a modifier – MOD1 – that would be billed under the same circumstances that HCPCS code G2211 is currently billed. When the modifier is billed, CMS would increase payment for the associated base E/M code by 16 percent.

AAHPM supports this proposal and recommends that CMS finalize the policy as proposed. AAHPM agrees that linking payment for visit complexity to the value of the base E/M services better recognizes the variation in work and complexity across different office and outpatient E/M visit levels. Notably, this change would provide additional resources to support longitudinal care to patients with serious illness, who often present with multiple comorbidities and complex health needs, therefore requiring higher levels of medical decision making and time to address their care needs.

Health Coaching Services

CMS proposes conditions of payment and valuation for 0591T (Health and well-being coaching face-to-face; individual, initial assessment, 60-90 minutes), 0592T (Individual, follow-up session, at least 30 minutes), and 0593T (Health and well-being coaching, group [2 or more individuals], at least 30 minutes) to support adequate capturing of the time and resources for health coaching.

While AAHPM recognizes the value of health coaching when conducted by appropriately trained and skilled professionals, and we believe health coaching can be helpful in supporting patients with serious illness achieve personal health goals, we are very concerned about the program integrity risks this proposal would pose. For example, we are concerned that unqualified individuals could furnish services, given that there are not specific requirements for minimum training standards or demonstrated competencies. While CMS identifies certain entities whose certification would qualify, CMS clarifies that certification would not be limited to those expressly-named entities, thereby providing significant latitude for individuals to rely on certifications that are less rigorous and robust. We also note that certain states may recognize different certifications, which could result in substantial variation in the quality of health coaching being delivered. Finally, we question how these services may interact with other services that may include similar elements of care, and whether – as a result – separate payment for health coaching could result in duplicative payment.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS proposes to reduce payment when a separately identifiable E/M visit – as identified when billed with Modifier-25 – is furnished on the same day by the same physician (or a physician in the same group practice) as a 0-, 10-, or 90-day global procedure. In these cases, CMS would pay the most expensive service at 100 percent, but all other surgical procedures and E/M visits would be paid at 50 percent.

While our members are not likely to be greatly affected by this proposal, AAHPM has serious concerns given the precedents this proposal sets. To begin, CMS proposes this significant change without any evidence and with very little justification. CMS also does not provide detailed information on the impacts of this proposal at the code or specialty level. Given that this proposal is expected to result in drastic reductions to certain specialties' overall allowed charges, we believe CMS should provide clear data on where duplication exists and what the magnitude of duplication is.

We also disagree with this approach given extensive work that has already been undertaken by CMS and the RUC to remove duplication. That is, for global services that are typically billed together with a separately identifiable E/M visit, CMS has already revised valuation to remove any identified duplication. We fail to understand how CMS could apply further de-duplication reductions when there is no duplication to extract.

We are further concerned that this policy will result in payments that do not cover the cost of delivering care. For example, for the services for which CMS has already removed duplication, the resources allocated to such services reflect the full set of resources required to furnish the service. As a result, payment reductions would inherently lead to insufficient reimbursement to cover the cost of care, meaning that physician practices would be forced to take on financial losses every time the service was delivered.

As a result of insufficient payment, we worry that this policy will have severe impacts on physician practices and the beneficiaries they serve. We are particularly concerned about the ongoing viability of small and independent practices, which are less able to offset losses. As a result, these practices may be forced to modify their operations, including to potentially schedule shorter appointments and reduce their Medicare caseload – or even to completely stop accepting new Medicare patients, resulting in significantly reduced patient access.

We therefore urge CMS not to apply payment reductions when global services are furnished on the same day as separately identifiable E/M visits. To the extent that duplication does exist, we believe CMS should make targeted valuation changes to precisely remove only those resources that evidence demonstrates are duplicative and nothing more, and we encourage CMS to work with the RUC to undertake such refinements.

Caregiver Training Services (CTS)

CMS seeks comment on whether the resource costs associated with direct care CTS, identified by HCPCS codes G0541 – 3, are best reflected through this existing coding or whether these resource costs are reflected in the valuation of other codes paid under the MPFS, such as E/M visits.

AAHPM believes that the resource costs associated with these CTS services are best reflected through coding that is distinct from E/M services and other services under the MPFS. Regrettably, current Medicare payment policies do not adequately recognize and provide for patients' caregiving needs. As a result, family members or other loved ones often provide this care without adequate training, support, or respite. We therefore supported the establishment of these CTS services as one way to address the existing caregiving deficit.

We are now concerned that CMS suggests that the resources required to deliver direct care CTS are better reflected through other codes. We disagree. These services require distinct work and practice expense to ensure that caregivers have the information and skills necessary to address the direct care needs of the patients under their care, including to avoid ulceration and prevent infection. These are resources that are not included in the typical E/M visit, which focus on evaluating patients and their care needs and engaging in medical decision making to develop effective treatment plans; eliminating separate payment for these codes based on an assumption that they are already captured in E/M visits would be highly problematic.

Given the importance of CTS services in supporting caregivers to maximize treatment outcomes for patients, along with the separate resources required to furnish CTS, AAHPM urges CMS to maintain

separate coding and payment for these direct care CTS. We also caution against any future payment reductions that would limit the delivery of these services.

Current Procedural Terminology (CPT) RFI

CMS raises several concerns about reliance on CPT coding and RUC valuation, including related to AMA conflicts of interest and the potential to de-emphasize prevention and lifestyle modification. CMS then asks several questions about assurances regarding the current CPT and RUC processes and alternatives it should consider to CPT for physician services codes.

AAHPM disagrees with any consideration of an alternative code set besides CPT to describe physician services. We believe CPT offers a comprehensive, well-considered approach for describing the physician services delivered in this country that cannot be replicated by other available code sets. We particularly appreciate that the CPT process ensures active physician engagement and participation as well as allows for broader participation by non-physician stakeholders through open and transparent processes. We also recognize that the CPT code set evolves with medical practice, with the CPT Advisory Panel routinely adding, revising, and deleting codes – including codes that describe new technologies – to align with the changing medical landscape.

AAHPM does not believe that other code sets, including the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS), could serve the same function as CPT. ICD-10-PCS, in particular, would be insufficient given its limited scope that focuses only on inpatient procedures reported by hospitals. Likewise, AAHPM does not support reliance on multiple competing physician code sets, which we believe could result in inconsistent billing and coding, duplicative and overlapping codes, misalignment in quality assessment, and imprecise clinical data exchange. We also point to the substantial administrative burden that a transition away from CPT would impose for physician practices – for example related to updating billing, coding, accounting, and electronic medical record systems, harmonizing longitudinal data, and training staff.

At the same time, AAHPM acknowledges that opportunities exist to modernize processes for valuation of physician services. While there are many aspects of the RUC process that we believe are essential, including the extensive involvement of physicians in developing valuation recommendations, we would support a move to the use of more objective, auditable data in service valuation. For example, we believe electronic medical record systems contain a wealth of data that could be used to inform estimates of time, intensity, and direct practice inputs. Paired with use of objective data, we would support an open and transparent valuation process that accurately reflects resources, but that also prioritizes the value of services to patients and the impacts on patient quality of life.

Ambulatory Specialty Model

In the CY 2026 MPFS final rule, CMS finalized the January 2027 launch of the Ambulatory Specialty Model (ASM), a new mandatory APM focused on enhancing quality of care and reducing costs for Medicare beneficiaries with heart failure or low back pain. In our comments last year, AAHPM raised numerous concerns about the ASM and the precedents it would set for future physician-focused payment models, including around mandatory participation requirements, extraction of guaranteed Medicare savings through cuts to physician payments, excessive risk requirements, individual-level performance assessment, and more. While we recognize that CMS finalized some changes to ASM relative to its proposals, we are disappointed that the core elements of the model that drove most of our concerns have

remained materially unchanged. ***AAHPM therefore continues to object to CMS' planned implementation of the ASM and urges CMS to rescind the model.*** AAHPM stands ready to work with CMS to develop specialty care models that provide more meaningful opportunities for specialists to engage in care transformation.

Updates to the Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

General

CMS proposes to sunset the traditional Merit-based Incentive Payment System (MIPS) reporting option following the CY 2028 performance year. Under this proposal, the MIPS Value Pathways (MVPs) would be the only MIPS reporting option for MIPS eligible clinicians that are not participating in a MIPS Alternative Payment Model (APM) beginning with the CY 2029 performance year.

AAHPM remains deeply concerned about this approach and strongly urges CMS to not sunset traditional MIPS and to maintain MVPs as a voluntary reporting option. The MVP framework, as currently designed, does not resolve fundamental flaws in the MIPS program, including the siloed structure of performance categories and the continued lack of meaningful linkage between quality and cost measures. As a result, clinicians often face redundant reporting requirements and are held accountable for duplicative measures. Additionally, MVPs are built on the existing MIPS measure set, which lacks clinical relevance for many specialties, including HPM. Given the limited availability of MIPS measures that are clinically relevant to palliative care under the MVP framework, we are concerned that HPM clinicians have few opportunities to be meaningfully assessed for the care they provide to patients with serious illness.

MVPs may offer a pathway to more meaningful performance measurement if they are redesigned to reflect patient-centered care, reduce administrative burden, and promote flexibility. ***Until that is achieved, AAHPM strongly urges CMS to preserve the traditional MIPS reporting option and maintain MVPs as voluntary as it continues to work with specialty societies to improve the reporting pathway.***

In particular, to ensure that MVPs are meaningful, AAHPM strongly urges CMS to prioritize the development of population-based MVPs that focus on specific patient populations rather than relying on a specialty-specific frameworks. MVPs centered on specific patient populations, such as patients with serious illness, would support higher quality, higher-value care by holding group practices accountable for outcomes that matter most to their patients. When paired with clinically meaningful measures and designed to reflect the realities of coordinated team-based care, population-focused MVPs can reduce duplicative reporting, ease administrative burden, and promote alignment across care teams. This is particularly important for patients with serious illness who often have multiple medical conditions which can further complicate their care. As a result, only structuring MVPs around individual specialties may not fully reflect the comprehensive care these patients receive, particularly when multiple specialists are involved. Developing population-based MVPs would better account for the multidisciplinary care needs of patients with serious illness.

Addition and Modification of MVPs

For CY 2027, CMS proposes to adopt three new MVPs (Diabetic Disease, Hypertension, and Hospitalist) and proposes modifications to all 27 previously finalized MVPs, including to designate certain measures in

each MVP as core measures. AAHPM includes comments on CMS' core measure proposals – including how they apply to MVPs – in our comments below.

As CMS considers modifications to the MVPs, AAHPM continues to recommend that CMS add the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Heard and Understood; Quality ID #495) measure to the measure sets for the (1) Vascular Surgery, (2) Neuropsychology, (3) Value in Primary Care, and (4) Pulmonology Care MVPs.

The *Heard and Understood* measure was developed by AAHPM in coordination with the National Coalition for Hospice and Palliative Care and RAND Health under a CMS-awarded cooperative grant. This patient-reported outcome performance measure (PRO-PM) focuses on patient experience, which is a high-priority area for MIPS and CMS' Meaningful Measures 2.0 initiative. The measure offers patients living with serious illness, their families, and caregivers a way to share feedback about the desired care they receive, as well as enables physicians, health systems, and payers to better understand how well the care they provide meets patients' needs and preferences. While other patient-reported experience measures exist, the *Heard and Understood* measure is the first one to focus on palliative care in physicians' offices and clinics.

Studies have shown that adding palliative care to the plan of care for patients with serious illness results in better symptom management and communication with health care providers, as well as decreased strain on family members or other caregivers.^{13,14} By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve the quality of medical care for patients with serious illness^{15,16,17} and quality of life^{18,19,20} both during and after disease-directed treatments.²¹ Furthermore, integrating palliative care into the care of patients living with serious illness delivers value to the health

¹³ Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association* 7 January 2004; 291(1):88-93.

¹⁴ Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly* September 2011; 89(3):343-380.

¹⁵ Bakitas MA, Tosteson TD, Li Z, et al. Early versus delayed initiation of concurrent palliative oncology care: patient outcomes in the ENABLE III randomized controlled trial. *J Clin Oncol*. 2015;33(13):1438-45. <http://www.ncbi.nlm.nih.gov/pubmed/25800768>

¹⁶ Smith G, Bernacki R, Block SD. The role of palliative care in population management and accountable care organizations. *J Palliat Med*. 2015;18(6):486-494. <http://www.ncbi.nlm.nih.gov/pubmed/25723619>

¹⁷ Riolfi M, Buja A, Zanardo C, Marangon CF, Manno P, Baldo V. Effectiveness of palliative home-care services in reducing hospital admissions and determinants of hospitalization for terminally ill patients followed up by a palliative home-care team: a retrospective cohort study. *Palliat Med*. 2014;28(5):403-411. <http://www.ncbi.nlm.nih.gov/pubmed/24367058>

¹⁸ Davis MP, Temel JS, Balboni T, Glare P. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. *Ann Palliat Med*. 2015;4(3):99-121. <http://www.ncbi.nlm.nih.gov/pubmed/26231807>

¹⁹ Rabow M, Kvale E, Barbour L, Cassel JB, Cohen S, Jackson V, Luhrs C, Nguyen V, Rinaldi S, Stevens D, Spragens L, Weissman D. Moving upstream: a review of the evidence of the impact of outpatient palliative care. *J Palliat Med*. 2013 Dec;16(12):1540-9. <http://www.ncbi.nlm.nih.gov/pubmed/24225013>

²⁰ Sidebottom AC, Jorgenson A, Richards H, Kirven J, Sillah A. Inpatient palliative care for patients with acute heart failure: outcomes from a randomized trial. *J Palliat Med*. 2015;18(2):134-142. <http://www.ncbi.nlm.nih.gov/pubmed/25479182>

²¹ Delgado-Guay MO, Parsons HA, Li Z, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 15 January, 2009, *Cancer*; 115(2):437-45.

care system. Palliative care reduces utilization of emergency department and hospital services by avoiding care that is inconsistent with a patient's goals and values, thus resulting in overall cost savings.^{22,23,24}

Palliative care has expanded rapidly in recent years across inpatient, ambulatory, home-based, and facility settings; yet there is much work to be done, both within and outside of specialist palliative care service delivery models. Studies show that seriously ill persons often report feeling silenced, ignored, and misunderstood in medical institutions.²⁵ Feeling heard and understood is a critical component of patient-centered decision-making, which reinforces dignity and is one of the key factors in patient-reported quality care.²⁶ It is important to measure how heard and understood patients feel in order to promote more universal adoption of key practices of shared decision making and generalist palliative care skills. Because of rapidly growing public demand for high-quality palliative care (from patients, but also from both specialist palliative care providers and from other providers focused on serious disease management), measuring patients' experiences in shared decision-making is critical to advancing person-centered care.

CMS has previously recognized the importance of the *Heard and Understood* measure by including it in several MVPs, including Advancing Cancer Care, Advancing Care for Heart Disease, Coordinating Stroke Care, Optimal Care for Kidney Health, and Neurological Conditions MVPs. This broad inclusion reflects the relevance of assessing whether patients feel that their needs and preferences are being heard and understood across a range of clinical settings and conditions.

AAHPM believes the same rationale supports inclusion of the *Heard and Understood* measure in the (1) Vascular Surgery, (2) Neuropsychology, (3) Value in Primary Care, and (4) Pulmonology Care MVPs. Measuring the experiences of patients, families, and caregivers is critical to advancing person-centered care and will promote more universal adoption of best practices to support shared decision making. Additionally, including the *Heard and Understood* measure will further encourage broader inclusion of palliative care teams, helping to support more comprehensive care and facilitate delivery of care consistent with what matters to patients. The measure also recognizes that patient-centered care and complex shared decision-making occurs across variety of practice settings and physician specialties and is specified in a manner that allows non-palliative care specialists who treat patients with serious illness to report the measure.

In the context of the Vascular Surgery MVP, palliative care can be essential to providing holistic care, particularly in patients with complex or advanced vascular conditions where surgical options may be limited. For these patients, palliative care can facilitate shared decision-making, helping patients and their families navigate care that aligns with the patients' values and goals.

²² Morrison RS, Dietrich J, Ladwig S, et al. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Aff (Millwood)*. 2011;30(3):454-463. <http://www.ncbi.nlm.nih.gov/pubmed/21383364>

²³ Lustbader D, Mudra M, Romano C, Lukoski E, Chang A, Mittelberger J, Scherr T, Cooper D. The impact of a home-based palliative care program in an accountable care organization. *J Palliat Med*. 2016 Aug 30 [Epub ahead of print]. <https://www.ncbi.nlm.nih.gov/pubmed/27574868>

²⁴ May P, Garrido MM, Cassel JB, et al. Cost analysis of a prospective multi-site cohort study of palliative care consultation teams for adults with advanced cancer: Where do cost savings come from? *Palliat Med*. 2017; 31(4):378-386. <https://www.ncbi.nlm.nih.gov/pubmed/28156192>

²⁵ Frosch, D. L., May, S. G., Rendle, K. A., Tietbohl, C., & Elwyn, G. (2012). Authoritarian physicians and patients' fear of being labeled 'difficult' among key obstacles to shared decision making. *Health Affairs*, 31(5), 1030-1038

²⁶ Gramling, R., et al., Feeling heard and understood: A patient-reported quality measure for the inpatient palliative care setting. *Journal of Pain and Symptom Management*, 2016. 51(2): pp. 150–154.t

Similarly, for the Neuropsychology MVP, integrating palliative care with neuropsychology can enhance the overall care of patients with serious neurological conditions, such as dementia, by ensuring symptom management and psychosocial support are tailored to the needs of the patients and their families. This can lead to improvements in daily functioning and can provide critical support to families as they navigate difficult decisions about treatment and end-of-life care.

For the Value in Primary Care MVP, inclusion of the *Heard and Understood* measure recognizes the important role of primary care clinicians in addressing the needs and preferences of patients with serious illness. Responsiveness to seriously ill patients' needs and preferences is important in supporting effective team-based care that is consistent with what matters to patients.

Finally, the Pulmonology Care MVP captures a broad range of pulmonology conditions, including chronic conditions like chronic obstructive pulmonary disease (COPD). As noted above, the *Heard and Understood* measure is highly responsive to the needs and preferences of seriously ill patients, helping to strengthen team-based care, promote more comprehensive treatment, and ensure that care is delivered in alignment with what matters most to patients.

For these reasons, AAHPM strongly urges CMS to add the Heard and Understood measure to the (1) Vascular Surgery, (2) Neuropsychology, (3) Value in Primary Care, and (4) Pulmonology Care MVPs.

MIPS Quality Performance Category

General

To make the MIPS program more meaningful to HPM practitioners, CMS must introduce improved quality and cost measures beyond those currently available in the MIPS inventory and provide incentives for their development and testing. AAHPM recognizes the Administration's commitment to reducing regulatory burden on providers and appreciates these efforts. However, unlike in other quality reporting programs, the addition of measures to MIPS does not increase clinician burden, as it does not expand the number of measures required for reporting. Rather, expanding the set of available measures provides clinicians with greater flexibility to select those that best reflect the care they deliver and that are most relevant to their patient population. Conversely, removing measures may inadvertently increase burden by leaving clinicians with fewer relevant options, forcing them to report on measures that are less applicable to their practice and that do not capture the value of the care they deliver. ***To that end, AAHPM continues to encourage CMS to work with societies to identify and add more meaningful measures to both MIPS and MVPs.***

As noted above, the *Heard and Understood* measure aligns with CMS' priorities to include more patient experience measures in its quality programs and provides essential feedback on how well care aligns with the needs and preferences of those living with serious illness. ***AAHPM continues to encourage CMS to explore inclusion of the Heard and Understood measure into additional MVPs as they are developed.***

AAHPM also recommends that CMS add the measure "Receiving Desired Help for Pain" (Help Wanted for Pain; CBE ID #3666) separately to the MIPS measure inventory. Developed alongside *Heard and Understood*, this measure evaluates the percentage of patients who report receiving the pain management support they desire during ambulatory palliative care visits. Including both *Help Wanted for Pain* and *Heard and Understood* in MIPS, including in MVPs, would enable more accurate assessment of

providers caring for patients with serious illness by capturing distinct, patient-centered aspects of palliative care quality.

MIPS Core Measures

CMS proposes to establish a new MIPS core measure designation that would be applied to specific MIPS quality measures under traditional MIPS and MVPs. Under the proposal, MIPS eligible clinicians would be required to report at least one MIPS core measure as one of the six measure required under traditional MIPS or as one of the four measures required under an MVP. This policy would replace the current requirement that clinicians report an outcome measure, or a high-priority measure when an applicable outcome measure is unavailable. Under the proposal, small practices would be exempt from the requirement. CMS also proposes a self-attestation process for clinicians for whom no applicable MIPS core measure is available.

AAHPM appreciates that CMS proposes to include the Heard and Understood measure as a core measure under traditional MIPS and as part of both the Advancing Cancer Care MVP and the Quality Care for Patients with Neurological Conditions MVP.

We also urge CMS to designate the Heard and Understood measure as a core measure for the following MVPs in which the measure is already included: (1) Advancing Care for Heart Disease MVP, (2) Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP, and (3) Optimal Care for Kidney Health MVP. Further, CMS should designate the Heard and Understood measure as a core measure in any MVPs it is added to in the future.

As discussed above, the *Heard and Understood* measure captures the experiences of patients with serious illness and their families by assessing whether care aligns with their needs and preferences. Including measures like *Heard and Understood* would advance person-centered care within MVPs by evaluating clinicians on whether the care they furnish truly meets patients' goals and values.

As part of CY 2026 rulemaking, CMS had sought input on a similar concept by which MVP participants would be required to select at least one quality measure from a subset of measures in each MVP. At the time, CMS referred to this concept as "core elements." While MVPs are intended to focus on defined types of care and patient populations, the introduction of "core elements" appears to run counter to that goal. At that time AAHPM urged CMS to instead incentivize the development and use of more patient-centered measures that directly reflect the care being provided rather than mandating broad, cross-cutting measures. Inclusion of overly broad measures risks adding reporting burden without yielding improvements in patient outcomes or providing patients with meaningful information.

To that end, AAHPM believes that cross-cutting measures, such as core measures, should only be included in MVPs on an optional basis, thereby maintaining flexibility for clinicians to select measures most relevant to their patients and practice settings.

Proposed Measure Changes

CMS proposes modifications to several measures including:

- ***Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life*** measure

- *Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days* measure

AAHPM supports the goals of the *Percentage of Patients Who Died from Cancer Receiving Systemic Cancer-Directed Therapy in the Last 14 Days of Life* measure, which is intended to encourage more timely enrollment in palliative care that prioritizes symptom management, rather than low utility and aggressive treatments among people dying of cancer. However, we would urge CMS to consider adding a secondary measurement period that would capture the last 30 days of life in addition to the last 14 days of life. We believe a 30-day measure can be an effective lever for prompting timely transition to appropriate palliative care, supporting better symptom management and a more positive end-of-life experience. Having both a 14-day and 30-day measurement period would provide a more comprehensive picture of end-of-life care for patients dying of cancer and create stronger incentives for earlier, patient-centered transitions to palliative care.

AAHPM also supports the intent of the *Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days* measure in incentivizing earlier referral to and initiation of hospice care for patients at end of life. However, we urge CMS to extend the time period that this measure captures to include hospice lengths of stay of less than seven days, which aligns with hospice utilization measures recommended by the Center to Advance Palliative Care (CAPC).²⁷ A three-day window captures only the most extreme cases of late referral and sets a low bar for "timely" hospice enrollment. There is strong and consistent evidence that longer hospice stays are associated with better outcomes, including improved symptom control, higher patient and family satisfaction, fewer in-hospital deaths, and lower end-of-life expenditures.^{28,29} Shorter stays are repeatedly identified as a marker of poorer-quality care.³⁰ Extending the window for this measure beyond three days to capture lengths of stay of less than seven days would more accurately distinguish timely, high-value hospice enrollment, as opposed to enrollment that occurs too late to deliver its intended benefit. AAHPM would welcome the opportunity to work with CMS and the measure steward to define a more appropriate length of time.

Addressing Topped Out Measures

As part of CY 2025 rulemaking, CMS finalized a policy to exempt certain topped out measures from the 7-point scoring cap; measures selected for exemption are frequently reported by certain specialties with limited measure choice in their specialty measure sets. During last year's rulemaking, CMS extended the policy by applying the analysis and criteria for limited measure choice to MVPs, in addition to the analysis of specialty measure sets.

As part of CY 2027 rulemaking, CMS proposes that topped out MIPS core measures subject to the 7-point scoring cap would no longer be subject to that cap and would instead be scored according to the defined topped out measure benchmark, beginning in the CY 2027 performance period.

²⁷ Center for Advance Palliative Care (CAPC), Recommended Quality Measures/Measure Areas, <https://www.capc.org/documents/download/735/>

²⁸ Kumar P, Wright AA, Hatfield LA, Temel JS, Keating NL. Family Perspectives on Hospice Care Experiences of Patients with Cancer. *J Clin Oncol*. 2017 Feb;35(4):432-439. doi: 10.1200/JCO.2016.68.9257. Epub 2016 Dec

19. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5455697/>

²⁹ Adams CE, Bader J, Horn KV. Timing of Hospice Referral: Assessing Satisfaction While the Patient Receives Hospice Services. *Home Health Care Manag Pract*. 2009 Feb 1;21(2):109-116. doi: 10.1177/1084822308323440. <https://pmc.ncbi.nlm.nih.gov/articles/PMC2802336/>

³⁰ Sedhom R, Gupta A, Smith TJ. Short Hospice Length of Service in a Comprehensive Cancer Center. *J Palliat Med*. 2021 Feb;24(2):257-260. doi: 10.1089/jpm.2019.0634. Epub 2020 Apr 17. <https://pmc.ncbi.nlm.nih.gov/articles/PMC5695752/>

AAHPM continues to urge CMS to extend the approach to all clinicians affected by the scoring cap policy. Many clinicians in specialties, such as HPM, do not have access to a defined specialty measure set and instead rely on a limited number of broadly applicable measures. Current scoring policies reduce points for clinicians who consistently deliver high-quality care, creating a system in which excellence is not rewarded but penalized. These effects are especially pronounced in specialties with a limited number of relevant measures, where topped-out measures may represent the only viable reporting options. When these measures become topped out and are capped or removed, clinicians are penalized for sustained high performance without any meaningful alternatives. ***We therefore continue to urge CMS to apply the policy universally to all topped-out measures. If universal application is not feasible, CMS should at minimum conduct a detailed and comprehensive review of how each specialty and subspecialty is affected by measure availability and MIPS scoring policies.***

Fast Healthcare Interoperability Resources (FHIR) Timeline RFI

CMS seeks feedback on the future transition to Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®)-based digital quality reporting (dQM) under the QPP, including the proposed timeline, key milestones, and implementation considerations. Specifically, CMS is considering a two-year transition period beginning with the CY 2028 performance period, during which existing reporting options would remain available while FHIR-based reporting is introduced for selected measures.

AAHPM appreciates CMS' interest in transitioning to the use of FHIR to collect quality data, which we agree would likely enable greater care coordination and information sharing. However, fully transitioning to electronic clinical quality measures (eCQMs), and eventually dQMs, will demand investments in technology, infrastructure, and workforce training, posing challenges for many organizations.

AAHPM is therefore concerned about the speed in which CMS is considering transitioning MIPS to FHIR-based reporting. This transition will likely impose substantial costs to implement or upgrade health information technology (HIT) systems, which would serve as a significant barrier to success for many clinicians across the country. As we have previously noted, HPM physicians have experienced challenges with adoption of certified electronic health record technology (CEHRT) due to the limited availability of CEHRT that is tailored towards the delivery of palliative care. We note that incentives to adopt CEHRT were not provided to hospice programs, where many AAHPM members practice. Even where CEHRT is used, our members face challenges related to direct electronic extractions of data to registries for purposes of MIPS reporting.

As a result, AAHPM cautions against CMS moving forward with FHIR-based data exchange without addressing these barriers. We urge CMS to work with Congress to secure funding for a new incentive program that supports hospices in adopting CEHRT. Such incentives would not only level the playing field and support hospices' quality assessment and improvement efforts but also lead to improvements in interoperable data exchange that could facilitate seamless care coordination and more effective care management. Until such time that hospices receive such incentive payments and have sufficient time to adopt modernized systems, CMS should refrain from imposing new CEHRT-related requirements on hospices and the HPM physicians who rely on their medical record systems, including requirements applicable to quality reporting programs.

Finally, we continue to urge CMS to adopt a thoughtful, long-term transition that recognizes the burden and operational challenges providers experience in updating their EHR systems to support interoperable

data exchange. CMS should undertake these efforts in a transparent manner that offers providers sufficient lead time for preparation and minimizes unnecessary burden on the provider community.

MIPS Improvement Activities Performance Category

Advance Care Planning Conversations to Support Patient Wellness and Care Preferences

Beginning with the CY 2027 performance period, CMS proposes a new Improvement Activity focused on advance care planning (ACP). Under the proposed activity, “MIPS eligible clinicians would engage patients and their caregivers in structured, proactive discussions about end-of-life preferences, advance care planning, and palliative care options as part of comprehensive wellness and care management.” The activity is intended to “integrate conversations about goals of care, symptom management, and quality of life into routine encounters with patients who have serious or life-limiting illness.” Participating clinicians would be required to document the use of standardized communication tools or frameworks; inclusion of wellness-oriented topics, such symptom relief, emotional well-being, social supports, and patient-identified priorities; coordination of care across relevant specialties, including primary care, palliative care, and behavioral health; and regular review and updating of advance directives or care preferences as patients’ goals and clinical circumstances evolve. CMS also emphasizes that clinicians must not attempt to influence patients’ ACP decisions.

AAHPM appreciates CMS’ ongoing focus and interest in adopting policies that further support ACP discussions. We support CMS’ proposal to add an Advance Care Planning Conversations activity to MIPS.

ACP is an important component of high-quality serious illness care. We consider ACP as a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of ACP is to help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness.³¹ Studies show that timely, meaningful ACP can improve patient and family satisfaction, decrease hospitalization and intensity of treatment near the end of life, increase hospice use and the likelihood of patients dying in their preferred place, and reduce stress, anxiety, and depression in surviving caregivers.^{32, 33, 34}

As CMS continues to explore ways to foster high-quality ACP discussions, we urge CMS to consider the following principles:

³¹ Sudore RL, Lum HD, You JJ, Hanson LC, Meier DE, Pantilat SZ, Matlock DD, Rietjens JAC, Korfage IJ, Ritchie CS, Kutner JS, Teno JM, Thomas J, McMahan RD, Heyland DK. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *J Pain Symptom Manage*. 2017 May;53(5):821-832.e1. doi: 10.1016/j.jpainsymman.2016.12.331. Epub 2017 Jan 3. PMID: 28062339; PMCID: PMC5728651.

³² Schichtel M, Wee B, Perera R, Onakpoya I. The Effect of Advance Care Planning on Heart Failure: a Systematic Review and Meta-analysis. *J Gen Intern Med*. 2020 Mar;35(3):874-884. doi: 10.1007/s11606-019-05482-w. Epub 2019 Nov 12. PMID: 31720968; PMCID: PMC7080664.

³³ Weissman JS, Reich AJ, Prigerson HG, et al. Association of Advance Care Planning Visits With Intensity of Health Care for Medicare Beneficiaries With Serious Illness at the End of Life. *JAMA Health Forum*. 2021;2(7):e211829. doi:10.1001/jamahealthforum.2021.1829

³⁴ Scott I, Reymond L, Sansome X, Carter H. Association of advance care planning with hospital use and costs at the end of life: a population-based retrospective cohort study. *BMJ Open*. 2024 Nov 7;14(11):e082766. doi: 10.1136/bmjopen-2023-082766. PMID: 39510772; PMCID: PMC11552563.

- **Capture role of health care agents and surrogate medical decision-makers.** A critical component of effective ACP is ensuring that patients clearly identify a health care agent or, among patients who do not have capacity to engage in ACP discussions, surrogate medical decision-makers, in accordance with state laws. Identification of such agents or surrogates should be a priority for patients as part of ACP discussions. AAHPM recognizes the complexities involved in identifying appropriate surrogate decision-makers and would welcome the opportunity to work with CMS to develop clear, practical guidance for making this determination.
- **ACP must not be a checkbox exercise.** Medical decision-making is not a single event but an ongoing process that evolves across different stages of illness and care. Meaningful ACP must be more than a static entry in the patient's record.³⁵ We appreciate that, as part of the Advance Care Planning Conversations Improvement Activity, CMS specifies that the clinician must document that there has been a regular review and updates to advance directives or care preferences to ensure that they remain accurate and reflective of patients' goals and clinical circumstances as they evolve.
- **Incentivize high quality, well-time ACP discussions.** Equally important is the quality and appropriateness of ACP discussions themselves. Clinicians across specialties frequently cite time constraints as a significant barrier to conducting ACP discussions, particularly when appointments are constrained by competing clinical priorities. We therefore urge CMS to consider approaches that incentivize meaningful, well-timed ACP discussions and create the conditions necessary for clinicians to conduct them effectively.

AAHPM would welcome the opportunity to serve as a resource as CMS continues to explore ways to support high-quality ACP discussions.

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Thank you, again, for the opportunity to provide feedback in response to the CY 2027 Medicare Physician Fee Schedule proposed rule. AAHPM would be pleased to work with CMS to address our feedback and recommendations above, particularly in response to the RFI on community-based palliative care. We believe our experience and expertise could be valuable to CMS as it contemplates options for expanding access to palliative care – a goal to which AAHPM is deeply committed – and we are hopeful that our collective efforts will enable patients with serious illness to receive the robust, interdisciplinary palliative care support they need. Please direct questions or requests for additional information to Wendy Chill, Senior Director of Health Policy and Government Relations, at wchill@aaahpm.org.

Sincerely,



Kimberly Curseen, MD, FAAHPM
President, American Academy of Hospice and Palliative Medicine

³⁵ McMahan RD, Hickman SE, Sudore RL. What Clinicians and Researchers Should Know About the Evolving Field of Advance Care Planning: a Narrative Review. *J Gen Intern Med*. 2024 Mar;39(4):652-660. doi: 10.1007/s11606-023-08579-5. Epub 2024 Jan 2. PMID: 38169025; PMCID: PMC10973287.