

STRENGTHENING MEDICARE FEE-FOR-SERVICE FOR HIGH-QUALITY PALLIATIVE CARE

Position from the Center to Advance Palliative Care (CAPC)



In this statement, CAPC offers what can be a comprehensive Medicare strategy for meeting the needs of beneficiaries with serious illness without the creation of a demonstration model or a new Medicare benefit. This includes both timely identification of beneficiaries in need, and sufficient payment to support interprofessional, holistic assessment and care planning, followed by longitudinal palliative care when warranted.

What is the Problem?

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

The existing Medicare Physician Fee Schedule can cover a good deal of palliative care program expenses but not all. Many palliative care leaders have [noted the revenue improvements](#) from the G2211 code/modifier, the principal care management codes that can be used by multiple providers each month, and other recent changes. However, the ability to cover a full interprofessional team's salaries varies significantly, depending on:

1. *Team composition.* High-quality teams with strong social services and spiritual care are usually unable to cover their full salary costs on Medicare billing.
2. *Time requirements.* Palliative care's mechanism of intervention requires intense conversations with patients, caregivers, and members of the treating clinical team. In addition, high-quality home-based palliative care programs must include in-person visits, but this introduces a great deal of unreimbursable "windshield time," particularly for those serving rural areas.
3. *Coding competency of the palliative care clinicians.* Unlike many other specialties, palliative care clinicians rarely have professional coding support and must make their own decisions on documentation and coding. As a result, palliative care is less likely than other specialties to optimize their Medicare fee-for-service billing revenue.



CAPC recommends a comprehensive Medicare strategy for meeting the needs of beneficiaries with serious illness without the creation of a demonstration model or a new Medicare benefit.

How Can We Improve Timely Identification of Beneficiaries in Need?

A **two-step approach that combines a life-limiting diagnosis** (as identified through a discrete list of ICD-10 codes) **with a second indicator of need** (as identified through past utilization) would allow identification of eligible beneficiaries based on existing claims data:

Two-Step Data Screening

Diagnoses

- Advanced cancer (locally advanced or metastatic); leukemia or lymphoma
- Heart failure or advanced heart disease
- Advanced lung disease, oxygen-dependent
- Advanced dementia or Alzheimer's disease
- Advanced kidney disease
- Advanced lung disease with home oxygen or hospitalized for the condition
- Frailty syndrome (weakness, slowness, low level of physical activity, fatigue, unintentional weight loss)

AND

One or more of these indicators of unmet need, impaired function, or high symptom burden

- One or more ED visits within past three months
- One or more hospital admissions within the past three or six months
- Home health episode from community referral
- Sequential home health episodes
- Durable medical equipment claims consistent with impaired function or high symptom burden
- Discharge from post-acute care with low functional score

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

However, claims-based identification processes will generate false positives and false negatives, and some areas of palliative care needs – such as caregiver distress or declining function without health services utilization – should also be accommodated to determine eligibility for palliative care services. Therefore, in addition to any proactive identification process, continued **access to palliative care, particularly palliative care assessment and care planning, should be available via clinician referral.**

Recommended Actions to Ensure Sustainability and Access

1. Establish a Comprehensive Palliative Care Assessment & Care Planning Code

Create a new Medicare HCPCS code, modeled on the Cognitive Assessment and Care Planning code 99843, to support a comprehensive assessment that would include, at minimum: physical symptoms, mental health needs, social needs, functional difficulties, caregiver distress, and illness understanding. Including spiritual needs would be valuable as well.

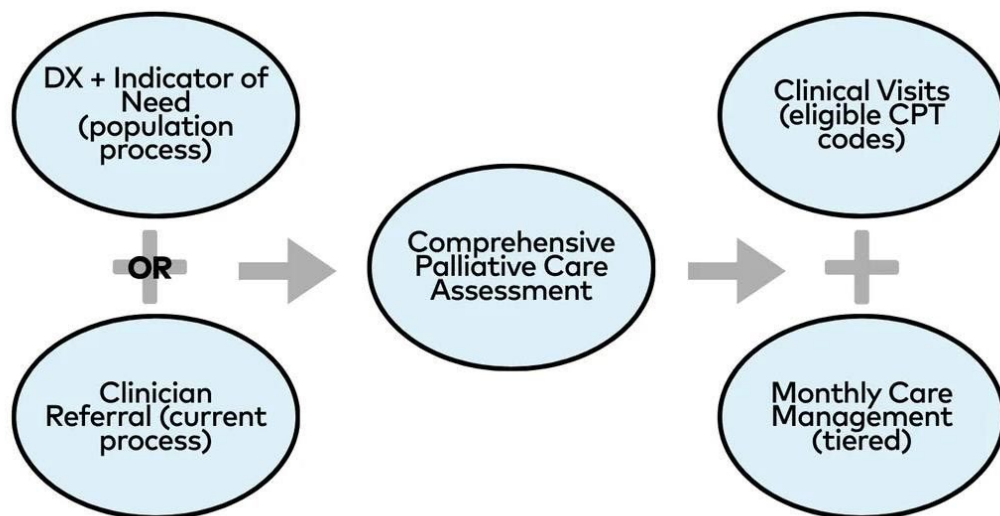
Beneficiaries eligible for this service would be based on either:

- A claims-based algorithm combining diagnosis with evidence of unmet need, such as a recent hospitalization or ED visit; and/or
- Referral from a clinician who recognizes an unmet need, such as caregiver distress, difficult treatment decisions, or inadequately controlled symptoms.

2. Require Interprofessional Care for Monthly Palliative Care Management

Currently, many community-based palliative care programs use the complex chronic care management or principal care management codes for longitudinal care of Medicare patients. If this were supplemented with a dedicated "intake" payment as recommended above, the existing codes can suffice for that purpose. However, it is preferred that CMS creates a new monthly palliative care management code, which can introduce requirements for interprofessional care on an ongoing basis. If a new code is created, we strongly recommend that any providers billing this must:

- Document active interprofessional collaboration to address the full range of palliative needs. In fact, CAPC will be releasing minimum specialty palliative care program standards by Summer 2027, and those can be used for provider eligibility to use this assessment code.
- Allow the continued use of encounter codes for the physician and/or advanced practice provider. This will incentivize continued medical care and mimics the earlier planned "serious illness option (SIP)" from CMMI.



3. Modernize Home Health Payment to Accommodate Patients with Serious Illness

We agree that the existing MMTA (medication, management, teaching, and assessment) category aligns well with patients in need of palliative care services. However the Home-Health Value-Based Purchasing discharge function measure disincentivizes admission of patients whose function is unlikely to improve. Therefore, we strongly recommend that CMS eliminate that measure for patients within the MMTA category.

Further, while some palliative care needs of home health patients can be met through the home health benefit, we urge CMS to distinguish this patient pathway from specialty community-based palliative care for purposes of any concurrent Part B billing.