AAVBC

American Academy
of Value Based Care

# Utilization Reduction in Serious Illness: A Clinical & VBC Guide to Palliative and Hospice Care

2026

# Utilization Reduction in Serious Illness: A Clinical & VBC Guide to Palliative and Hospice Care

## Table of Contents

**INTRODUCTION.......... 3**
**CLINICAL SNAPSHOT.......... 3**
**INDICATORS FOR CONSIDERING PALLIATIVE CARE.......... 6**
- Core Clinical Triggers for Palliative Care Referral.......... 6
- The Surprise Question.......... 6
- Prognostic, Functional, and Cognitive Tools for Early Palliative Identification.......... 6
- Role of Primary Care, Specialists, and UM Teams.......... 9
- Translating Risk Identification Into Early Advance Care Planning.......... 9

**ACP AS A UTILIZATION REDUCTION STRATEGY.......... 11**
**INTEGRATING PALLIATIVE CARE ACROSS CARE SETTINGS.......... 13**
- Inpatient Utilization Management Trigger Criteria.......... 14
- Outpatient Palliative Care.......... 15
- Home-Based Palliative Care.......... 15
- Co-Management With Primary and Specialty Care.......... 16

**TIMELY HOSPICE UTILIZATION.......... 16**
- Medicare Hospice Levels of Care: Distribution and Utilization Implications.......... 17
- The Timing Problem: Hospice Is Introduced Too Late.......... 17
- Clinical and Utilization Benefits of Earlier Hospice Enrollment.......... 17
- Barriers to Timely Hospice Utilization and High-Value Mitigation Strategies.......... 18

**FINANCIAL IMPACT OF PALLIATIVE AND HOSPICE CARE.......... 20**
- The Non-Hospice Spending Problem.......... 20
- Why This Matters for Value-Based Care.......... 21
- Aggressive End-of-Life Care vs Palliative-Oriented Care.......... 21
- Timing Matters: Early vs Late Palliative Care.......... 22
- Financial Implications for Value-Based Models.......... 22

**QUALITY MEASUREMENT AND PERFORMANCE MEASURES.......... 22**
- Quality Tie-Ins: Palliative & Hospice Care in Value-Based Programs.......... 23
- CMS Hospice Quality Reporting Program (HQRP): Current Measures (2025–2026).......... 23
- Medicare Advantage Star Ratings Alignment.......... 27
- Strategic Importance for Medicare Advantage Plans.......... 28

**DOCUMENTATION AND CODING.......... 28**
- Common Serious Illness Codes Seen with Palliative Care.......... 29
- Advance Care Planning (ACP) CPT Codes.......... 31
- Documentation to Support Medical Necessity & Quality Reporting.......... 31
- Hospice Documentation vs Hospice Claims Reporting.......... 32

**KEY TAKEAWAYS FOR UTILIZATION REDUCTION.......... 32**
**REFERENCES.......... 34**

# Introduction

The AAVBC supports clinical models emphasizing care that prevents avoidable hospitalizations while supporting quality of life for individuals with serious illness. For many patients with advanced disease, repeated emergency department visits, hospitalizations, and intensive interventions often reflect uncontrolled symptoms, limited care coordination, or a lack of documented care preferences rather than improved clinical outcomes.

Palliative and hospice care addresses these gaps by proactively managing symptoms, supporting patients and caregivers, and aligning treatment decisions with documented goals of care. When integrated earlier in the disease course, these services improve patient and caregiver experience while often reducing reliance on hospital-based care.[1-3]

# 1. CLINICAL SNAPSHOT

**Palliative care** is specialized, interdisciplinary care for patients with serious illness. Defined by the World Health Organization as an approach that **improves quality of life** through the prevention and relief of suffering, it addresses symptoms, psychosocial distress, and the burdens of advanced disease while supporting both patients and their families.[1] Palliative care may be provided at **any stage of illness — it is not limited to the end of life** and does not require discontinuation of disease-directed treatment.[2]

**Hospice care** is a specific form of palliative care **reserved for patients with a terminal illness and a life expectancy of six months or less**, when the clinical **focus shifts away from curative intent toward comfort-focused, supportive care.**[4] Under the Medicare Hospice Benefit, patients elect hospice in exchange for forgoing curative treatment related to the terminal diagnosis, while gaining access to comprehensive interdisciplinary services, most often delivered in the home or community setting.[4]

**Advance care planning (ACP)** is a continuous, patient-centered process of aligning medical decision-making with a patient's values, goals, and preferences — not a one-time form or a task reserved for the final days of life.[5,6] The documentation of advance directives is a critical component of effective palliative and hospice care delivery. Advance directives clarify patient goals, guide treatment intensity, and reduce unwanted high-acuity care near the end of life.

## Why This Belongs in a VBC Framework

AAVBC emphasizes that the goal in VBC is not to reduce utilization in isolation, but to support care that is appropriate, timely, and aligned with each individual’s goals, lived experience, and clinical trajectory. This reflects a core principle—delivering the right care, at the right time, in the right setting. For individuals and families, this includes understanding the differences between palliative care and hospice, and recognizing how the choice of setting—home, inpatient hospice, or facility-based care—can meaningfully shape comfort, support, and overall experience. Early integration of palliative care allows these decisions to be made thoughtfully, rather than during moments of crisis, while addressing common drivers of avoidable acute care use such as uncontrolled symptoms, uncertainty in care preferences, caregiver strain, and fragmented transitions.[2,3]

In practice, patterns such as fewer emergency department visits, reduced hospitalizations, and less reliance on high-intensity interventions near the end of life often reflect care that is more closely aligned with what matters to the person receiving it. These changes emerge through proactive symptom management, clear communication, and shared decision-making—ensuring that the chosen site of care and level of support match the individual's needs—rather than through limiting access to services.[3,7]

## Prevalence and Utilization Impact

Hospice and palliative care represents a substantial component of end-of-life care in the Medicare population.

| Metric | Key Finding | Value Interpretation |
|---|---|---|
| **Hospice enrollment among Medicare decedents** | ~52.8% of Medicare beneficiaries who died in FY 2024 received hospice care[3] | Hospice is now a common component of end-of-life care in Medicare, but nearly half of eligible patients still do not receive it |
| **Annual Medicare hospice users** | ~1.84 million beneficiaries enrolled in FY 2024 — largest single-year increase since 2021[3] | Hospice utilization continues to grow as clinicians increasingly recognize the role of comfort-focused care in serious illness |
| **Median hospice length of stay** | ~17 days[3] | Indicates late referral patterns, with many patients entering hospice only in the final weeks of life despite earlier clinical eligibility |
| **Routine Home Care (RHC)** | 98.8% of hospice days occur in the home setting[3] | Hospice care is primarily delivered in the home or community, allowing many patients to avoid hospitalization during advanced illness |
| **Medicare spending in last year of life** | ~3.1% lower spending among hospice users compared with similar non-hospice patients[7] | Lower spending reflects reduced hospital and ICU utilization, not reduced access to care |
| **Break-even point for hospice enrollment** | Total Medicare spending becomes lower for hospice users beginning at day 11 of enrollment[7] | Earlier hospice referral allows symptom management and care planning to stabilize patients outside hospital settings |
| **Longer hospice stays (>6 months)** | ~11% reduction in Medicare spending vs non-hospice benchmarks; up to 25% reduction in CKD/ESRD populations[7] | Earlier hospice involvement improves symptom control and reduces repeated hospitalizations |
| **Acute care use during hospice enrollment** | ~$2.0 billion in non-hospice Medicare spending occurred during hospice election in FY 2024[3] | Suggests care coordination challenges and delayed hospice transitions in some patients |
| **ICU use in final 30 days of life** | ~29% of Medicare decedents receive ICU care in the final month of life[8] | High ICU utilization near death often reflects uncontrolled symptoms or lack of documented care preferences |

## ICD-10 and Billing Coding Context

Accurate coding in serious illness care supports both clinical continuity and appropriate risk adjustment. Documentation must reflect genuine clinical assessment and the patient's stated goals. The **AAVBC**

**encourages comprehensive representation of clinical complexity which directly supports both continuity of care and appropriate risk adjustment.**[9,10]

| ICD-10-CM/CPT Code | Clinical Application | Key Documentation Note |
|---|---|---|
| **Z51.5 (Palliative care encounter)** | Reported alongside — never instead of — the primary serious illness diagnosis to signal palliative involvement in both inpatient and outpatient settings. Does not generate an HCC directly but reinforces the clinical complexity of underlying conditions that do, such as advanced cancer, end-stage organ disease, and advanced dementia[9,10] | Pair with primary diagnosis code(s); document the clinical rationale for palliative involvement specifically[10] |
| **99497 ACP, first 30 min** | Billable face-to-face ACP encounter (>16min) focused on discussing care goals, advance directives, and treatment preferences in the context of the patient's illness. Can be billed alongside an E/M visit when documented separately[11] | Document: topics discussed, patient's expressed preferences, participants present, and total time spent. "Discussed goals of care" alone does not support billing[11] |
| **99498 ACP, each additional 30 min** | Add-on code for each additional 30-minute increment of ACP beyond 99497. Used when complexity warrants extended discussion. Cannot be billed independently[11] | Same documentation standards as 99497; document why the extended time was clinically necessary[11] |

> Documentation must reflect genuine clinical assessment and the patient's stated goals. Coding should represent the care delivered — accurate representation of clinical complexity supports both continuity of care and appropriate risk adjustment.

The ICD-10-CM code Z51.5 is used to indicate that a patient is receiving palliative care services. This code may be reported in both inpatient and outpatient settings and is frequently used **alongside primary diagnosis codes**, including in hospice-related encounters. While Z51.5 does not replace the need to code underlying serious illness diagnoses, it provides important clinical context that signals palliative involvement and supports documentation of care intent.

**HCC mapping**: The code **Z51.5 is not a CMS Hierarchical Condition Category (HCC)** and does not directly generate a risk adjustment factor. However, its use can play an **indirect role in risk-adjusted care models** by reinforcing the clinical severity, complexity, and advanced nature of underlying conditions that *do* map to HCCs (e.g., advanced cancer, end-stage organ disease, advanced dementia).

## 2. INDICATORS FOR CONSIDERING PALLIATIVE CARE

Early identification of patients who would benefit from palliative care is the most critical step in reducing avoidable utilization. When palliative services are introduced late, often during a terminal hospitalization, the window to prevent emergency department visits, ICU admissions, and unwanted interventions has already been lost.[3,12] In contrast, timely identification allows care teams to address symptoms, clarify goals, and stabilize care plans before crises occur.[3,13]

Patients with serious illness are not defined by a single diagnosis or age. They are identified through patterns of utilization, symptom burden, functional change, and the complexity of care decisions they face.[14-16]

## Core Clinical Triggers for Palliative Care Referral[2,4,5,14-18]

Several clinical indicators reliably signal elevated risk for avoidable acute care use and unmet palliative needs. These triggers should prompt consideration of early palliative involvement, regardless of care setting:

- **Two or more hospitalizations for the same condition within six months**
- Persistent or poorly controlled symptoms — pain, dyspnea, anxiety, nausea, or delirium — despite standard therapy
- Progressive functional decline: reduced mobility, increasing dependence in activities of daily living, or unintentional weight loss
- Advanced or refractory disease with limited or diminishing treatment options
- Caregiver strain or psychosocial distress, which often precedes crisis-driven utilization
- Absence of documented advance care planning, especially in patients with serious illness or limited prognosis

These indicators reflect situations where care is often reactive rather than planned. Palliative care intervenes by stabilizing symptoms, supporting caregivers, and establishing a care trajectory aligned with patient goals.

## The Surprise Question

Simple prognostic tools can support, but should not replace, clinical judgment. The widely used "surprise question" — "Would you be surprised if this patient died in the next 12 months?" — has demonstrated utility in identifying patients at elevated risk of mortality and high healthcare utilization.[19] A response of "no" should prompt a deeper assessment of palliative needs and goals of care.

Functional status measures, such as declining performance status or increasing dependency, further strengthen risk stratification. Prognostic scores and performance scales are most effective when used as signals for conversation and planning, not as rigid eligibility thresholds.[19,20]

## Prognostic, Functional, and Cognitive Tools for Early Palliative Identification

| Tool/ Assessment | What It Measures | How It Is Used in Practice | Relevance to Utilization Reduction | Key Considerations |
|---|---|---|---|---|
| **Surprise Question[19]** | Clinician-perceived 12-month mortality risk | Single-question screen — "Would you be surprised if this patient died in the next 12 months?" — used to prompt further assessment of palliative needs and goals of care | Identifies patients at elevated risk for late-stage escalation, ICU use, and repeated hospitalizations when care goals are unclear | Subjective; intended to trigger conversations, not determine eligibility |

| Tool/ Assessment | What It Measures | How It Is Used in Practice | Relevance to Utilization Reduction | Key Considerations |
|---|---|---|---|---|
| **Karnofsky Performance Status (KPS)**[17] | Global functional status and ability to carry out daily activities | Scored from 100 (normal function) to 0 (death); declining scores indicate worsening illness trajectory | Functional decline is strongly associated with increased care needs and hospital utilization near end of life[19] | Best interpreted longitudinally rather than as a single point-in-time score |
| **Palliative Performance Scale (PPS)**[18] | Functional status, ambulation, oral intake, and cognitive status | Commonly used in palliative and hospice settings to assess disease trajectory and guide care planning | Lower PPS scores correlate with increased symptom burden and higher likelihood of care transitions[19] | Supportive prognostic tool; not a strict hospice eligibility requirement |
| **ADL/IADL Assessment**[21] | Functional independence and need for assistance with daily activities | Evaluates dependence in basic and instrumental activities of daily living across care settings | Functional dependence frequently precedes emergency department visits and unplanned hospitalizations | Sensitive to social support availability and home environment; reassess regularly |
| **Cognitive Screening**[22] | Cognitive impairment and decision-making capacity | Identifies patients with impaired understanding, memory, or judgment who may require surrogate decision-making | Cognitive impairment increases risk of care misalignment and non-beneficial high-intensity interventions | Supports early surrogate identification and advance care planning before capacity is lost |
| **Symptom Burden Assessment (patient-reported)**[19,20] | Pain, dyspnea, anxiety, depression, and fatigue | Structured symptom screening conducted in clinic, hospital, or home settings | Uncontrolled symptoms are a leading driver of crisis-driven ED visits and hospital admissions | Requires routine reassessment to remain clinically actionable |
| **Caregiver Burden Assessment (Zarit Burden Interview)**[23] | Caregiver stress, capacity, and burnout | Identifies caregiver strain that threatens the stability of home-based care | Caregiver distress frequently precipitates emergency utilization and unplanned hospital transfers | Consistently underdocumented despite its strong association with avoidable utilization |
| **Disease Specific Prognostic Scores**[20] | Condition-specific mortality or disease progression risk | Used selectively to contextualize prognosis at clinical inflection points — for example, advanced cancer, heart failure, or ESRD | Helps frame goals-of-care discussions at disease milestones that directly influence utilization patterns | Should complement — not replace — holistic clinical assessment and shared decision-making |

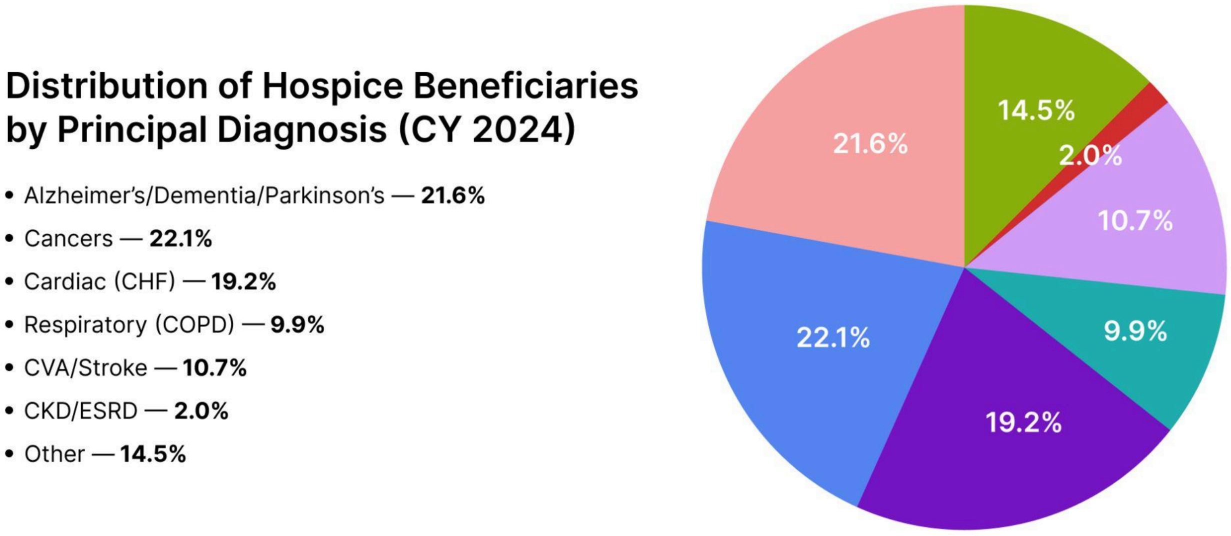
**AAVBC Tip:** None of these tools should be used as rigid eligibility criteria. Their value lies in prompting timely palliative involvement, advance care planning, and proactive symptom management before avoidable crises occur.

## Disease-Specific Patterns Associated With High Utilization[17]

While palliative care eligibility is not diagnosis-limited, certain conditions consistently generate high utilization when care needs are unmet.[24] In these populations, hospital-based interventions often provide diminishing benefit while increasing burden. Early palliative involvement helps reframe care toward symptom relief, realistic expectations, and coordinated outpatient or home-based management.[14]

- **Advanced cancers**, particularly with metastatic or treatment-refractory disease
- **Heart failure** with recurrent decompensation, frequent admissions, or intolerance to guideline-directed therapies
- **Chronic obstructive pulmonary disease (COPD)** with repeated exacerbations or chronic oxygen dependence
- **Advanced dementia, Alzheimer's disease, and Parkinson's disease**, especially with feeding difficulties, recurrent infections, or repeated hospital transfers
- **Cerebrovascular accident (CVA/stroke)** with significant functional loss
- **End-stage renal disease or advanced CKD**, particularly in patients experiencing symptom burden, frailty, or treatment fatigue

As illustrated in the figure below, **neurodegenerative conditions** — Alzheimer's disease, dementia, and Parkinson's disease — and **cancer** together account for the largest share of hospice **enrollment at 43.7% combined**, while cardiac, respiratory, and cerebrovascular diseases represent a substantial and growing proportion.[3] This distribution underscores the importance of non-cancer palliative care pathways and earlier hospice identification in chronic organ failure and neurologic disease.[3,14]



Distribution of Hospice Beneficiaries by Principal Diagnosis (CY 2024)

**Neurodegenerative conditions** (Alzheimer's disease, dementia, Parkinson's disease) and **cancer** together **account for over 40% of hospice enrollment,** while cardiac, respiratory, and cerebrovascular diseases represent a substantial and growing share. This distribution underscores the importance of non-cancer palliative care pathways and earlier hospice identification in chronic organ failure and neurologic disease.[17]

## Role of Primary Care, Specialists, and UM Teams

Early identification works best when responsibility is shared. When these roles operate in silos, palliative care is delayed. When aligned, identification becomes proactive and systematic.[14,19]

### Primary Care Providers

- Uniquely positioned to recognize gradual functional and cognitive decline over time
- Best placed to initiate goals-of-care conversations within established, trusted relationships
- Can normalize palliative care as a routine component of serious illness management — not a last resort

### Specialists

- Identify disease-specific inflection points where treatment burden begins to outweigh benefit
- Examples: oncologist recognizing treatment-refractory disease; cardiologist identifying GDMT intolerance in advanced heart failure; nephrologist discussing dialysis withdrawal in ESRD
- Well positioned to introduce palliative co-management at the point of clinical transition

### Utilization Management and Care Coordination Teams

- Can identify high-risk patterns invisible at the point of care — repeated ED visits, escalating admissions, short hospice stays
- Positioned to prompt referrals systematically, before individual clinicians recognize the need
- Critical for closing the gap between clinical eligibility and actual palliative engagement

## Translating Risk Identification Into Early Advance Care Planning

Identifying a high-risk patient is only meaningful if it triggers action. ACP should begin at the point of identification and be revisited regularly — not deferred until hospitalization or terminal decline.[3,19]

### What ACP Is — and Is Not

- ACP is a **continuous process** of conversation and documentation, not a one-time form or end-of-life event[5,6]
- Appropriate for **all patients with serious illness**, including Medicare beneficiaries in their 60s and 70s and younger patients with progressive disease
- Most effective when initiated **before a health crisis** — when decisions can be made thoughtfully, not under duress[5,6]

### Core Components of a Complete Advance Care Plan

- **Healthcare proxy/durable power of attorney for health care** — designates a trusted surrogate decision-maker
- **Living will** — documents preferences for specific interventions: CPR, mechanical ventilation, artificial nutrition, and intensive care

- **POLST form** — a signed medical order, immediately actionable across care settings; appropriate for patients with advanced or progressive illness[5,6]
- **Documented goals-of-care conversation** — required for HEDIS ACP measure credit and CPT 99497/99498 billing; must include patient goals, treatment preferences, surrogate information, and participants[11,22]

**Communication Principles That Improve Uptake**

- **Normalize the conversation**: Frame ACP as routine care for all patients, not a signal of imminent decline
- **Explore values first**: Ask what matters most, what quality of life means, what the patient most wants to avoid
- **Include surrogates** with the patient's permission — especially when cognitive decline is a risk
- **Explicitly explore** cultural, religious, and personal values — do not assume preferences based on demographics
- **Document specifically**: Vague entries such as "goals of care discussed" do not support billing, quality credit, or clinical guidance for other team members[6,22]

**Why ACP Reduces Utilization — Key Evidence**

- Patients with documented advance care plans experience **fewer hospitalizations** and **fewer unwanted ICU stays** near end of life[5,6]
- ACP is associated with care more closely aligned with patient preferences and **improved end-of-life quality**[5,6]
- Families of patients with completed ACP report **reduced emotional burden** and lower rates of prolonged grief[22]
- These effects translate directly into **reduced avoidable utilization** and lower total cost of care in the final stages of illness[5,6,22]

**Quality and Incentive Alignment**

- The **HEDIS Advance Care Planning measure** (introduced 2022) tracks ACP documentation among older adults and those with serious illness as a core quality indicator[2]
- **Medicare Advantage plans** are explicitly incentivized to improve ACP rates as part of quality and utilization management strategies[2]
- ACP represents a rare alignment of **patient autonomy, clinical quality, and cost stewardship** — making it one of the highest-value activities in a VBC primary care practice

## 3.ACP as a UTILIZATION REDUCTION STRATEGY

Advance care planning (ACP) is often framed as an ethical or communication activity—but within value-based care, it plays a central role in supporting care that is timely, appropriate, and aligned with the individual’s goals. ACP is best understood as an ongoing, documented process that aligns medical decision-making with a patient’s values, priorities, and preferences across the trajectory of health and illness, rather than a single document or one-time conversation.[5,6]

AAVBC supports a proactive approach to ACP within primary care, particularly for adults over age 50–60, both with and without serious illness. This includes discussions around living wills, goals of care, healthcare surrogate designation, financial considerations, and end-of-life preferences, with clear documentation incorporated into the longitudinal medical record (e.g., scanned into the EMR). Establishing this foundation early—and revisiting it as health status evolves—provides clarity not only for patients and families, but for all clinicians involved in care delivery.

When palliative care is introduced in the context of this clarity, patterns of care often shift in meaningful ways. With shared understanding, uncertainty is reduced, transitions are more intentional, and escalation during moments of crisis is less likely to default to high-intensity interventions that may not reflect patient preferences. This allows palliative care teams to engage proactively and supports timely hospice consideration when appropriate. Changes in utilization, such as fewer unplanned hospitalizations, emerge as a reflection of coordinated, goal-concordant care rather than a primary objective.[5,12]

## Evidence Snapshot: Palliative Care Consultation and Utilization Impact

A large Medicare retrospective analysis of patients with advanced cancer found that palliative care consultation represented a clear utilization inflection point — with high utilization preceding consultation and significantly lower utilization afterward.[13] Following palliative care consultation, patients experienced:[13]

- **~47%** fewer hospitalizations
- **~48%** fewer invasive procedures
- **~54%** reduction in chemotherapy use
- **Increased hospice enrollment**

Critically, **earlier palliative involvement produced greater reductions** in aggressive end-of-life care than late consultation — underscoring timing as the primary determinant of impact.[13]

## Evidence Snapshot: Hospice Enrollment and Cost Impact

A large, nationally representative Medicare cohort study demonstrated that hospice enrollment is associated with significantly lower hospitalization-related costs during the final months of life.[24] Key findings:[24]

- Savings were driven primarily by **reduced inpatient utilization** — not cost shifting to families
- Hospice users experienced **lower total health care expenditures across payers**, including Medicare and family out-of-pocket spending, in the final days, weeks, and months of life
- Findings were based on propensity score-matched non-hospice controls, strengthening the validity of the comparison

Interdisciplinary palliative care teams address the core drivers of avoidable utilization once ACP has established care direction. These teams typically include physicians or advanced practice providers, nurses, social workers, and spiritual care professionals — each contributing to a coordinated, patient-centered care plan.[19,2]

## The Four Core Functions That Drive Utilization Reduction

All effective palliative care models — regardless of setting — consistently deliver the following:[2,19]

- **Aggressive symptom management** — proactive control of pain, dyspnea, nausea, anxiety, and delirium before they trigger crisis-driven ED visits
- **Ongoing goals-of-care discussions** — reinforced and updated as illness progresses, ensuring care remains aligned with patient priorities
- **Psychosocial and caregiver support** — directly addressing the distress and caregiver strain that most commonly precipitate unplanned hospitalizations and panic-driven transfers
- **Care coordination across settings** — preventing fragmentation during transitions between home, clinic, hospital, and hospice

When symptoms are controlled and care plans are explicit, patients are significantly less likely to seek emergency care for distress-driven crises. Caregivers are better supported, reducing panic-driven hospital transfers.[2,19,23]

### Operationalizing ACP-Enabled Palliative Care at Scale

High-performing systems do not rely on ad hoc referrals to activate palliative care. They embed palliative involvement into standard workflows and EHRs once ACP and risk identification thresholds are met.[15,16]

### Why Default Pathways Matter

Reliance on discretionary referrals consistently delays palliative engagement and limits its utilization impact. Clinicians are busy, prognostic uncertainty is common, and without a system-level prompt, high-risk patients are routinely missed until a crisis occurs.[15,16]

High-performing organizations have implemented automatic or default palliative consult triggers based on diagnosis, functional decline, age, or utilization patterns. Evidence from these programs demonstrates:[15,16,25]

- **Increased palliative consultation rates** across inpatient and outpatient settings
- **Earlier consults** — occurring approximately one day sooner in the hospital course, meaningfully expanding the window for goals-of-care work
- **More hospice referrals** and higher rates of documented DNR orders, reflecting improved alignment with patient preferences
- **Clinician opt-out rates under 10%** — demonstrating broad acceptance when palliative care is normalized rather than framed as exceptional

### Relationship to Hospice and End-of-Life Care

Early palliative care does not replace hospice. It extends the runway toward appropriate, timely hospice utilization.

Patients engaged in palliative care with documented advance care plans are more likely to:[4,12,24]

- **Complete ACP** formally, with documented preferences and surrogate designation
- **Transition to hospice earlier** when eligible — weeks to months before death rather than days
- **Experience longer hospice stays** — allowing the full benefit of symptom management, caregiver support, and care coordination to be realized
- **Avoid terminal hospitalizations** — dying in their preferred setting, most often at home

**A critical clinical and ethical point:** Palliative care does not hasten death. Evidence consistently demonstrates that early palliative involvement improves symptom control, patient and family satisfaction, and quality of life — while facilitating smoother, earlier transitions to hospice when aligned with patient goals.[2,4,12,24]

## 4. INTEGRATING PALLIATIVE CARE ACROSS CARE SETTINGS

Palliative care achieves the greatest utilization reduction when it is **integrated across care settings**, rather than deployed as a late-stage, inpatient-only service. Value-based care organizations should approach palliative care as a **distributed capability** that follows the patient across settings and over time.

### Core Mechanisms Shared Across All Settings

Regardless of setting, all effective palliative care models consistently deliver these four functions — which directly address the root causes of avoidable ED visits, hospitalizations, and ICU admissions:[2,19]

- **Aggressive symptom management** — pain, dyspnea, nausea, anxiety, and delirium
- **Iterative goals-of-care discussions** — reinforced and updated as illness evolves
- **Psychosocial and caregiver support** — addressing distress that precipitates crisis utilization
- **Care coordination** — particularly during high-risk transitions between settings

### Inpatient Palliative Care

*Primary role: Stabilize care during acute illness and prevent escalation to ICU or non-beneficial intervention.*

Inpatient palliative teams deliver the highest value when consulted **early in the admission** — not after ICU transfer or clinical deterioration has already occurred.[19,24]

High-value inpatient functions include:

- Rapid symptom control during acute episodes
- Intensive goals-of-care and decision-support conversations
- Prevention of **default ICU escalation** when benefits are limited or goals are comfort-focused
- Facilitation of appropriate discharge planning, including hospice referral
- Interrupting cycles of repeated admissions when integrated with post-discharge follow-up

## Inpatient Utilization Management Trigger Criteria[15,19,24]

| Trigger | What It Indicates | Palliative Action |
|---|---|---|
| **≥2 hospitalizations in past 6 months** | Recurrent acute escalation | Initiate inpatient palliative consult |
| **ICU admission or ICU transfer being considered** | High-intensity care with uncertain benefit | Palliative consult for goals-of-care support |
| **Advanced cancer or end-stage organ disease** | Life-limiting illness | Palliative involvement early in admission |
| **Prolonged length of stay without clear plan** | Care plan misalignment | Palliative support for decision-making |
| **No documented ACP or unclear code status** | High risk for unwanted escalation | Urgent ACP discussion with palliative support |
| **Comfort-focused goals being considered** | Declining function, poor prognosis, comfort-focused goals | Initiate hospice discussion and eligibility assessment |

## Outpatient Palliative Care

*Primary role: Prevent hospitalization by managing symptoms and expectations upstream, before crises occur.*

Outpatient palliative care is most effective when embedded within:[5,12]

- Oncology clinics
- Advanced heart failure and pulmonary programs
- High-acuity primary care practices

Outpatient palliative clinicians focus on **longitudinal symptom management, anticipatory guidance, and advance care planning** — reducing ED use and unplanned admissions driven by distress or uncertainty before they occur.[5]

## Outpatient (Clinic-Based) Care Utilization Management (UM) Trigger Criteria[15,19,24]

| Trigger | What It Indicates | Palliative Action |
|---|---|---|
| **Declining function (Karnofsky ≤70 or PPS ≤70)** | Reduced physiologic reserve; functional decline | Refer to outpatient palliative care |
| **Persistent symptoms despite treatment** | Unmet palliative care need | Palliative symptom management |
| **≥2 ED visits in past 12 months** | Crisis-pattern utilization | Longitudinal palliative follow-up |
| **ACP absent or outdated** | High risk during next health event | Initiate or update ACP |

| Trigger | What It Indicates | Palliative Action |
|---|---|---|
| **Limited benefit from ongoing disease-directed therapy** | Need to realign care goals | Palliative-supported care planning |
| **Hospice consideration** | Hospice consideration<br>Approaching hospice eligibility | Begin hospice education and planning |

## Home-Based Palliative Care

*Primary role: Prevent emergency escalation at its point of origin — the home.*

Home-based palliative care targets patients with limited mobility, high symptom burden, or caregiver strain — populations at **highest risk for emergency utilization** who are least able to access traditional outpatient services.[7,14]

Key functions include:

- In-home symptom assessment and proactive management
- Real-time caregiver support, education, and respite planning
- **Rapid response to changes in condition** — preventing default 911 calls and hospital transfers
- Early post-discharge follow-up to stabilize high-risk care transitions

### Home-Based/Community Care Utilization Management (UM) Trigger Criteria[15,19,24]

| Trigger | What It Indicates | Palliative Action |
|---|---|---|
| **Homebound or difficulty attending clinic** | Access barrier to standard care | Enroll in home-based palliative care |
| **Caregiver strain or burnout** | Imminent home care failure | In-home caregiver support and education |
| **Frequent after-hours calls or EMS use** | Uncontrolled symptoms at home | Home symptom management plan; rapid response protocol |
| **Recent discharge with high readmission risk** | Fragile care transition | Early post-discharge palliative follow-up within 7 days |
| **Fluctuating or uncontrolled symptoms** | Escalation risk | Rapid palliative reassessment |
| **Hospice consideration** | Approaching hospice eligibility | Assess hospice eligibility and timing |

## Co-Management With Primary and Specialty Care

Palliative care should function as a **co-management service** — not a replacement for existing care relationships. Clear role delineation prevents duplication, conflicting messaging, and fragmented care.[2,19]

- **Primary care**: longitudinal relationships, early ACP initiation, ongoing risk identification

- **Specialists**: identification of disease-specific inflection points where goals need to be revisited
- **Palliative care**: symptom control, communication support, care coordination across settings

### Model Comparison: Utilization Impact by Care Setting

| Model | Primary Setting | Key Utilization Levers | Most Effective For |
|---|---|---|---|
| **Inpatient Palliative Care** | Hospital | Prevents ICU escalation, clarifies goals during acute admissions | Patients hospitalized with advanced illness or recurrent exacerbations |
| **Outpatient Palliative Care** | Clinic-based | Prevents ED visits and admissions through proactive management | Patients with progressive illness but not yet frequently hospitalized |
| **Home-Based Palliative Care** | Patient home | Prevents emergency calls and transfers | Patients with high symptom burden, frailty, or caregiver strain |

Palliative care reduces utilization most effectively when delivered as a continuum across inpatient, outpatient, and home-based settings, rather than as a late-stage inpatient consult alone.

## 5. TIMELY HOSPICE UTILIZATION

Hospice care is most effective when introduced early enough to influence the course of care — not during the final days of life. In value-based care, timely hospice utilization is a critical mechanism for reducing avoidable hospitalizations, ED visits, and intensive interventions near the end of life while improving patient and caregiver experience. Despite its benefits, hospice is frequently introduced too late to achieve its full clinical or utilization impact.

### The Medicare Hospice Benefit: What It Is in Practice

The Medicare Hospice Benefit provides comprehensive, interdisciplinary palliative care for patients with a prognosis of six months or less who elect to focus on comfort rather than curative treatment for the terminal illness.[4,26] Services are delivered under a per diem payment structure and typically include:[4,26]

- Physician and nursing services
- Medications related to the terminal diagnosis
- Durable medical equipment and supplies
- Psychosocial and spiritual support
- Caregiver education and respite services

Care is most often delivered in the home or community setting. Inpatient hospice levels are reserved for short-term symptom crises or caregiver support — not as the default care model.[3]

An important clinical and counseling point: under Medicare rules, patients agree to forgo curative treatment for the terminal condition in exchange for coordinated, all-inclusive comfort-focused care. While this structure enables high-quality end-of-life care, it also contributes to delayed referral when hospice is framed as a last resort rather than an active, supported phase of care.[4,26]

## Medicare Hospice Levels of Care: Distribution and Utilization Implications[17]

| Hospice Level of Care | Typical Site of Care | Share of Hospice Days | Primary Purpose | Utilization Management |
|---|---|---|---|---|
| **Routine Home Care (RHC)** | Patient home, assisted living, SNF | ~98–99% | Ongoing interdisciplinary hospice care focused on symptom control and support | Confirms hospice is fundamentally a **home-based care model** that prevents ED visits and hospital admissions |
| **Continuous Home Care (CHC)** | Patient home | ~0.1% | Short-term intensive nursing care during acute symptom crises | Functions as a **hospital-at-home substitute**, preventing inpatient admission during symptom escalation |
| **Inpatient Respite Care (IRC)** | Inpatient hospice or contracted facility | ~0.2–0.3% | Temporary relief for exhausted caregivers (≤5 days) | Prevents caregiver burnout that often precipitates avoidable hospitalizations |
| **General Inpatient Care (GIP)** | Hospice unit or hospital | <1% | Short-term management of uncontrolled symptoms | Appropriate for brief stabilization only; upstream palliative care reduces reliance on GIP |

## The Timing Problem: Hospice Is Introduced Too Late

Late referral remains a persistent, measurable challenge:[3,8]

- Median hospice length of stay is approximately **17 days** — reflecting delayed referral, not a shortage of eligible patients
- More than **25% of hospice patients** receive care for one week or less
- Approximately **47% of Medicare fee-for-service decedents** utilize hospice, meaning more than half still die without hospice support, often experiencing fragmented or hospital-based end-of-life care
- When hospice is initiated very close to death, its ability to manage symptoms, support caregivers, and prevent hospital-based escalation is significantly constrained

## Clinical and Utilization Benefits of Earlier Hospice Enrollment

When hospice is introduced months rather than days before death, patients consistently experience:[7,19,24]

- Fewer ED visits and hospitalizations in the final months of life
- Reduced ICU utilization and invasive interventions
- Greater likelihood of **dying at home** in accordance with patient preferences
- Improved symptom control, caregiver support, and family satisfaction
- Lower total Medicare spending, with savings beginning as early as **day 11 of enrollment**[7]

Even among hospice users, late enrollment limits benefit — underscoring that improving timing matters more than simply increasing referral rates.[3]

## Hospice Eligibility as a Dynamic, Ongoing Assessment

Hospice eligibility is not a one-time determination. Prognosis, functional status, and disease trajectory evolve — particularly in chronic and progressive illnesses.[4,19] High-value clinical practices include:

- Reassess hospice eligibility **periodically** in all patients with advanced illness, at each significant clinical change
- Use **functional decline, symptom burden, and care goals** — not diagnosis alone — as triggers for discussion
- Introduce hospice as an option **before crisis hospitalizations occur**
- Frame the conversation around what hospice adds, not what it removes; earlier ACP-informed discussions allow hospice to be framed as a supportive transition rather than a sudden shift in goals

## What Success Looks Like in Hospice Under Value-Based Care

Success is not defined by higher enrollment rates alone, but by earlier, more appropriate, and better-aligned use of the benefit.[3,7] High-performing value-based organizations demonstrate:

- Hospice lengths of stay measured in **weeks to months**, not days
- High RHC utilization with **minimal reliance on GIP**
- Fewer terminal hospitalizations and ICU deaths
- Strong linkage between ACP, palliative care, and hospice referral
- Equitable hospice access across diagnoses, race, language, and geography

Timely hospice utilization supports reduced total cost of care in the final months of life, avoidance of low-value and non-beneficial interventions, improved patient experience and family satisfaction, and better alignment between care delivered and patient goals.[3,5,7,24]

## Barriers to Timely Hospice Utilization and High-Value Mitigation Strategies[1,19,26]

| Barrier Category | Specific Barrier | How It Presents | Utilization Impact | Mitigation Strategy |
|---|---|---|---|---|
| **Patient and Family Perceptions** | Hospice perceived as "giving up" | Patients associate hospice with imminent death or abandonment | Delayed acceptance; continued hospital-based escalation | Reframe hospice as added support for comfort, symptom control, and caregiver relief |
| | Fear of losing clinician relationship | Patients worry they will lose their PCP or specialist | Resistance to referral; prolonged low-benefit treatment | Clarify that hospice complements, not replaces, existing relationships |
| | Limited understanding of hospice services | Families unaware hospice includes medications, equipment, nursing, and 24/7 support | Crisis-driven ED use despite eligibility | Provide concrete examples: home visits, on-call clinicians, medication delivery |

| Barrier Category | Specific Barrier | How It Presents | Utilization Impact | Mitigation Strategy |
|---|---|---|---|---|
| **Clinician-Related Barriers** | Discomfort with prognostic uncertainty | Clinicians delay discussions until prognosis is "certain" | Late referrals; very short hospice stays | Base discussions on functional trajectory and decline, not exact prognosis |
| | Concern about stopping disease-directed therapy | Hospice viewed as mutually exclusive with treatment | Continued low-benefit interventions | Educate on hospice eligibility criteria and concurrent care models |
| | Limited training in hospice conversations | Clinicians avoid or rush discussions | Poor patient understanding; resistance | Provide communication scripts and ACP-linked framing for hospice discussions |
| **System and Workflow Barriers** | Hospice introduced only during hospitalizations | Referral occurs late, during terminal admissions | Missed utilization reduction opportunity | Trigger hospice discussions earlier in outpatient and palliative workflows |
| | Lack of standardized referral pathways | Referrals rely on individual clinician discretion | Inconsistent utilization; equity gaps | Implement standardized hospice referral prompts for high-risk patients |
| | Fragmented goals-of-care documentation | ACP not visible or accessible across settings | Default escalation during emergencies | Ensure ACP and hospice discussions are documented and accessible across care settings |
| **Payment and Policy Barriers** | Requirement to forgo curative treatment | Patients hesitate to elect hospice | Prolonged high-intensity care | Educate on Medicare Care Choices Model and MA VBID concurrent care demonstrations |
| | Misunderstanding of hospice coverage | Assumptions that hospice limits services | Underutilization | Clarify benefit structure and per diem coverage concretely |
| **Equity and Trust Barriers** | Historical mistrust of the healthcare system | Particularly affects Black and African American patients | Later enrollment or non-enrollment | Culturally sensitive education; engage trusted community voices |
| | Cultural beliefs about end-of-life care | Hospice seen as culturally inappropriate | Avoidance of hospice | Tailor discussions explicitly to cultural and spiritual values |
| | Language barriers | Poor understanding of hospice role and benefit | Delayed or declined enrollment | Provide interpreter-supported hospice education at every opportunity |

Hospice utilization improves most when **barriers are addressed upstream**, through advance care planning and palliative care integration, rather than during crisis hospitalizations. Systems that normalize hospice discussions early achieve **longer hospice stays, fewer terminal admissions, and better patient and caregiver experience**.

## 6. FINANCIAL IMPACT OF PALLIATIVE AND HOSPICE CARE

End-of-life care represents one of the most concentrated periods of Medicare spending. A disproportionate share of expenditures occurs in the final months of life, driven by hospitalizations, ICU stays, ED visits, and acute services that often do not improve outcomes or align with patient goals.[3,8] While hospice significantly moderates this spending, substantial non-hospice utilization persists even after hospice election — representing an important and addressable utilization management opportunity.[3]

### The Non-Hospice Spending Problem

CMS analyses show that approximately 45–47% of beneficiaries who elect hospice continue to utilize non-hospice Medicare services (Parts A and B) during their hospice election period.[3] In FY 2024 this translated into:[3]

- Nearly **$2.0 billion** in non-hospice Medicare spending during active hospice enrollment
- Average daily non-hospice spending of **$13.57 per beneficiary** — roughly 7% of the daily hospice payment of $184.90
- Total hospice payments of **$27.2 billion** across 147.2 million hospice days for approximately 1.8 million beneficiaries

### Why This Matters for Value-Based Care

Hospice enrollment alone does not eliminate high-cost utilization. Timing, coordination, and upstream integration determine whether cost avoidance is fully realized.[3,7] Non-hospice spending during hospice election is most commonly attributable to:[3,7]

- Late hospice enrollment following acute hospitalizations
- Fragmented transitions into hospice
- Limited advance care planning prior to hospice election
- Continued treatment of unrelated or poorly defined conditions
- Emergency utilization during poorly managed symptom crises

Hospice is most effective at reducing Medicare expenditures when introduced earlier and preceded by structured palliative care and ACP — rather than layered onto existing high-intensity utilization patterns.[3,7,13]

## Hospice vs Non-Hospice End-of-Life Care: Cost Comparison[3,7,8,27]

| Cost Factor | Hospice Care | Non-Hospice End-of-Life Care |
|---|---|---|
| **Total Medicare spending** | Lower overall spending; savings increase with longer hospice duration | Higher spending due to inpatient, ICU, and procedural use |
| **Average daily cost near death** | **≈$230/day** in last 180 days of life | Can exceed **$6,000 - $20,000/day** in the final 1–3 days |
| **Hospital & ICU use** | Substantially reduced | High, especially in final weeks |
| **Family out-of-pocket costs** | Generally lower; most services covered under hospice benefit | Higher due to copays, deductibles, and uncovered services |

## Aggressive End-of-Life Care vs Palliative-Oriented Care[13,19]

Aggressive end-of-life care is consistently associated with substantially higher costs than a palliative-oriented approach, particularly when aggressive interventions continue into the final weeks of life.

| Feature | Aggressive Care | Palliative-Oriented Care |
|---|---|---|
| **Final month of life cost** | Mean ≈**$18,131** | Mean ≈**$12,678** |
| **Relative cost difference** | **≈43% higher** | Lower intensity, fewer procedures |
| **Hospital utilization** | High LOS, ICU use, procedures | Reduced admissions and LOS |
| **Chemotherapy near death** | Common in last 14 days | Significantly reduced |

## Timing Matters: Early vs Late Palliative Care

The **timing** of palliative care consultation is one of the strongest determinants of cost impact.[5,13]

| Timing of Palliative Care | Average Cost Reduction | Interpretation |
|---|---|---|
| **Within last week of life** | **≈$451** | Too late to meaningfully alter utilization |
| **>4 weeks before death** | **≈$4,643** | Substantial avoidance of admissions and ICU care |
| **Early, repeated consults** | Greatest savings among highest-cost patients | Compounding effect over time |

### Hospice Cost Impact Over the Last Year of Life[3,7,8]

| Cost Measure | Hospice Users | Non-Hospice Patients |
|---|---|---|
| **Average total cost (last year of life)** | **≈$62,819** | **≈$71,517** |
| **Hospital utilization** | Significantly lower | Significantly higher |
| **ED visits** | Reduced | Increased |

### Avoidable Acute Utilization at End of Life[5,24,25]

| Utilization Metric | Observed Reduction With Palliative Care |
|---|---|
| **Hospitalizations** | **47% reduction** after consultation |
| **Hospital admissions (community SCPCT)** | **41% reduction** |
| **ED visits (final month of life)** | **34% reduction** |
| **ED visits per 1,000 patients** | **≈200 fewer visits** |

### Financial Implications for Value-Based Models

| Model | Why This Matters Financially |
|---|---|
| **Medicare Advantage** | Reduced medical loss ratio through avoided Part A utilization; stronger CAHPS and Stars performance supports quality bonus payments |
| **ACO/ACO REACH** | Palliative and hospice care reduce total cost of care within attributed populations; supports shared savings calculations |
| **Delegated risk groups** | Margin protection through avoided ICU admissions, terminal hospitalizations, and readmissions |
| **Health systems** | Lower uncompensated ICU utilization; reduced terminal length of stay; improved throughput and resource allocation |

Palliative and hospice care reduce total cost of care by preventing avoidable hospitalizations, ICU use, and aggressive interventions near the end of life. The greatest financial impact occurs when these services are introduced early, weeks to months before death, rather than during terminal hospitalizations.

## 7. QUALITY MEASUREMENT AND PERFORMANCE MEASURES

Quality measurement programs increasingly recognize that high-quality serious illness and end-of-life care is inseparable from utilization management. Palliative and hospice care influence multiple CMS, NCQA, and Medicare Advantage quality frameworks by improving patient experience, reducing burdensome care, and aligning care with patient goals.[2,3,8]

These measures should be used to **align palliative and hospice strategies with existing quality programs** rather than creating parallel initiatives. They can also guide daily practice toward proactive symptom management and early ACP conversations.

## Quality Tie-Ins: Palliative & Hospice Care in Value-Based Programs:

| Quality Program/ Framework | Measure or Domain | What Is Being Measured | Relevance to Utilization Reduction |
|---|---|---|---|
| **CMS Hospice Quality Reporting Program (HQRP)**[11] | Hospice process and outcome measures | Symptom screening and management (pain, dyspnea), care processes, and hospice service delivery standards | Standardized symptom assessment and proactive management reduce crisis-driven ED visits and hospital transfers near end of life |
| **Hospice CAHPS (CMS)** | Patient and caregiver experience survey | Communication quality, emotional support, care coordination, responsiveness of hospice team | Poor communication and unmet emotional needs are common drivers of emergency calls and hospital transfers; high CAHPS performance reflects better crisis prevention |
| **NCQA HEDIS**[13] | Advance Care Planning (ACP) measure | Documentation of advance care plans among older adults | Higher ACP documentation rates are associated with care aligned to patient preferences and reduced use of unwanted high-intensity services |
| **CMS Quality Payment Program (MIPS)**[14] | Advance Care Plan quality measure, ties back to NCQA | Presence of documented advance care plan or surrogate decision-maker | Incentivizes early goals-of-care conversations that prevent nonbeneficial ICU admissions and late-stage escalation |
| **National Consensus Project (NCP)**[15] | Eight quality domains of palliative care | Symptom management, psychosocial support, communication, care coordination, ethical/legal aspects | These domains directly address the root causes of avoidable utilization in serious illness populations |
| **AAHPM PRO-PM Framework**[16] | Patient-Reported Outcome Performance Measures | Patient-reported symptom burden, emotional distress, caregiver experience | Early detection of worsening symptoms allows intervention before ED visits or hospital admissions occur |

## CMS Hospice Quality Reporting Program (HQRP): Current Measures (2025–2026)[28]

The HQRP assesses hospice performance using a combination of claims-based measures, patient and caregiver experience data, and quality indicators related to symptom control and care processes. Hospices that perform well under HQRP consistently demonstrate earlier enrollment, longer hospice stays, fewer inpatient transitions, and lower rates of late hospital utilization.[28]

## Core HQRP Measure Categories

| Measure Category | What Is Assessed | Why It Matters for Utilization |
|---|---|---|
| **Claims-Based Measures** | Care patterns from Medicare claims — live discharge rates, transitions, chemotherapy in final 14 days | Identifies potentially avoidable hospital use and poor care transitions |
| **Hospice Care Index (HCI)** | Composite quality score using claims-based indicators | Rewards hospices that minimize disruptive, high-intensity care patterns |
| **CAHPS Hospice Survey** | Patient and caregiver experience across 8 domains | Experience correlates strongly with reduced crisis-driven utilization |
| **HIS Comprehensive Assessment** | Symptom screening and care processes documented within 5 days of admission | Early symptom identification reduces unmanaged crises leading to ED visits |
| **Hospice Visits in the Last Days of Life (HVDL)** | Whether patients received in-person visits in final days before death | Higher performance associated with fewer terminal hospitalizations |

**HVLDL** is a CMS claims-based measure that tracks whether hospice patients received in-person visits from hospice clinicians, such as nurses or social workers, in the final days before death. It is used by CMS and payers to assess hospice responsiveness and adequacy of support at the end of life. The measure is designed to ensure patients and caregivers receive timely care during the period of highest symptom burden and risk.

Hospices that perform well under HQRP tend to demonstrate **earlier enrollment, longer hospice stays, fewer inpatient transitions, and lower rates of late hospital utilization**.

### A. HIS Comprehensive Assessment at Admission

**The Hospice Care Index (HCI)** is a CMS composite claims-based measure that evaluates overall hospice care patterns across the hospice episode, including short stays, live discharges, and acute care use during hospice. It is used by CMS, Medicare Advantage plans, and ACOs to compare hospice performance and identify care coordination issues. The measure is designed to flag late referrals and utilization patterns that undermine quality and value-based care goals.

**The HIS evaluates whether the hospice interdisciplinary team completes key elements of a holistic patient assessment within 5 days of hospice admission** — serving as a quality checkpoint for early evaluation of clinical symptoms, psychosocial needs, and care planning. Early assessment reduces unmanaged symptoms that drive ED visits and hospital transfers.[28,29]

| Measure | What CMS Measures | Clinical Meaning | Utilization / VBC Relevance |
|---|---|---|---|
| **HIS Comprehensive Assessment** | Completion of a comprehensive patient assessment within 5 days of hospice election | Confirms early evaluation of symptoms, psychosocial needs, spiritual needs, and care planning | Early assessment reduces unmanaged symptoms that drive ED visits and hospital transfers |

| Measure | What CMS Measures | Clinical Meaning | Utilization / VBC Relevance |
|---|---|---|---|
| **Pain Screening** | Whether pain screening occurred at admission | Identifies presence of pain | Prevents pain-driven crises |
| **Pain Assessment** | Use of standardized assessment when pain is present | Ensures pain severity is quantified | Supports timely treatment escalation |
| **Pain Treatment** | Timely intervention when pain is identified | Demonstrates active symptom control | Reduces avoidable acute utilization |
| **Dyspnea Screening** | Screening for shortness of breath | Identifies high-risk respiratory symptoms | Prevents respiratory-related hospitalizations |
| **Dyspnea Treatment** | Treatment when dyspnea is identified | Confirms symptom management | Reduces panic-driven ED use |
| **Opioid Bowel Regimen** | Bowel regimen prescribed with opioid therapy | Prevents opioid-related complications | Avoids constipation-related ED visits |

### B. Hospice Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Patient/Caregiver Experience

The CAHPS Hospice Survey is a nationally standardized survey administered to family members or close friends of patients who died while receiving hospice care. Fielded monthly across 47 questions, results are publicly reported through the Care Compare program on Medicare.gov. Hospice CAHPS domains function as **leading indicators of utilization risk** — poor scores in communication, symptom management, and caregiver support are consistently associated with higher rates of ED use, inpatient transfers, and fragmented end-of-life care.[3,28]

**Hospice CAHPS Survey: Publicly Reported Domains, Sample Questions, and Improvement Strategies**

| Publicly Reported Domain | Representative Survey Question(s) | What Low Scores Signal | High-Value Improvement Actions |
|---|---|---|---|
| **Communication with the Hospice Team** | How often did hospice staff keep you informed about your loved one's condition?Did staff listen carefully and explain things clearly? | Poor understanding of care plan; uncertainty during symptom changes | Standardize caregiver communication scripts; ensure daily check-ins during symptom changes; document preferred communication method |
| **Pain and Symptom Management** | How often was your loved one's pain or breathing discomfort well controlled?Did staff respond quickly when symptoms worsened? | High risk of crisis-driven ED visits or inpatient transfer | Implement rapid symptom escalation protocols; ensure 24/7 on-call responsiveness; proactively adjust meds before weekends/holidays |
| **Emotional and Spiritual Support** | Did hospice staff provide emotional support to you and your loved one?Were spiritual needs respected? | Distress, anxiety, or lack of trust in care | Normalize early chaplain/social work involvement; offer support proactively, not only on request; document cultural and spiritual preferences |

| Publicly Reported Domain | Representative Survey Question(s) | What Low Scores Signal | High-Value Improvement Actions |
|---|---|---|---|
| **Timeliness of Care and Responsiveness** | How quickly did hospice staff respond when you needed help?Did you receive help as soon as you thought it was needed? | Delays that precipitate ambulance calls or ED use | Track response times; implement "urgent symptom" response thresholds; reinforce after-hours response expectations |
| **Training and Support for Family Caregivers** | Did hospice staff teach you how to care for your loved one?Did you feel prepared to manage symptoms at home? | Caregiver burnout; panic-driven escalation | Provide written and verbal symptom action plans; reinforce caregiver education at every visit; confirm understanding using teach-back |
| **Overall Rating of Hospice Care** | Overall, how would you rate the care your loved one received from hospice? | Global quality perception; reputational risk | Focus on consistency across domains; address service failures quickly; use real-time caregiver feedback to intervene before survey completion |
| **Willingness to Recommend the Hospice** | Would you recommend this hospice to family and friends? | Trust and perceived value deficit | Improve continuity of staff; reinforce hospice role as active care; ensure smooth transitions at enrollment and during symptom crises |

**Hospice CAHPS domains function as leading indicators of utilization risk.** Poor scores in communication, symptom management, and caregiver support are consistently associated with higher rates of emergency department use, inpatient transfers, and fragmented end-of-life care (CMS 2025).

### D. Administrative & Compliance Measures

| Measure | Description | Impact |
|---|---|---|
| **HQRP Reporting Compliance** | Timely submission of HIS and CAHPS data | Failure results in payment penalties |
| **Public Reporting Eligibility** | Data completeness thresholds | Determines Care Compare visibility |

## National Consensus Project (NCP) Quality Domains

The NCP defines eight core domains of high-quality palliative care, increasingly reflected in CMS and payer quality frameworks.[2] The NCP framework reinforces that utilization reduction is an outcome of comprehensive, interdisciplinary care — not isolated interventions.[2]

| NCP Domain | Utilization Relevance |
|---|---|
| **Structure & process of care** | Enables early identification of high-risk patients |
| **Physical symptom management** | Prevents ED visits for pain and dyspnea |

| NCP Domain | Utilization Relevance |
|---|---|
| **Psychological & psychiatric care** | Reduces anxiety-driven hospital use |
| **Social determinants & caregiver support** | Prevents caregiver-triggered escalation |
| **Spiritual & cultural care** | Improves acceptance of hospice |
| **Care of the dying patient** | Reduces terminal hospitalizations |
| **Ethical & legal aspects** | Supports ACP and POLST completion |

The NCP framework reinforces that utilization reduction is an outcome of comprehensive, interdisciplinary care, not isolated interventions.

## PRO-PMs as Leading Indicators of Utilization Risk

Patient-Reported Outcome Performance Measures (PRO-PMs) are emerging as early warning signals for impending utilization risk. Used longitudinally, they allow organizations to intervene earlier with palliative care — before utilization spikes.[30]

| PRO-PM | What It Signals | Utilization Implication |
|---|---|---|
| **Symptom burden scores** | Poor pain or dyspnea control | High ED and hospitalization risk |
| **Functional decline** | Reduced reserve | Imminent hospice eligibility |
| **Caregiver distress** | Support gaps | Crisis-driven admissions |
| **Quality-of-life measures** | Misaligned care goals | Late escalation |

Used longitudinally, PRO-PMs allow organizations to **intervene earlier with palliative care**, before utilization spikes.

## Medicare Advantage Star Ratings Alignment

Although hospice services are carved out of traditional MA payment, palliative and hospice care meaningfully influence MA Star Ratings through downstream quality, utilization, and experience measures. Rather than impacting a single Star measure, **palliative and hospice care function as enabling infrastructure that improves performance across multiple Star domains.**[3,8]

| Star Domain/Measure Type | Mechanism of Impact | Why It Improves Stars |
|---|---|---|
| **Patient Experience (CAHPS-based measures)** | Better symptom control, communication, and caregiver support | Higher satisfaction and trust translate into improved experience scores |
| **Care Coordination Measures** | Earlier ACP, clearer goals of care, smoother transitions | Fewer complaints, better continuity across settings |
| **Hospital Utilization Measures** | Reduced ED visits, admissions, ICU stays near end of life | Lower rates of avoidable acute care improve plan performance |

| Star Domain/Measure Type | Mechanism of Impact | Why It Improves Stars |
|---|---|---|
| **Readmissions (Indirect)** | Hospice and palliative care prevent late discharges and rebound admissions | Fewer 30-day readmissions among seriously ill members |
| **Quality-of-life measures** | Misaligned care goals | Late escalation |

## Burdensome Care as a Quality Signal

CMS and MedPAC analyses consistently show that high-performing MA plans have lower rates of burdensome care near the end of life, including:[3,8]

- ICU admissions in the final days of life
- Mechanical ventilation and invasive procedures without patient-aligned goals
- Terminal hospital deaths

Lower rates of burdensome care reflect better serious-illness management, earlier palliative involvement, and more appropriate hospice transitions — all of which align with CMS quality goals even when hospice costs themselves are carved out.[8]

## Hospice Care Index and MA Plan Oversight

The HCI aggregates multiple claims-based indicators of hospice quality, flagging care patterns that signal poor coordination or inappropriate utilization. While reported at the hospice level, MA plans increasingly use HCI performance to:[3,28]

- Select high-quality hospice partners
- Monitor utilization patterns among enrolled members
- Reduce non-hospice spending during hospice election
- Support overall quality and experience strategies

## Strategic Importance for Medicare Advantage Plans

MA plans that actively integrate palliative and hospice care into serious-illness pathways consistently demonstrate:[3,8,28]

- Higher patient and caregiver satisfaction
- Fewer crisis-driven hospitalizations
- More predictable end-of-life utilization
- Stronger alignment with CMS quality priorities

As CMS continues to emphasize care experience, coordination, and avoidance of non-beneficial care, palliative and hospice programs serve as **foundational enablers of Star performance** — not optional add-ons.[3,8]

# 8. DOCUMENTATION AND CODING

Accurate, specific documentation in serious illness care serves the clinical record first — and quality reporting, billing, risk adjustment, and program evaluation second.[9,10] For primary care clinicians operating in value-based models, documentation directly determines quality credit, shared savings eligibility, audit protection, and care continuity across settings.

### ICD-10-CM Coding: Palliative and Hospice Care

Z51.5 designates an encounter for palliative care and is reported alongside — never instead of — the primary serious illness diagnosis, in both inpatient and outpatient settings. As covered in Section 1, Z51.5 does not generate an HCC directly but reinforces the clinical complexity of underlying conditions that do.[9,10]

| ICD-10-CM Code | Description | Appropriate Use |
|---|---|---|
| **Z51.5** | Encounter for palliative care | May be used **with** active disease diagnoses to indicate palliative focus |

**Key point:** Z51.5 **does not replace** the primary diagnosis. It signals that care is palliative in nature and should be used **in addition to** serious illness diagnoses when appropriate (CMS ICD-10-CM Guidelines).

## Common Serious Illness Codes Seen with Palliative Care

| Condition Category | Examples of ICD-10-CM Codes |
|---|---|
| **Advanced cancer** | C34.x, *C50.x*, C61.x, *C78.x* |
| **Heart failure** | I50.22, I50.23, I50.32, I50.84 |
| **COPD/respiratory failure** | J44.9, J96.10 |
| **CKD/ESRD** | N18.4, N18.5, N18.6 |
| **Dementia** | F03.90, G30. |
| **Neurologic disease** | G20, G12.21 |

### Oncology

| ICD-10-CM Code | Condition | Clinical Context | Palliative/Hospice Relevance |
|---|---|---|---|
| **C34.90** | Malignant neoplasm of unspecified part of lung | Advanced or metastatic lung cancer | High symptom burden; early palliative care improves outcomes |
| **C50.919** | Malignant neoplasm of breast, unspecified | Progressive or metastatic breast cancer | Triggers ACP, symptom management, hospice discussion |
| **C61** | Malignant neoplasm of prostate | Advanced or castration-resistant disease | Often prolonged trajectory; palliative care underused |
| **C78.*** | Secondary malignant neoplasm (metastases) | Metastatic spread | Strong indicator for palliative involvement |

## Heart Failure

| ICD-10-CM Code | Condition | Clinical Context | Relevance |
|---|---|---|---|
| **I50.22** | Chronic systolic heart failure | Persistent symptoms despite therapy | Common non-cancer hospice diagnosis |
| **I50.23** | Acute on chronic systolic HF | Recurrent hospitalizations | Strong trigger for palliative consult |
| **I50.32** | Chronic diastolic HF | Frail, elderly patients | Often overlooked for hospice eligibility |
| **I50.84** | End stage heart failure | Advanced HF with persistent symptoms despite maximal guideline-directed therapy | Strong indicator for palliative care referral and potential hospice eligibility |

## Pulmonary Disease

| ICD-10-CM Code | Condition | Clinical Context | Relevance |
|---|---|---|---|
| **J44.9** | COPD, unspecified | Advanced COPD with dyspnea | High ED and hospitalization risk |
| **J96.10** | Chronic respiratory failure, unspecified | Oxygen or ventilator dependence | Supports hospice eligibility when progressive |

## Chronic Kidney Disease

| ICD-10-CM Code | Condition | Clinical Context | Relevance |
|---|---|---|---|
| **N18.4** | CKD stage 4 | Progressive renal decline | Early palliative care recommended |
| **N18.5** | CKD stage 5 | Pre-ESRD | Hospice consideration if dialysis declined |
| **N18.6** | End-stage renal disease | Dialysis dependence or withdrawal | Clear hospice trigger when goals shift |

## Dementia & Neurodegenerative Disease

| ICD-10-CM Code | Condition | Clinical Context | Relevance |
|---|---|---|---|
| **F03.90** | Unspecified dementia | Advanced cognitive decline | Major hospice population |
| **G30.9** | Alzheimer's disease | Late-stage disease | High caregiver burden |
| **G20** | Parkinson's disease | Advanced motor and non-motor symptoms | Often long hospice stays |
| **G12.21** | Amyotrophic lateral sclerosis (ALS) | Progressive neuromuscular failure | Early palliative and hospice essential |

## Advance Care Planning (ACP) CPT Codes

Advance care planning is separately billable, quality-measured, and highly scrutinized in audits. Documentation must demonstrate time, content, and patient participation.

| CPT Code | Description | Time Requirement | Key Documentation Elements |
|---|---|---|---|
| **99497** | ACP, first 30 minutes | ≥16 minutes | Goals of care discussed, patient consent, participants, decisions made |
| **99498** | Each additional 30 minutes | Add-on | Only billable with 99497 |

**Reminder:** Generic documentation such as "discussed goals of care" does not support billing, quality measure credit, or audit defense.

## Documentation to Support Medical Necessity & Quality Reporting

| Documentation Area | What Must Be Explicit | Why It Matters |
|---|---|---|
| **Serious illness status** | Diagnosis, functional trajectory, and current clinical status | Establishes eligibility for palliative and hospice care; supports accurate risk adjustment |
| **Symptom burden** | Specific symptoms: pain with location and severity, dyspnea, anxiety, fatigue | Supports medical necessity and informs the care plan |
| **Goals of care** | Patient's stated priorities, what they want to avoid, what quality of life means to them | Drives utilization decisions; guides care in emergencies |
| **ACP status** | Surrogate decision-maker named; advance directives completed; POLST if appropriate | Required for HEDIS ACP measure credit; ensures guidance is accessible across settings |
| **Care coordination** | Palliative or hospice involvement; transitions planned; communication with specialists | Supports quality reporting and care transitions |
| **Benefit-burden balance** | Clinical judgment on whether current interventions align with patient goals | Reduces non-beneficial care; supports appropriate resource use |

## Hospice Documentation vs Hospice Claims Reporting

A common and consequential source of confusion: clinicians are responsible for clinical documentation, not hospice claims coding. Clinicians should not document hospice levels of care — this is determined and billed by the hospice agency.

| Responsibility | Who Holds It |
|---|---|
| **Prognosis discussion and documentation** | Treating clinician |
| **Goals-of-care conversations and ACP** | Treating clinician — billable under CPT 99497/99498 |
| **Hospice referral** | Treating clinician |

| | |
|---|---|
| **Hospice eligibility certification** | Hospice medical director and attending clinician (co-certification) |
| **Level of care determination and billing** | Hospice agency — revenue codes 0651, 0652, 0655, 0656 |
| **Ongoing clinical care plan** | Interdisciplinary hospice team |
| **Quality reporting — HQRP, HIS, CAHPS** | Hospice agency |
| **ICD-10 coding accuracy** | Clinician and hospice agency, in coordination |

**Clinicians should not document hospice "levels of care"**—this is determined and billed by the hospice agency.

# 10. KEY TAKEAWAYS FOR UTILIZATION REDUCTION

Palliative and hospice care are not ancillary services within value-based care—they are essential components of caring for individuals with serious illness. AAVBC affirms that their role is not to limit care or manage utilization as an endpoint, but to support care that is aligned with each person's goals, clinical condition, and lived experience. This reflects a foundational principle: delivering the right care, at the right time, in the right setting, particularly during periods of increasing complexity and vulnerability.

When introduced early and supported consistently, these approaches help reduce avoidable, crisis-driven care by addressing symptoms proactively, clarifying goals, and strengthening continuity across settings. The resulting patterns—fewer unplanned hospitalizations, more care delivered in the preferred setting, and less reliance on non-beneficial interventions—reflect care that is better coordinated and more aligned with patient priorities.[3,7,13,24]

Across this guide, a consistent theme emerges: earlier integration supports more intentional care, more informed and supported decision-making, and stronger alignment between what matters to the person and the care delivered.

## High-Impact Actions to Prioritize

The following actions consistently deliver the greatest utilization and cost impact:[3,5,7,13,19,24]

- **Identify serious illness earlier** — use diagnosis, functional decline, symptom burden, and utilization patterns as triggers, not prognosis alone. The Surprise Question, KPS, PPS, ADL/IADL assessment, and caregiver burden screening are practical, validated starting points
- **Embed ACP longitudinally** — treat it as an ongoing clinical process, not a one-time documentation event. Document specifically: goals, preferences, surrogate designation, and treatment choices. Bill appropriately using CPT 99497/99498
- **Integrate palliative care upstream** — across inpatient, outpatient, and home-based settings, before crisis hospitalizations occur. Default consult pathways and standardized triggers outperform ad hoc referrals consistently

- **Normalize hospice discussions earlier** — frame hospice as a supported, active phase of care aligned with patient goals, not a last-minute transition or withdrawal of care. Timing is the primary determinant of both clinical and financial impact
- **Reduce burdensome end-of-life care** — including late ICU admissions, mechanical ventilation without patient-aligned goals, and terminal hospital deaths. These are quality signals, not just cost drivers
- **Strengthen caregiver support and responsiveness** — caregiver strain is one of the most consistent and underdocumented predictors of avoidable ED visits and inpatient transfers near end of life
- **Document to reflect care** — goals-of-care conversations, functional status, and serious illness diagnoses must be recorded in specific, clinically meaningful terms to support billing, quality credit, risk adjustment, and care continuity

## What to Implement First: Practical Sequencing

For organizations building or strengthening serious-illness programs, sequencing matters. The following order yields the fastest and most sustainable returns:

| Step | Goal | Expected Impact (Goal) |
|---|---|---|
| 1 | **Standardize palliative care referral triggers** using diagnosis, functional decline, repeated admissions, and symptom escalation | Earlier palliative engagement; fewer late consults; reduced crisis-driven utilization |
| 2 | **Operationalize ACP documentation and billing** — ensure care teams document goals-of-care conversations clearly, completely, and consistently | HEDIS ACP credit; better care continuity; reduced emergency escalation |
| 3 | **Align inpatient and outpatient workflows** — prevent palliative care from being limited to late inpatient consults by embedding it in clinics and transitions of care | Upstream prevention; reduced avoidable hospitalizations |
| 4 | **Formalize hospice referral pathways** — reduce reliance on individual clinician discretion; embed structured hospice consideration into serious-illness workflows | Longer hospice stays; fewer terminal admissions; lower total cost of care |
| 5 | **Use quality data as early warning signals** — monitor CAHPS Hospice domains, ACP rates, HCI performance, and utilization patterns to identify breakdowns before costs and harms increase | Proactive intervention; better patient and caregiver experience; Star rating protection |

## Three Reinforcing Mechanisms That Sustain VBC Performance

Palliative and hospice care improve VBC performance through three mechanisms that compound over time:[3,7,13,24,28]

### 1. Utilization Stabilization

Preventing crisis-driven ED visits, hospitalizations, ICU use, and terminal admissions addresses the largest and most concentrated drivers of end-of-life spending. Palliative care consultation reduces hospitalizations by approximately 47%, ED visits by 34%, and invasive procedures by 48% when introduced early. Hospice enrollment produces lower total Medicare spending beginning at day 11 — with greater savings accruing over longer enrollment periods.

### 2. Quality and Star Alignment

Improved patient and caregiver experience, better care coordination, and reduced burdensome care directly support CMS quality programs, HEDIS measures, and Medicare Advantage Star Ratings. CAHPS Hospice domains, the HEDIS ACP measure, and the Hospice Care Index all reflect the downstream quality effects of early, well-coordinated serious-illness care. These are not parallel initiatives — they are the same work measured from a different angle.

### 3. Predictable Cost Trajectories

Earlier hospice enrollment and effective palliative management shift care from variable, high-cost inpatient settings to predictable, home-based models — protecting margins in risk-based arrangements. The average total Medicare cost in the final year of life is approximately $62,819 for hospice users compared with $71,517 for non-hospice patients. For patients with longer hospice stays, savings reach 11% or more compared with non-hospice benchmarks — and up to 25% in CKD and ESRD populations.

### A Final Clinical Note

The AAVBC believes the goal of palliative and hospice care integration is not to reduce utilization as an end in itself. It is to ensure that every seriously ill patient receives care that is appropriate, consistent with their goals, and free from interventions that add burden without benefit. The utilization and cost benefits documented throughout this guide are outcomes of better care — not the product of restricting access to services.

When primary care clinicians, specialists, and care teams work together to identify patients early, initiate honest and compassionate conversations, document care goals clearly, and connect patients with the right level of support at the right time — the clinical, human, and financial outcomes align

## REFERENCES

1. World Health Organization Regional Office for Europe. Palliative care. WHO Europe. Accessed March 2026. https://www.who.int/europe/news-room/fact-sheets/item/palliative-care
2. National Coalition for Hospice and Palliative Care. Clinical Practice Guidelines for Quality Palliative Care: Quality Measures. 4th ed. National Coalition for Hospice and Palliative Care; 2024. https://www.nationalcoalitionhpc.org/clinical-practice-guidelines/quality-measures/
3. Centers for Medicare & Medicaid Services. Hospice Monitoring Report (2025). CMS; 2025. https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf
4. Centers for Medicare & Medicaid Services. Medicare Hospice Care Coverage. CMS; 2025. https://www.cms.gov/medicare/payment/fee-for-service-providers/hospice
5. National Institute on Aging. Advance Care Planning and Advance Directives for Health Care. NIA; 2024. https://www.nia.nih.gov/health/advance-care-planning/advance-care-planning-advance-directives-health-care
6. Kozlov E, Llaneza DH, Trevino K. Older patients' and their caregivers' understanding of advanced care planning. *Curr Opin Support Palliat Care*. 2022;16(1):33-37. doi:10.1097/SPC.0000000000000583

7. Alliance for Care at Home. The Value of Hospice in Medicare. Alliance for Care at Home; 2024. https://allianceforcareathome.org/wp-content/uploads/Value_Hospice_in_Medicare.pdf
8. Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy (March 2025). MedPAC; 2025. https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC-1.pdf
9. Centers for Disease Control and Prevention and National Center for Health Statistics. ICD-10-CM Official Guidelines for Coding and Reporting, FY 2024. CDC; 2024. https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024/ICD-10-CM-Guidelines-October%201%20FY2024FINALv.2.pdf
10. Centers for Disease Control and Prevention. ICD-10-CM Official Coding and Reporting Tool (FY 2025). CDC; 2025. https://icd10cmtool.cdc.gov/?fy=FY2025
11. Medicare.gov. Cognitive Assessment and Care Plan Services: Coverage and Costs. U.S. Centers for Medicare & Medicaid Services. Accessed March 2026. https://www.medicare.gov/coverage/cognitive-assessment-care-plan-services
12. Petrillo LA, Fitzgerald Jones K, El-Jawahri A, Sanders J, Greer JA, Temel JS. Why and how to integrate early palliative care into cutting-edge personalized cancer care. *Am Soc Clin Oncol Educ Book*. 2024;44(3):e100038. doi:10.1200/EDBK_100038
13. Sheridan PE, LeBrett WG, Triplett DP, et al. Cost savings associated with palliative care among older adults with advanced cancer. *Am J Hosp Palliat Care*. 2021;38(10):1250-1257. doi:10.1177/1049909120986800
14. Harrison KL, Kotwal AA, Smith AK. Palliative care for patients with noncancer illnesses. *JAMA*. 2020;324(14):1404-1405. doi:10.1001/jama.2020.15075
15. American Academy of Family Physicians. Risk Stratification in Population Health Management. AAFP; 2019. https://www.aafp.org/pubs/fpm/issues/2019/0500/p21.pdf
16. Brar R, Friedman MI, Dacosta N, et al. Automated identification of patients with advanced illness. *AMIA Annu Symp Proc*. 2022;2022:269-278.
17. MDCalc. Karnofsky Performance Status Scale. MDCalc. Accessed March 2026. https://www.mdcalc.com/calc/3168/karnofsky-performance-status-scale
18. Victoria Hospice Society. Palliative Performance Scale (PPS). Victoria Hospice Society; 2020. https://micmt-cares.org/sites/default/files/2020-04/Palliative_Performance_Scale1.pdf
19. Center to Advance Palliative Care. Identifying Palliative Care (Webinar Slides). CAPC. https://media.capc.org/recorded-webinars/slides/IDing_pal_care.FINAL_webinra_July_20.pdf
20. Yoong SQ, Bhowmik P, Kapparath S, Porock D. Palliative prognostic scores for survival prediction of cancer patients: a systematic review and meta-analysis. *J Natl Cancer Inst*. 2024;116(6):829-857. doi:10.1093/jnci/djae036
21. Covinsky KE, Eng C, Lui LY, et al. Association of functional impairment in middle age with hospitalization, nursing home admission, and death. *JAMA Intern Med*. 2019;179(5):668-675. doi:10.1001/jamainternmed.2019.0008
22. Silveira MJ, Kim SYH, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N Engl J Med*. 2010;362(13):1211-1218. doi:10.1056/NEJMsa0907901
23. Higginson IJ, Gao W, Jackson D, Murray J, Harding R. Short-form Zarit Caregiver Burden Interviews were valid in advanced conditions. *J Clin Epidemiol*. 2010;63(5):535-542. doi:10.1016/j.jclinepi.2009.06.014
24. Zuckerman RB, Stearns SC, Sheingold SH. Hospice use, hospitalization, and Medicare spending at the end of life. *J Gerontol B Psychol Sci Soc Sci*. 2016;71(3):569-580. doi:10.1093/geronb/gbv109
25. Pearl Health. Transforming Palliative Care in Medicare. Pearl Health. Accessed March 2026. https://www.pearlhealth.com/blog/transforming-palliative-care-in-medicare
26. Medicare.gov. Hospice Care: Who's Eligible and What's Covered. U.S. Centers for Medicare & Medicaid Services; 2025. https://www.medicare.gov/coverage/hospice-care

27. Aldridge MD, Moreno J, McKendrick K, Li L, Brody A, May P. Association between hospice enrollment and total health care costs for insurers and families, 2002-2018. *JAMA Health Forum*. 2022;3(2):e215104. doi:10.1001/jamahealthforum.2021.5104
28. Centers for Medicare & Medicaid Services. Hospice Quality Reporting Program: Current Quality Measures. CMS; 2024. https://www.cms.gov/medicare/quality/hospice/current-measures
29. Centers for Medicare & Medicaid Services. FY 2026 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Program. CMS; 2026. https://www.cms.gov/newsroom/fact-sheets/fy-2026-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting-program
30. American Academy of Hospice and Palliative Medicine. PRO-PM Implementation Guide: Elevating Patient and Caregiver Voices. AAHPM; 2024. https://aahpm.org/wp-content/uploads/2024/03/AAHPM22_PRO-PM_IMPLEMENTATION_GUIDE.pdf

## Medical Disclaimer

The information provided by the American Academy of Value-Based Care (AAVBC) in this document, including but not limited to utilization management guidance, and related content, is intended for educational and informational purposes only. This content is designed to assist healthcare providers, organizations, and professionals in understanding and applying Value-Based Care principles, practices, and regulatory compliance standards.

AAVBC does not provide legal, clinical, or medical advice. The content presented should not be interpreted or relied upon as specific legal, medical, clinical, or professional guidance. While efforts are made to ensure the accuracy and currency of the information provided, AAVBC does not guarantee that the materials presented are complete, comprehensive, or without error.

Providers and healthcare professionals must independently evaluate all content and guidance presented herein in the context of applicable laws, regulations, clinical guidelines, payer policies, patient-specific conditions, and contraindications. Any treatments, procedures, diagnostic approaches, medications, or strategies discussed are illustrative and should not be directly applied without a thorough and independent review of current, evidence-based clinical resources, and regulatory requirements.

For coding, documentation, utilization management, quality measures (including STAR ratings), and compliance matters, users are responsible for consulting official guidelines issued by regulatory bodies, including but not limited to the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), relevant state agencies, and other authoritative entities.

AAVBC expressly disclaims liability for any loss, claim, or damages arising directly or indirectly from the use or reliance on information provided in this document. Users should consult their organization's legal counsel, compliance officer, or qualified professional advisor for advice specific to their situation.

By accessing and using this document, you agree to AAVBC’s terms and acknowledge that the use of the content is at your own risk and discretion.