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AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

December 15, 2025

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission
425 I Street NW, Suite 701
Washington, DC 20001

Subject: Follow-up to September 2025 Discussion on Access to
Specialized Services Under the Medicare Hospice Benefit

Dear Chair Chernew:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), I am writing in follow-up to the Medicare Payment Advisory Commission (MedPAC or Commission) September 2025 public meeting, during which the Commission continued its examination of access to specialized services under the Medicare hospice benefit for beneficiaries with cancer or end-stage renal disease. While AAHPM was pleased that our previously submitted comment letter informed Commission deliberations, several of the discussion points that arose during this session raised significant concerns. We offer preliminary feedback below, and we request a meeting with you and/or your team to address these considerations in greater detail.

AAHPM, along with our membership of physicians, nurses, social workers, spiritual care providers, pharmacists, and other health professionals, prioritizes efforts to increasing quality of life patients facing serious illness as well as their families and caregivers. As part of our work, we are committed to strengthening hospice care, to ensure that patients near the end of life, along with their families and caregivers, receive timely and equitable access to high-quality services and supports across all geographies and communities. This includes promoting reforms that improve program integrity, optimize the experience of care, and support the free exercise of reasonable and independent judgment in clinical decisions made by hospice physicians and interdisciplinary team members, including certification of terminal illness.

Hospice as a Unique, Holistic Experience for Maximizing Terminally Ill Patients' Quality of Life

As the Commission is aware, patients who require hospice are at a particularly stressful and vulnerable point in their lives. The hospice benefit is intended to ease many of their stressors, including pain and other symptoms, thereby contributing to increased comfort and improved quality of life in their final days, weeks, or months. It offers a comprehensive and holistic approach to management of care for terminally ill patients, including by identifying the goals and outcomes of greatest importance to patients and their families and caregivers. Hospice teams provide physical, psychosocial, and spiritual support consistent with patient-centered goals in a manner that minimizes burden on the patients, families, and caregivers, while also offering support throughout the grieving process for families and caregivers.

AAHPM was therefore concerned with comments raised at the September meeting suggesting that patients could receive "hospice-like" care without enrolling in hospice – i.e., that a patchwork of wraparound services would result in an experience that is similar to hospice care. AAHPM disagrees with this characterization, which fails to account for both the experience of care that patients may receive and the unique aspects of hospice care that are not routinely otherwise provided for Medicare beneficiaries.

To begin, wraparound services are often difficult to access or absent altogether in rural areas. When they are available, patients may not be aware of or able to access services readily. Particularly for patients with serious illness who are at the end of life but have not elected hospice, managing immediate and acute medical needs is likely to take priority. Moreover, these patients may be managing multiple medical conditions, numerous prescriptions, and medical visits with myriad providers, further limiting their ability to seek out and benefit from wraparound services. In contrast, hospice offers a one-stop shop that offers beneficiaries the support to address not only their medical needs, but also their psychological and spiritual needs as well.

Hospice support for patients and families through the final days and weeks of terminal illness is also unmatched through other Medicare services. The hospice benefit is highly regulated, with hospices required to follow rules around what services must be furnished, who must furnish services, and how services must be furnished, in order to support patients at the end of life with interdisciplinary, holistic, and patient-centered care. Hospice teams are required to be interdisciplinary, including at a minimum a hospice physician; a registered nurse; a social worker, marriage and family therapist, or a mental health counselor; and a pastoral or other counselor. These teams, led by the hospice physician, meet regularly to review cases and update patients' plans of care – a phenomenon that is not present in many home health or primary care programs. Additionally, hospice clinical staff are distinctly trained to manage symptoms in the home, including in training and supporting caregivers in administering medications for symptom relief. Chaplains, social workers, and volunteers also contribute to addressing the complex social, spiritual, emotional, and/or physical needs of dying individuals and their families, including by helping to address anticipatory grief – again, services that are either difficult to coordinate outside the hospice benefit, or not available altogether. Through these interdisciplinary teams, hospices provide 24/7 access to expert clinicians who can make changes to patients' plans of care as needed. Support is provided both telephonically and, if need be, through in-person visits. In-person visits can provide nursing support to help to address immediate patient needs, including symptom management and proper use of medical equipment. More intensive in-person care can also be furnished in times of crisis or acute need, including care that meets criteria for hospice continuous home care and general inpatient levels of care, which are highly prescribed levels of intensive care that are not available outside of the hospice benefit. This type of

24/7 support is excessively difficult to arrange for outside of hospice, where the only option at 2 a.m. for many patients and families is the emergency room. Hospices also provides rapid access to medical equipment such as hospital beds and oxygen in the home and wound care supplies – equipment that may be slow and complex to arrange for patients who have not elected hospice.

Finally, hospices offer respite care and bereavement counseling to families and caregivers to provide relief and comfort during the most challenging times. Respite care can improve caregivers' well-being and reduce the risk of burnout, support better care for patients, and strengthen the patient-caregiver relationship. Likewise, bereavement care through hospices supports families and caregivers contending with grief and loss. Hospices are required to develop bereavement plans of care that reflect the needs of the bereaved. These bereavement services are available to family members and others in the bereavement plan of care for up to a year following the death of the patient. Unfortunately, respite care is not otherwise covered as a Medicare benefit, meaning that family members and caregivers of patients who do not elect hospice and instead opt for patchwork wraparound services would be unable to readily access respite care. And while the bereaved may be able to access bereavement counseling separately, such access is not assured for family members and caregivers outside the hospice benefit given the shortage of mental health professionals and challenges with insurance coverage.

These distinctions between hospice care and care furnished outside of the hospice benefit are reinforced by abundant evidence demonstrating that hospice improves end-of-life care relative to non-hospice care.[1,2,3,4,5,6] While of course there may be anecdotes of individuals who were able to obtain adequate supports outside of hospice at the end of life, there is absolutely no evidence at the population level that Medicare beneficiaries are accessing substitutions for hospice outside of the hospice program.

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[1] Currow DC, Agar MR, Phillips JL. 2020. Role of hospice care at the end of life for people with cancer. *J Clin Oncol* 38:937-943. DOI:10.1200/JCO.18.02235

[2] Harrison KL, Cenzer I, Ankuda CK, Hunt LJ, and Aldridge MD. 2022. Hospice improves care quality for older adults with dementia in their last month of life. *Health Affairs* 41(6): 821-830

[3] Kumar P, Wright AA, Hatfield LA, Temel JS, Keating NL. 2017. Family perspectives on hospice care experiences of patients with cancer. *J Clin Oncol* 35(4):432–439. doi: 10.1200/jco.2016.68.9257.

[4] Parast L, Haas A, Teno J, Elliott M, Griffin BA, Price RA. 2022. Hospice care experiences among decedents with Huntington's Disease. *J Pain Symptom Manage* 64(1):70-79. doi: 10.1016/j.jpainsymman.2022.02.342. Epub 2022 Mar 6. PMID: 35263620; PMCID: PMC10859183.

[5] Teno JM, Gozalo PL, Lee IC, Kuo S, Spence C, Connor SR, and Casarett DJ. 2011. Does hospice improve quality of care for persons dying from dementia? *Journal of the American Geriatrics Society* 59: 1531-1536. https://doi.org/10.1111/j.1532-5415.2011.03505.x

[6] Zhu E, McCreedy E, Teno JM. 2024. Bereaved respondent perceptions of quality of care by inpatient palliative care utilization in the last month of life. *J Gen Intern Med* 39(6):893-901. doi: 10.1007/s11606-023-08588-4. Epub 2024 Jan 19. PMID: 38240917; PMCID: PMC11074062.

Support for Concurrent Care Options, including a Transitional Care Program

As we noted in our previous letter, AAHPM fully supports beneficiary access to concurrent care and treatments while receiving hospice care. We believe the current requirement for patients to forgo disease-directed care reflects a major structural problem with the current Medicare hospice benefit and forces beneficiaries and their families to face a difficult choice. Too often, this requirement results in patients delaying hospice election, or declining hospice care altogether.

Not only would concurrent care address the Commission's concerns about insufficient access to high-cost palliative care services, but it would also increase uptake of hospice care by removing the requirement for patients to waive access to all Medicare services related to their terminal condition. This requirement delays hospice election and deprives many beneficiaries and their families/caregivers of the supportive end-of-life care furnished by hospices to which they are entitled.

Allowing concurrent care – for example, through a transitional program as the Commission considered – could also address concerns that were raised during the Commission discussion about conflicts of interest that case managers experience. A transitional program would remove concerns that hospice election would result in termination of services like dialysis or radiation therapy, thereby allowing case managers to consider the benefits and appropriateness of hospice services on their own merit.

We also highlight data that suggest limited likelihood of increased total spending or utilization when concurrent care services are furnished. For example, evaluation results from the Medicare Care Choices Model found that the model – which allowed patients to continue receiving curative treatment while electing hospice – resulted in reduced overall Medicare expenditures and acute care service use.[7] A separate study on veterans with concurrent care also found that use of high-intensity palliative care services was fairly limited and that the majority of patients died with hospice-style care at home or in inpatient hospice, rather than in acute inpatient hospital settings,[8] suggesting that the ability to access concurrent disease-directed care does not translate into excessive utilization of such services among patients who have elected the hospice benefit. Paired with data that show that hospice election results in overall Medicare savings, including for longer hospice stays,[9] we believe the case is strong that concurrent care would not raise overall Medicare spending. Notably, data also suggest that concurrent care would improve quality outcomes. The MCCM evaluation results found the model to improve quality of care and patient and caregiver satisfaction. Research looking at Medicare hospice patients with access to concurrent care services through the Veterans Administration also found that patients receiving concurrent dialysis care had substantially longer hospice lengths of stay than those who did not,[10] which we believe itself serves as a meaningful quality endpoint.

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[7] Mathematica. Evaluation of the Medicare Care Choices Model: Fifth and final annual evaluation report. November 2023. Accessed from https://www.cms.gov/priorities/innovation/data-and-reports/2023/mccm-fifth-annrpt on October 9, 2025.

[8] Hemrajani A, Lo SS, Vahlkamp A, et al. 2023. Concurrent hospice healthcare utilization in the hematology/oncology patient population at Veterans Affairs. *J Clin Oncol* 41(16_suppl). doi:10.1200/JCO.2023.41.16_suppl.12125

[9] NORC at the University of Chicago. 2023. Value of hospice in Medicare: Final report. Downloaded from https://www.norc.org/content/dam/norc-org/pdf2023/Value%20of%20Hospice%20in%20Medicare_Final%20Report.pdf on October 9, 2025.

[10] Wachterman MW, Corneau EE, O'Hare AM, et al. 2022. Association of hospice payer with concurrent receipt of hospice and dialysis among US veterans with end-stage kidney disease: A retrospective analysis of a national cohort. *JAMA Health Forum* 3(10):e223708. doi:10.1001/jamahealthforum.2022.3708.

Insufficiency of Budget Neutral Reform Options

As we noted in our previous letter, AAHPM believes that the costs of furnishing specialized services can be prohibitively high and result in excessive financial risk for hospices, which we believe the Commission's analysis also supports. This analysis, presented at the September meeting, found that costs for dialysis would amount to roughly 40 to 50 percent of total hospice payments for a stay, while blood transfusion costs would range from roughly 30 to 50 percent, and radiation therapy costs would range from less than 10 percent to greater than 30 percent. Such costs are not trivial, with hospices guaranteed to lose money on each patient that requires these services. For hospices with small patient populations, which cannot spread risk across a large patient pool, this level of financial burden could be ruinous.

We also note that the Commission focused its discussion on patients with cancer or ESRD, who require dialysis, chemotherapy, blood transfusions, and radiation. However, patients with cancer may also require other costly treatments, including expensive medications, that are not accounted for in the Commission's analysis. For example, as we mentioned in our last letter, metastatic lung cancer patients now often take erlotinib for palliation, which can cost between $6,200 and $,8400 per month. Further, patients with numerous other conditions – such as Huntington's disease, multiple sclerosis, and ALS – may also require high-cost palliative treatments. If the goal is to truly remove barriers to hospice election by supporting access to specialized services, it is not clear that policies should just be limited to ESRD and cancer, or to the four types of specialized services considered. However, policies that would provide equitable access regardless of terminal condition or needed specialized services would further strain hospices' ability to remain fiscally sound – particularly if the only solutions considered were budget neutral within the current hospice payment system.

For these reasons, we underscore our concerns with budget neutral reform options and reiterate our support for options that would either furnish new payments to hospices or offer direct payment to providers of specialized services or treatments separate from payments to hospices.

Conclusion

Thank you, again, for considering our comments regarding Medicare hospice services. As noted above, we would appreciate the opportunity to discuss our comments and perspectives with you in greater detail. Wendy Chill, Senior Director, Health Policy and Government Relations, can serve as the main point of contact. You can reach her at wchill@aahpm.org or (847) 375-6744. We look forward to meeting with you.

Sincerely,

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