National Alliance for Care at Home

October 13, 2025

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

Re: Alliance Comments on September 2025 Meeting – "Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease and beneficiaries with cancer" session

Dear Chairman Chernew:

The National Alliance for Care at Home (Alliance) is the unified voice for providers delivering high-quality, person-centered healthcare to individuals, wherever they call home. Our members are providers of different sizes and types—from small rural agencies to large national companies—including government-based providers, nonprofit organizations, systems-based entities, and public corporations. Our members, including over 1,500 providers representing 10,000 offices and locations, serve over 4 million patients nationwide through a dedicated workforce of over 1 million employees, staff, and volunteers. Formed through the joint affiliation of the National Association for Home Care & Hospice (NAHC) and the National Hospice and Palliative Care Organization (NHPCO), the Alliance is dedicated to advancing policies that support care in the home for millions of Americans at all stages of life, individuals with disabilities, those with chronic and serious illnesses, and Americans at the end of life who depend on those supports.

We thank the Medicare Payment Advisory Commission (MedPAC) for recognizing the critical importance of ensuring access to hospice services for beneficiaries with end-stage renal disease (ESRD) and beneficiaries with cancer in its April and September meetings.

Given the thoughtful discussion at these meetings, we recommend MedPAC:

- Continue its work analyzing and developing options to better align Medicare payments with the cost of care for specialized palliative care services used by patients with diagnoses like End Stage Renal Disease (ESRD) and certain cancers within the Medicare hospice benefit.

- Revisit and discontinue the recommendation from your March 2014 Report to Congress on including hospice as part of Medicare Advantage (MA).[1]

Our detailed comments are provided below.

HOSPICE PAYMENTS SHOULD BE BETTER ALIGNED WITH THE COSTS OF PROVIDING CERTAIN HIGH-COST, SPECIALIZED PALLIATIVE CARE SERVICES

We commend MedPAC for analyzing and developing options to address concerns regarding payment adequacy and beneficiary access to high-cost, symptom-alleviating treatments such as dialysis, chemotherapy and radiation, and blood transfusions under the hospice benefit. As MedPAC staff observed, many beneficiaries with ESRD decline hospice because it would mean potentially stopping dialysis, which often is itself a life sustaining treatment. As MedPAC staff reported, only about 31% of Medicare decedents with ESRD used hospice in 2023, compared to 52% of decedents overall, and those ESRD patients who did elect hospice had a median hospice stay of just 6 days (versus 18 days median for all hospice decedents). Similarly, patients with terminal cancer might be reluctant to enroll in hospice if it means they will encounter difficulties accessing palliative blood transfusions or palliative chemotherapy and radiation to manage symptoms. Per MedPAC, patients with cancer are more likely to elect hospice, but have shorter stays; and patients with blood cancer (especially those transfusion dependent) have shorter stays than patients with other cancers.[2] For dialysis and blood transfusion patients, stopping these treatments results in death in a short period of time. When patients are at the end of life, these treatments shift from curative to palliative and are needed for symptom and pain relief rather than as life-sustaining treatments.

Terminally ill beneficiaries deserve access to high-quality hospice care wherever they call home, including reasonable and necessary palliative treatments. While many hospice providers today provide these specialized palliative care treatments, the expenses can quickly surpass current payment levels, limiting access and delaying hospice enrollment, particularly among those with ESRD and certain cancers. Hospices *want* to serve these patients and offer the necessary interventions to manage patient symptoms. Medicare's current hospice per diem payment system has done a good job of encouraging efficient care delivery and limiting unnecessary treatments; however, the fixed daily rate is not sufficient to cover the costs of these expensive, specialized palliative care services. According to MedPAC's analysis, the estimated treatment costs as a percentage of total hospice payments for the stay would be 40%-50% for palliative dialysis, roughly 30%-50% for palliative blood transfusions, and less than 10%-30% or more for palliative radiation.[3] Ultimately, to remove barriers for patients with ESRD and cancer who seek

[1] https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar14_ch13.pdf
[2] https://www.medpac.gov/wp-content/uploads/2025/09/September-2025-public-meeting-transcript-SEC.pdf
[3] https://www.medpac.gov/wp-content/uploads/2025/09/Tab-F-Hospice-ESRD-cancer-Sept-2025-SEC.pdf

hospice care, Medicare payments must better aligned with the actual costs of providing high-cost, specialized palliative services.

MedPAC should also consider the chilling effect that current audit practices may have on hospice's willingness and capacity to furnish expensive, specialized palliative treatments.[4] Frequent medical review activities that focus on, among other things, long lengths of stay and general inpatient care, may trigger fears about the provision of certain life sustaining interventions when administered for a palliative purpose. Hospice providers may be reluctant to provide palliative dialysis, transfusions, or other treatments if doing so heightens the risk of payment recoupments or costly audit appeals.

During its September 2025 meeting, MedPAC discussed potential policy directions to improve access to specialized palliative care services under the Medicare hospice benefit, such as:

- **Enhanced Data Reporting**: Hospices would be required to report the provision of certain specialized palliative care services on the claims they submit to Medicare.
- **Outlier Payments**: Create a high-cost outlier payment within the hospice payment system, in which Medicare pays providers who furnish certain specialized palliative care services an outlier payment for a portion of costs above a fixed-loss amount.
- **Add-on Payments for Specialized Palliative Care Services**: Provide an add-on payment to hospices when they furnish certain specialized palliative care services (e.g., dialysis, blood transfusions, chemotherapy, or radiation), in addition to the hospice per diem payment amount.
- **Case-mix Adjustments**: Pay higher bundled daily payment rate for hospice enrollees with certain diagnoses (e.g., ESRD, Leukemia) that tend to use specialized palliative care services, but regardless of whether such patients actually receive such services.
- **Voluntary Transitional Program**: Offer hospice patients the option to receive certain specialized palliative care services outside of the hospice benefit for a transitional period/specified number of treatments.

Each of the options presents potentials benefits and trade-offs. For example, outlier payments could help target additional funds to providers incurring unusually high costs for providing specialized palliative care services, but may be administratively complex. Add-on payments offer simplicity and predictability, but risk overpayment and overprovision of services. Case-mix adjustments could account for patient complexity, but setting appropriate rates and paying a higher payment amount regardless of whether specialized palliative service are actually provided does not offer much improvement over the current per diem payment incentives and would introduce new incentives around coding. Enhanced data reporting would be important for establishing the payment amounts and adjudicating payments for any of these payment options.

[4] https://allianceforcareathome.org/wp-content/uploads/Hospice_Audit_Survey_Report.pdf

With regards to a transitional program, while it may help patients reluctant to enroll in hospice, MedPAC commissioners expressed concerns regarding which entity would be ultimately responsible for clinical oversight and care coordination.[5] We note that the evaluation of the Center for Medicare and Medicaid Innovation's (CMMI) Value-Based Insurance Design (VBID) Model test found that transitional care was infrequently used under the Hospice Component of VBID. Some of the barriers noted were: "reliance on non-hospice providers to refer beneficiaries" and "beneficiaries declining to participate, perhaps because they do not want to have to stop curative treatment after a certain number of days[.]"[6]

Continued analysis of these policy options is important to understand their potential impact on access, quality, and the sustainability of specialized palliative care services under the Medicare hospice benefit. The goals should be to remove barriers to electing hospice and the ability to access the full range of services needed for the palliation and management of the patient's terminal condition. At the same time, the incentive to provide unnecessary care should be minimized. Given the complex trade-offs involved, we are supportive of MedPAC's ongoing evaluation of these options and its work will be critical to informing future policy decisions to better support patient access to specialized palliative care services under the Medicare hospice benefit. Finally, we are also supportive of developing clearer clinical guidelines regarding when these treatments are appropriate for palliative purposes and how frequently they should be provided towards end-of-life.

HOSPICE SHOULD NOT BE ADMINISTRED BY MEDICARE ADVANTAGE PLANS

During both the April 2025 and September 2025 meetings, commissioners raised questions about hospice and Medicare Advantage (MA), its history, payment considerations, and the potential implications of including hospice as part of the MA benefit package, with MA Organizations (MAOs) administering the hospice benefit for MA enrollees.

Hospice care is different from other services delivered by Medicare. It is a holistic, interdisciplinary model that addresses the medical, psychological, emotional, and spiritual needs of patients and families. Because hospices are already responsible for providing all items and services for patients at end-of-life, and payment is a set amount with statutory spending limits, the hospice benefit is already a risk-based delivery model. When Medicare Advantage, originally called Medicare+Choice, was established under the Balanced Budget Act of 1997, hospice services were intentionally carved out. Currently, MA beneficiaries who elect hospice have their hospice benefit administered by Original Medicare, while retaining their MA plan for any supplemental benefits not covered by Original Medicare. This process is a seamless experience without burdens for patients or providers. This intentional carve-out also preserves the integrity of hospice care for patients by ensuring direct payment from CMS to hospice providers without

[5] https://www.medpac.gov/wp-content/uploads/2025/09/September-2025-public-meeting-transcript-SEC.pdf
[6] https://www.cms.gov/priorities/innovation/data-and-reports/2025/vbid-2020-2023-eval-report

interference from MAOs. The decision to forgo future curative care and elect to receive palliative care and support through the Medicare hospice benefit is an immensely personal choice for patients and their families.

In 2014, MedPAC recommended including hospice in MA, primarily to improve care coordination. However, it is important to note that hospice already functions as managed care for patients facing terminal illness, negating the need for MA once treatment shifts from curative to palliative in nature. Evidence has shown that efforts to integrate (or "carve-in") hospice into Medicare Advantage have created more problems than solutions. In 2021, hospice was included a component under the VBID Model test. However, in March 2024, CMS announced it would end the VBID Hospice Component, sunsetting it early by December 31, 2024, due to "operational challenges" and limited participation.[7] Data revealed challenges such as administrative burdens, difficulty creating networks, and delayed payments for claims. Lower reimbursement rates raised concerns about the financial viability of hospices and decreased access to hospice care. The demonstration did not result in increased or earlier access to hospice or better care coordination.

Administering the hospice benefit through MA would likely impose barriers to care by inserting an intermediary between beneficiaries, their families, and their doctors. Patients may lose the ability to choose the right hospice for them at the right time. This has particularly important implications for rural areas and small communities, where hospice provider supply is already limited. As MedPAC has observed, hospice use is already lower in rural areas: in 2023, 52.6% of urban decedents used hospice, while only 44.9% of decedents in urban non-adjacent rural regions used hospice.[8] Ultimately, patients may be improperly steered toward or away from hospice care, a deeply personal decision. As CMS has observed, just "[s]lightly over 20% of hospices users have a lifetime length of stay in hospice of between 1 and 4 days."[9] Even modest delays that result from MA utilization management efforts could significantly compromise the timely delivery of care, impeding a hospice's ability to respond swiftly and effectively to rapidly escalating patient needs.

Additionally, including hospice as part of MA would upend how the hospice benefit is administered and result in costly administrative burdens for hospices, including delays in payment that threaten the viability of small and rural providers. Payment rates lower than Medicare would further exacerbate this, leading to MA plans only contracting with large or low-cost providers. MAOs have never had responsibility for administering the Medicare hospice benefit. As demonstrated by the unsuccessful CMMI demonstration, there are significant operational challenges that would be costly for MAOs, if they were even able to overcome.

[7] https://www.cms.gov/priorities/innovation/innovation-models/vbid/vbid-hospice-announcement
[8] https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch9_MedPAC_Report_To_Congress_SEC.pdf
[9] https://www.cms.gov/files/document/hospice-monitoring-report-2025.pdf

The current design of hospice not only delivers quality care for beneficiaries, it also saves Medicare money each year. The way the hospice benefit is administered is working well for both providers and patients, including those that remain enrolled in MA plans after electing to receive hospice care. Upending how millions of seniors receive hospice care risks compromising the quality and integrity of the benefit for all. The Alliance does not believe that allowing MA plans to offer hospice services adds value for beneficiaries. If anything, it creates complexities for providers and compromises access for beneficiaries. Including hospice in MA would create entirely *new* challenges for MAOs, providers, and terminally ill beneficiaries and their families.

CONCLUSION

In conclusion, we urge MedPAC to continue its efforts to ensure that Medicare payments more accurately reflect the costs of delivering specialized palliative care services within the hospice benefit. These services are often critical for providing pain and symptom relief for patients with ESRD and cancer, who may be reluctant to elect the hospice benefit or face access issues in receiving these treatments. We appreciate MedPAC's thoughtful work on policy options aimed at expanding access to these high-cost treatments and encourage continued analysis to determine the best approach to support patients while maintaining program integrity. Additionally, given the operational issues and negative implications for access and quality observed during the VBID Model test, we strongly recommend that MedPAC revisit and withdraw its 2014 recommendation to include hospice in MA. Preserving the hospice benefit as it is currently administered through the Original Medicare program is essential for protecting timely access, maintaining high-quality care, and upholding the patient and family centered foundation of end-of-life services for all Medicare beneficiaries.

We appreciate your consideration of our comments. The Alliance looks forward to continued collaboration with MedPAC to strengthen and expand care at home nationwide. If you have any questions, your staff should feel free to contact the Alliance's chief government affairs officer, Scott Levy, at slevy@allianceforcareathome.org.

Sincerely,

Steven Landers, MD, MPH
Chief Executive Officer
National Alliance for Care at Home