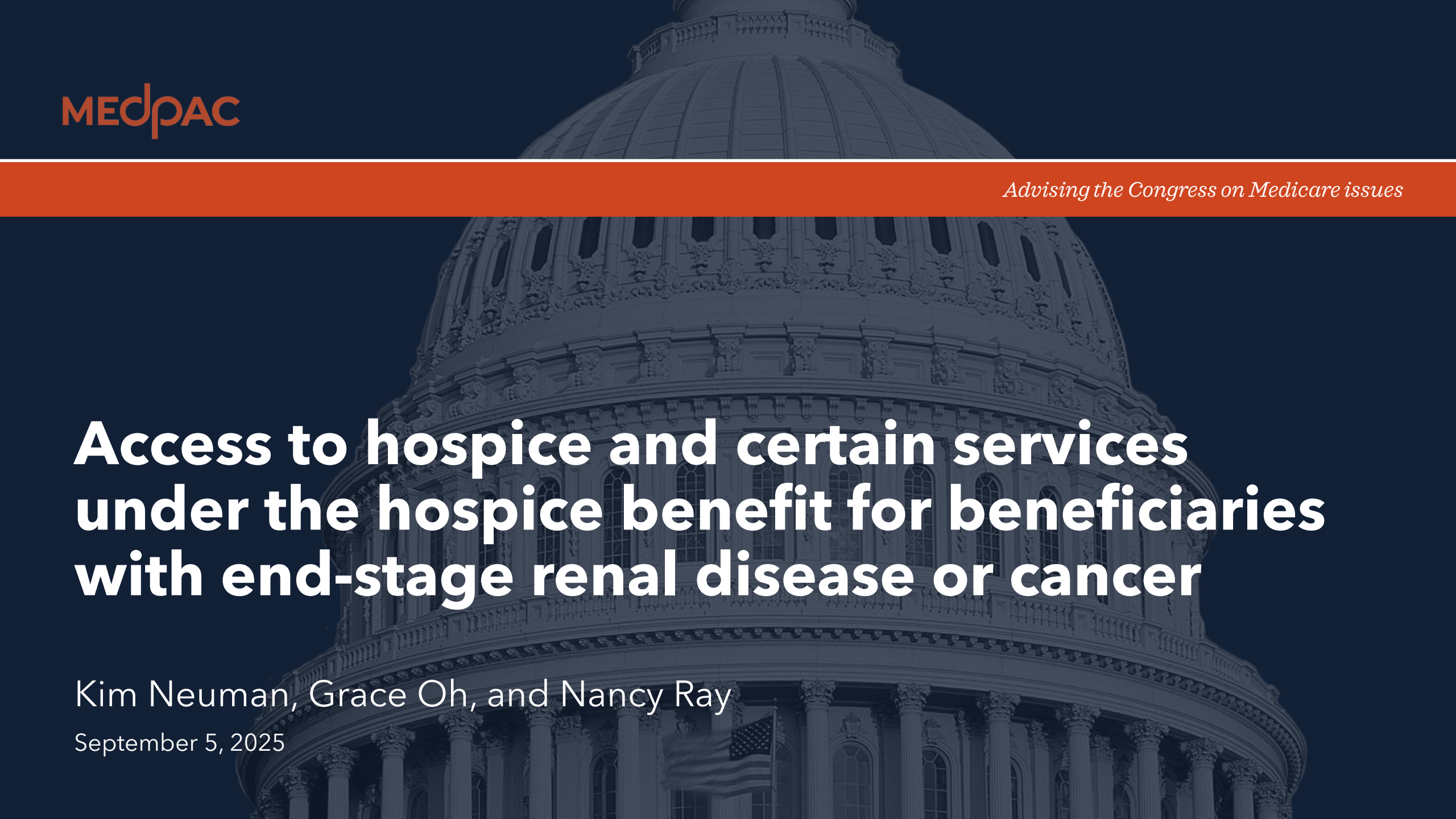
MEDPAC

Advising the Congress on Medicare issues



Access to hospice and certain services under the hospice benefit for beneficiaries with end-stage renal disease or cancer

Kim Neuman, Grace Oh, and Nancy Ray

September 5, 2025

Questions raised about access to certain services under the hospice benefit and hospice payment adequacy for certain patients

- Hospice provides Medicare beneficiaries with an option for end-of-life care focused on symptom management and quality of life
- Roughly half of Medicare decedents choose to enroll in hospice
- In the 2024 and 2025 hospice proposed rules, CMS stated:
  - Beneficiaries may believe Medicare policy prohibits hospices from providing dialysis, radiation, blood transfusions, and chemotherapy
  - Such services are covered under the hospice benefit if the hospice provider determines the service is beneficial for an individual patient's symptoms
  - It has received comments that the cost of these services exceed the hospice payment rate
  - CMS sought comment on whether hospice payment changes were warranted

Note: CMS (Centers for Medicare & Medicaid Services), ESRD (end-stage renal disease).
Source: CMS FY 2025 hospice proposed rule (https://www.federalregister.gov/documents/2024/04/04/2024-06921/medicare-program-fy-2025-hospice-wage-index-and-payment-rate-update-hospice-conditions-of); CMS FY 2024 hospice proposed rule (https://www.federalregister.gov/documents/2023/04/04/2023-06769/medicare-program-fy-2024-hospice-wage-index-and-payment-rate-update-hospice-conditions-of).

Project overview

- Project seeks to examine
  - Access to hospice for beneficiaries with ESRD or cancer, and current experience with provision of dialysis, radiation, blood transfusions, and chemotherapy in hospice
  - Whether hospice payment system influences access to high-cost palliative services and whether changes to improve hospice payment accuracy are warranted
- Project involves literature review, stakeholder interviews and site visits, and data analysis
- Initial findings presented at April 2025 meeting
- Additional analyses presented today:
  - Drugs furnished by hospice providers to cancer patients
  - Estimated costs of certain services relative to Medicare's hospice payment during a stay

Note: ESRD (end-stage renal disease).

Presentation roadmap

1. Background on hospice
2. Summary of prior data analyses and interviews
3. Drugs furnished to cancer patients by hospice providers
4. Comparison of hospice payments versus estimated costs for selected services
5. Potential future policy directions

Medicare hospice benefit

- Hospice is voluntary: a personal choice made by beneficiary and family
- Hospice offers palliative and supportive services for terminally ill beneficiaries
  - Eligibility criteria: Life expectancy ≤6 months if disease runs its normal course
  - Beneficiary agrees to receive palliative care for terminal illness and related conditions under hospice benefit and forgo care for those conditions outside of hospice
- Hospice provider assumes financial risk for services that are reasonable and necessary for palliation of the terminal illness and related conditions
- Medicare generally pays hospice the same daily rate regardless of the number of visits or services furnished

Roles of certain specialized services in hospice

- Specialized services are often furnished with a goal of extending life outside of hospice, but may be palliative for some hospice patients; e.g.:
  - Dialysis: Reduces symptoms of uremia and fluid overload and improves comfort
  - Radiation: Palliates pain from bone metastases
  - Blood transfusion: Improves fatigue and patient perceptions of well-being
- Services raise complex issues for hospices:
  - When is the purpose of a service comfort?
  - Does service affect individual's prognosis and eligibility for hospice?
  - Whether services are consistent with hospice model of care and patient's wishes?
- To navigate these complex individual circumstances, Medicare permits hospices to decide whether to offer specialized services, relying on the medical judgement of the hospice physician and patient preferences

Source: Grubbs et al. (2014), Romano and Palomba (2014), Kalantar-Zadeh et al. (2020), Sekeres et al. (2020), Yerramilli and Johnstone (2023), Alcorn et al. (2024).

Summary of prior analyses of Medicare data (April 2025)

- Decedents with ESRD are less likely to use hospice and have shorter hospice stays compared with decedents overall
- Decedents with cancer are more likely to use hospice but have shorter stays; those with blood cancer have shorter stays than those with other cancers
- Limited Medicare data on provision of dialysis, radiation, blood transfusions, and chemotherapy under hospice benefit
  - Not reported on Medicare claims
  - Limited reporting on costs reports (radiation and chemotherapy)

Note: ESRD (end-stage renal disease).
Source: MedPAC analysis of data from Medicare claims and the Medicare Common Environment.

Summary of MedPAC interview findings (April 2025)

Commission staff conducted interviews

- 12 clinicians in various specialties (cancer, nephrology, and palliative care)
- 9 hospice providers and 3 ESRD facilities (clinical and administrative staff)
- Multiple family caregivers

Interview findings

- Determining if a service is palliative (provides symptom relief) for an individual patient involves medical judgement by hospice physician and depends on individual patient's clinical condition
- General consensus that dialysis, radiation, and blood transfusion may be palliative for some, but less consensus about palliative role for chemotherapy in hospice
- Hospices that furnish these services reported multiple reasons for doing so depending on patient (e.g., symptom relief, ease decision to transition to hospice, or help patient reach goal)
- Interviewees viewed these services as cost prohibitive for many hospices; some cited examples of other high-cost services
- Some dialysis- and transfusion-dependent patients who wish to enroll in hospice may be apprehensive about withdrawing from these treatments upon hospice enrollment

Source: MedPAC analysis of stakeholder interviews.

Examining drugs reported on hospice claims, 2017

- Medicare lacks data on the provision of specific services by hospice providers
  - Such data could be useful in informing future potential hospice payment policy changes
- However, hospices were previously required to report on claims the drugs they furnished during hospice stays (ending October 2018)
- We examined hospice claims data on drugs furnished to hospice patients in 2017 with two goals:
  - To get a sense of claims reporting compliance and feasibility of service-level claims reporting for hospice providers
  - To analyze data on hospice provision of chemotherapy to cancer patients (a type of service CMS raised questions about and that we included in our clinician interviews)

Most hospices reported that drugs were furnished during hospice stays in 2017

- Approximately 90% of hospices (4,013 of 4,488) reported that drugs were furnished during hospice stays and paid for under the hospice benefit
- Among hospices that reported at least one drug claim line in 2017:
  - Drugs were reported, on average, for 87% of stays
  - Five therapeutic classes of drugs accounted for about 80% of those drug claim lines reported by hospices (e.g. central nervous system; analgesic, anti-inflammatory or anti-fever; cardiovascular; gastrointestinal; and respiratory agents)

Source: MedPAC analysis of hospice claims, 2017

Reported use of chemotherapy drugs for hospice enrollees with cancer, 2017

- Hospice enrollees with cancer received many therapeutic classes of drugs, but receipt of antineoplastic drugs (i.e., chemotherapy) was less than 1%
- Drugs classified as antineoplastic drugs were reported on claims for both enrollees with cancer and non-cancer diagnoses, which may indicate that some of these drugs were used for non-cancer indications
- Data are consistent with MedPAC stakeholder interviews that chemotherapy is not generally provided in hospice
  - A number of clinicians expressed view that chemotherapy is generally not palliative for hospice patients, while a few said it might be in limited circumstances (certain product and patient)

Source: MedPAC analysis of hospice claims, 2017

Assessing hospice payment adequacy for patients receiving certain services

- Medicare's hospice payments are intended to cover all services provided by hospice during the stay
- Under a PPS, it is expected that a provider may earn a profit on some cases and incur a loss on others, but that it balances out over their patient population
- However, a mismatch between payments and costs for patients with certain characteristics can create potential access concerns if it is easy to identify in advance which patients are likely to be costly and avoid those costs by not admitting those patients or not furnishing costly services

Note: PPS (prospective payment system).

Illustrative comparisons of estimated costs of certain treatments and hospice payments to inform payment adequacy

- We estimated the cost of providing dialysis, blood transfusions, and radiation during a hospice stay relative to Medicare's payment for the stay under different hypothetical scenarios
  - Modeled 2 scenarios for each type of treatment with assumptions about hospice LOS, treatment frequency, and cost for each service in 2019
- Across the scenarios, we find estimated treatment costs for:
  - **Dialysis** amounted to roughly 40% to 50% of total hospice payments for stay
  - **Blood transfusions** ranged from roughly 30% to 50% of total hospice payments for stay
  - **Radiation** ranged from less than 10% to greater than 30% total hospice payments for stay

Note: LOS (length of stay). Assumptions on hospice LOS and treatment frequency were informed by the literature, our interviews with clinicians, analysis of Medicare data, and input from MedPAC's staff physician. Literature included Ernecoff et al. (2022) and Wachterman et al. (2022) for dialysis; Egan et al. (2023) for blood transfusion; Alcorn et al. (2024) and Yerramilli and Johnstone (2023) for radiation. A proxy for the cost of treatment was estimated based on the average fee-for-service payment rate per dialysis, blood transfusion, and radiation treatment for beneficiaries with end-stage renal disease or cancer in the 30 days before hospice enrollment.

Source: MedPAC estimates for hypothetical scenarios.

Implications of illustrative scenarios for palliative dialysis, blood transfusions, and radiation

- Cost of these specialized services could represent a substantial portion of Medicare's hospice payment for a stay in which they are furnished
- For some hospice providers seeking to offer palliative dialysis, blood transfusions, or radiation, the hospice payment system may create a disincentive to furnish these services
- In March 2025, we concluded that aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries
  - Aggregate Medicare margin: nearly 10% in 2022 and projected to be 8% in 2025
  - Suggests potential for budget-neutral payment adjustments to address payment adequacy for some hospice stays

Source: Medicare Payment Advisory Commission, 2025.

Potential policy directions to improve access to certain specialized services under the hospice benefit

Enhanced data reporting	Medicare lacks data on the provision of certain services by hospice providers → Explore whether hospices should report the provision of certain services on claims; such data could be used to model the effects of new payment approaches
Hospice payment policy changes	Medicare's hospice payment system may create a disincentive for hospices to offer certain services that may be palliative for some hospice patients → Explore whether changes to the hospice payment system are warranted to improve payment accuracy for such services
Voluntary transitional program	Interviewees said that concerns about ceasing services such as dialysis and blood transfusions dissuades some beneficiaries who wish to elect hospice from doing so → Explore the potential to develop a voluntary "transitional program"

Potential policy direction: Enhanced data reporting

Hospices would report the provision of certain specialized services on the claims that they submit to Medicare

Advantages

- Would provide data that policymakers could use to develop approaches aimed at improving the accuracy of the hospice payment system
- Precedent for such an approach

Disadvantages/complexities

- Would increase administrative burden on hospice providers

Potential policy direction: High-cost outlier payments

Create a high-cost outlier payment within the hospice payment system, in which Medicare pays providers who furnish certain specialized services an outlier payment for a portion of costs above a fixed loss amount

Advantages

- Targets funds to providers furnishing specialized services to beneficiaries
- Would increase incentives to furnish specialized services to beneficiaries
- Maintains bundled nature of hospice payment system
- Involves sharing of cost by provider and government

Disadvantages/complexities

- Some may view outlier payments, which compensates for a portion of higher cost, as insufficient
- May be subject to imprecision in estimation of budget-neutral fixed loss amount

Potential policy direction: Add-on payments for specialized palliative services

Provide an add-on payment to hospices when they furnish certain specialized palliative services (e.g., dialysis, blood transfusions, or radiation) in addition to the daily hospice payment rate

Advantages

- Targets funds to providers furnishing specialized services to beneficiaries
- Would increase incentives to furnish specialized services to beneficiaries

Disadvantages/complexities

- Unbundles some hospice services
- Potential for inappropriate provision of services by some hospice providers, spurred by additional payments
- Program integrity safeguards may be needed but could be challenging to successfully implement

Potential policy direction: Case-mix adjustments

Pay higher bundled daily payment rate for hospice enrollees with certain diagnoses (e.g., ESRD, leukemia) who tend to use certain specialized services

Note: ESRD (end-stage renal disease).

Advantages

- Maintains bundled nature of the payment system
- Targets funds to providers who treat beneficiaries with certain diagnoses

Disadvantages/complexities

- Hospice providers who do not offer a specialized service (e.g., dialysis) would still be paid for treating beneficiaries with certain diagnoses (e.g., ESRD)
- Increase in payment rate for certain diagnosis groups may be insufficient to increase incentives
- Estimating case-mix adjusters may be subject to imprecision

Potential policy direction: Voluntary transitional program

Offer hospice enrollees the option to receive certain specialized services that would be paid for outside the hospice benefit for some transitional period or up to a specified number of treatments

Advantages

- Offers a voluntary transition to hospice for beneficiaries who wish to elect hospice but would like to taper off life-sustaining treatments (e.g., dialysis) when in hospice rather than withdraw upon election

Disadvantages/complexities

- Some complexity in designing the voluntary program including establishing the length of the transitional period or the number of treatments that would be offered
- Would increase Medicare program spending (not budget neutral)

Discussion

- Questions
- Feedback on materials
- Potential policy directions and future analytic work
- This work is intended to be included in a chapter in MedPAC's June 2026 report to the Congress

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

meetingcomments@medpac.gov

www.medpac.gov

@medicarepayment