

Access to hospice and certain complex palliative services for beneficiaries with end-stage renal disease or cancer

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Presentation roadmap

- 1 Background on hospice & project overview
- 2 Summary of interviews and data analyses
- 3 Potential policy directions
- 4 Discussion

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

Project overview

- CMS raised questions about access to complex palliative services under the hospice benefit and hospice payment adequacy for certain patients
- In November 2023, Commissioners discussed a workplan outlining research on complex palliative services
- The Commission's research examines:
 - 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 complex palliative services
 - Policy approaches to consider if changes to the hospice PPS are warranted
- Research involves interviews, site visits, literature review, and data analyses
- Findings presented during April and September 2025 meetings

Note: ESRD (end-stage renal disease). PPS (prospective payment system).

Source: Centers for Medicare & Medicaid Services. 2023. *Proposed rule for fiscal year 2024*. Federal Register 88, no. 64 (April 4): 20022–20057.

Centers for Medicare & Medicaid Services. 2024. *Proposed rule for fiscal year 2025*. Federal Register 89, no. 66 (April 4): 23778–23838.

Roles of certain complex palliative services in hospice

- Specialized services 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 transfusions: Improve fatigue and patient perceptions of well-being
- Services raise complex issues for hospices:
 - Under what circumstances is the service furnished for comfort/palliative purposes?
 - Does service affect individual's prognosis and eligibility for hospice?
 - Are services consistent with hospice model of care?
- Under Medicare, hospice providers decide whether to offer specialized services, relying on the medical judgement of the hospice physician and preferences of the patient and family

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 MedPAC interview findings

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

- Whether a service is palliative (provides symptom relief) involves medical judgement by hospice physician and depends on individual patient's clinical condition
- More consensus around palliative role of dialysis, radiation, and blood transfusion than chemotherapy in hospice
- Hospices reported multiple reasons for furnishing these services depending on patient (e.g., symptom relief, ease decision to transition to hospice, 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.

Summary of prior analyses of Medicare data

- 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
 - Hospices were previously required to report information on the drugs they furnished during hospice stays on claims, from April 2014 through September 2018
- Hospice enrollees with cancer received many therapeutic classes of drugs in 2017, but receipt of antineoplastic drugs (i.e., chemotherapy) was <1%

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

Cost to a hospice providing these services could represent a substantial portion of Medicare's hospice payment for a stay

- We estimated the cost of providing dialysis, blood transfusions, and radiation during a hospice stay relative to Medicare's payment for the stay under two hypothetical scenarios for each type of treatment with assumptions about hospice LOS, treatment frequency, and cost for each service in 2019
- Findings:
 - 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 <10% to >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.

For some hospice providers, the hospice payment system may create a disincentive to furnish complex palliative services

- For our forthcoming March 2026 report, the Commission concluded that aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries
 - Aggregate Medicare margin: 8% in 2023; projected 9% in 2026
- Suggests potential for budget-neutral payment adjustments to address payment adequacy for some hospice stays

Source: Medicare Payment Advisory Commission, March 2026 (forthcoming).

Potential policy approaches to address hospice payment accuracy and beneficiary access to complex services

- We explored several different approaches policymakers could consider
- Approaches focus on data reporting and payment changes
- Approaches do not change the structure of the Medicare hospice benefit or the hospice physician's role in determining the mix of palliative services offered to a patient under hospice

Summary of potential policy approaches

Enhanced data reporting

To inform potential policymaking, hospices would report the provision of certain complex palliative care services

Hospice payment policy changes

Two potential payment policy approaches:

- *High-cost outlier payment for certain complex palliative services where Medicare pays hospices a portion of costs above a fixed loss amount*
- *Add-on payment to hospices for certain complex palliative services in addition to the daily hospice payment rate*

Voluntary transitional program

Voluntary transitional program that would give hospice enrollees the option to receive certain complex palliative services paid for outside the hospice benefit for some transitional period or up to a specified number of treatments

Principles to consider when evaluating approaches to address beneficiary access to complex palliative services

- Maintain incentives for efficiency present in the hospice bundled payment approach
- Target any additional payments toward providers that are furnishing high-cost services in an efficient manner
- Structure any changes to minimize vulnerability to fraud and abuse

Enhanced data reporting for certain complex palliative services

Advantages

- Data could inform modeling and new payment policy approaches if warranted
- Precedent for such an approach

Disadvantages/complexities

- Would increase reporting burden on hospice providers

Design considerations

- Which services hospices report
- Length of time for enhanced data reporting
- How hospices report data (e.g., report on claims they submit to CMS)

High-cost outlier payments for certain complex palliative services

Advantages

- Targets funds to providers furnishing costly services
- Maintains bundled nature of hospice payment system
- Helps retain incentives for efficiency

Disadvantages/complexities

- Some may view payments as not sufficiently increasing incentives to furnish high-cost services

Design considerations

- What services are eligible for an outlier payment
- What share of costs above fixed-loss amount would Medicare pay
- What is the target amount of spending that outlier payments would account for
- What type of data sources would be used to estimate provider costs for outlier services

Add-on payments to hospice providers for certain complex palliative services

Advantages

- Targets funds to providers furnishing certain costly services
- Would increase incentives to furnish these 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 challenging to implement

Design considerations

- What services are eligible for an add-on payment
- How to set add-on payment rate
- Size of reduction to hospice base rate needed for budget neutrality
- How to ensure program integrity and provision of services consistent with palliative nature of hospice benefit

Voluntary transitional program for certain complex palliative services

Advantages

- May increase access to hospice for some beneficiaries (e.g., those dependent on dialysis or transfusions)
- Paying nonhospice providers directly for certain complex palliative services may be operationally easier for some hospices

Disadvantages/complexities

- Paying for certain services outside of hospice could lessen hospices' role in managing that care
- May increase Medicare program spending, depending on design

Design considerations

- What services are eligible for transitional program
- What length of time or number of treatments would be appropriate
- How to promote collaboration between the specialist administering transitional treatments and hospice physician
- How to minimize the potential for unintended financial incentives or undermining the hospice benefit criteria

Summary

- Findings from interviews, literature, and data analyses:
 - Decedents with ESRD and cancer less likely to use hospice or have shorter stays than other decedents
 - Some clinicians raised concerns about access to hospice for dialysis- and transfusion-dependent patients
 - Lack of data on hospices' provision of complex palliative services
 - Potential disincentive in hospice payment system to provide certain complex palliative services for some hospices
- Commission has explored potential approaches to address beneficiary access to complex palliative services
 - Enhanced data reporting to inform potential policymaking
 - Hospice payment changes: high-cost outlier or add-on payment
 - Voluntary transitional program

Note: ESRD (end-stage renal disease).

Discussion

- Questions
- Feedback on materials
- This work is intended as an informational chapter in MedPAC's June 2026 report to the Congress

Medicare Payment Advisory Commission

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