MEDPAC

Advising the Congress on Medicare issues

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

Kim Neuman, Grace Oh, and Nancy Ray

April 11, 2025

Presentation roadmap

1. Background on hospice and project overview
2. Roles of certain specialized services in hospice
3. Limited data available to assess whether hospices furnish certain services under the hospice benefit
4. Hospice use among beneficiaries with ESRD and cancer and experience with models of concurrent care
5. Interviews with clinicians, providers, and family caregivers
6. Summary and next steps

Medicare hospice benefit

- Palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll
- Eligibility criteria:
  - Life expectancy of 6 months or less if disease runs its normal course
  - Beneficiaries can be enrolled longer than 6 months if continue to meet criteria
- When beneficiaries elect hospice:
  - Agree to receive palliative care for their terminal illness and related conditions under hospice benefit and forgo care for those conditions outside of hospice
  - Services for unrelated conditions are covered outside of hospice by FFS or Part D
- Hospice benefit is carved out of MA and paid by FFS*

Note: FFS (fee-for-service), MA (Medicare Advantage)
* Under the Center for Medicare and Medicaid Innovation's value-based insurance design model hospice benefit component, some MA plans were responsible for the provision of hospice care to their enrollees from 2021 to 2024.

Hospice payment system

- Hospice provider assumes financial risk for all services that are reasonable and necessary for palliation of the terminal illness and related conditions
- Medicare FFS pays a prospective daily rate for hospice
- Payment rate based on four levels of care:
  - Routine home care (RHC) (>98% of days)
  - 3 other levels of care (GIP, CHC, IRC) are paid higher rates
- Hospice payment rate is generally not affected by the number of visits or cost of nonvisit services provided by hospice on a given day*

Note: FFS (fee-for-service), GIP (general inpatient care), CHC (continuous home care), IRC (inpatient respite care).
* For beneficiaries receiving RHC in the last 7 days of life, Medicare pays hospice providers the standard RHC rate plus an additional amount for registered nurse and social worker visits (based on number of hours of visits). For CHC, Medicare pays hospices based on an hourly rate instead of daily rate (based on number of hours of nurse and aide visits).

Motivation for examining access to hospice for beneficiaries with ESRD and cancer

- MedPAC has shown hospice use is substantially lower among decedents with ESRD than decedents overall
- 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 received comments that the cost of these services > hospice payment rate
  - CMS sought comment on whether hospice payment changes were warranted
- November 2023 workplan and commissioner interest

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).

Examining access to hospice care for beneficiaries with ESRD and beneficiaries with cancer

- Project seeks to examine:
  - Access to hospice care for beneficiaries with ESRD and beneficiaries with cancer
  - Current experience with provision of dialysis, radiation, blood transfusions, and chemotherapy in hospice
- Approach:
  - Review of relevant literature
  - Analysis of *available* Medicare data (claims, cost reports, hospice enrollment data)
  - Interviews with clinicians, hospice providers, dialysis providers, and family caregivers
- Today's presentation represents our initial look at these issues

Note: ESRD (end-stage renal disease).

Role of specialized services in hospice

- When used outside of hospice, dialysis, radiation, blood transfusions, and chemotherapy are often used with a goal of extending life
- For certain hospice patients, these services may be palliative; for example:
  - 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
- Medicare permits, but does not require, hospices to offer specialized services for palliative purposes
- Services raise complex issues for hospices:
  - When is the purpose of a service comfort?
  - Does service affect individual's prognosis and eligibility for hospice?

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).

Medicare generally lacks data on how frequently hospice providers furnish certain services

Claims data

- No current data on how frequently hospices furnish dialysis, radiation, blood transfusions, or chemotherapy
- Data available only for services paid by FFS Medicare *outside the hospice benefit, as "unrelated" to the terminal condition*

Cost-report data

- Hospices report costs by category of expense
- Specific fields for palliative radiation and chemotherapy
- No specific fields for dialysis or radiation (not able to separately identify these costs)

Note: FFS (fee-for-service).

Few freestanding hospices reported incurring costs for palliative radiation or chemotherapy in 2023

- In 2023, 3% of freestanding hospices reported costs for palliative radiation and 1% for palliative chemotherapy
- More large and nonprofit hospices reported costs for these services; e.g., the share reporting palliative radiation costs was:
  - Largest quartile (7%) vs. smallest quartile (<1%)
  - Nonprofits (9%) vs. for profit (2%)
- Caveat: Completeness and accuracy of data reporting in these specific cost-report fields is unknown

Note: Hospice provider–size quartile is calculated based on providers' total number of Medicare-covered days.
Source: MedPAC analysis of Medicare cost reports, hospice claims data, and Provider of Services file.

Average FFS payment for these services generally exceeds Medicare's hospice daily payment rate

- No data on costs for hospices to furnish dialysis, transfusion, or radiation treatments
- To get a rough sense, we estimated average FFS payment for these services per treatment day when beneficiaries are not enrolled in hospice
- *Note: Hospice patients who receive such services might receive them once or multiple times in a hospice stay but not every day*

	Medicare payment amount, 2019
Hospice RHC rate	$196 per day (Days 1–60) $154 per day (Days 61+)
Average FFS payment for patient not enrolled in hospice	
Dialysis	$284 per treatment day
Transfusion	$708 per treatment day
Radiation	$618 per treatment day

Note: FFS (fee-for-service), RHC (routine home care). Average FFS payment rate per dialysis, blood transfusion, and radiation treatment is based on claims for beneficiaries with end-stage renal disease (dialysis), blood cancer (transfusion), or any cancer (radiation) in the 30 days before hospice enrollment. The average FFS payment for a blood transfusion reflects payments for the transfusion (CPT 36430) and red blood cells; it does not include payments for other related services such as laboratory services. For radiation treatments, we included (1) radiation therapy HCPCS codes from the American Society of Radiation Oncology, Restructured BETOS Classification System, and the Agency for Healthcare Research and Quality's Clinical Classification Software codes; and (2) HCPCS codes associated with ablation therapy as identified by MedPAC staff physician. Payment estimates may not fully reflect physician management services associated with these three treatments.

Source: MedPAC analysis of Medicare claims and Medicare common environment data.

Access to hospice and use of specialized services covered outside of hospice and paid for by FFS Medicare

- We used FFS Medicare claims data to ascertain what can be known about access to hospice and use of specialized services covered outside of hospice and paid for by FFS Medicare:
  - Beneficiaries with ESRD: Use of dialysis outside of hospice, paid for by FFS Medicare
  - Beneficiaries with cancer: We focused on beneficiaries with blood cancer who may rely on blood transfusions compared with beneficiaries with other cancers and those without cancer

Note: FFS (fee-for-service), ESRD (end-stage renal disease).

Historically, decedents with ESRD have lower hospice use rates than other decedents

	Decedents with ESRD	All Medicare decedents
Share of decedents who used hospice		
2010	27%	44%
2019	30	52
2023	31	52
Among hospice decedents, lifetime LOS (days), 2023		
Median	6	18
(10th percentile, 90th percentile)	(2, 28)	(2, 278)
Average	23	96

Note: ESRD (end-stage renal disease), LOS (length of stay). Includes all Medicare decedents, including those enrolled in fee-for-service Medicare or Medicare Advantage.
Source: MedPAC analysis of Medicare hospice claims and enrollment files from CMS.

Snapshot of FFS decedents with ESRD who used hospice, 2019

- One-third of FFS decedents with ESRD in 2019 elected hospice:
  - More likely to be older, White, not dually eligible, newer to dialysis, and diagnosed with Alzheimer's disease
  - Similar inpatient admissions, SNF days, and home health days in the last year of life
  - Less ICU use in the last month of life
  - Less likely to die in hospital (8% vs. 60%)
- We lack data on decedent use of dialysis that the hospice paid for
- Outside of hospice, about 1 in 8 decedents with ESRD received dialysis during their hospice stay, paid for by FFS Medicare:
  - Use of dialysis outside of hospice was higher among decedents in for-profit hospices

Note: FFS (fee-for-service), ESRD (end-stage renal disease), SNF (skilled nursing facility), ICU (intensive care unit).
Source: MedPAC analysis of Medicare claims and Acumen LLC data files on use of hospice by Medicare beneficiaries with ESRD.

Decedents with cancer had higher rate of hospice use but shorter stays in 2019

- Decedents with cancer were more likely to use hospice, but for a shorter time, than decedents without cancer
- Hospice decedents with blood cancer were less likely to use hospice and had shorter stays than those with other cancers

	Decedents		
	With blood cancer	**With other cancer**	**Without cancer**
Share of decedents who used hospice	57%	66%	45%
Among hospice decedents, lifetime LOS (days)			
Median	9	16	20
(10th percentile, 90th percentile)	(2, 101)	(2, 132)	(2, 346)
Average	41	53	114

Note: LOS (length of stay). Analysis includes only FFS beneficiaries who died in 2019 and who were not in Medicare Advantage in 2018 and 2019. We define beneficiaries with cancer as those with a cancer primary diagnosis on a claim for inpatient or outpatient hospital services, physician services, or hospice services in the last year of life. We define beneficiaries with blood cancer as those with leukemia, multiple myeloma, and myelodysplastic syndrome.

Source: MedPAC analysis of Medicare hospital inpatient, outpatient, physician, and hospice claims and data from the Medicare Common Environment.

FFS Medicare payments for blood transfusions or radiation for hospice users with cancer was rare in 2019

- Very few hospice beneficiaries with blood cancer received a blood transfusion paid for by FFS Medicare during hospice
- Very few hospice beneficiaries with any type of cancer received radiation paid for by FFS Medicare during hospice
- This is not unexpected since these services typically treat cancer symptoms and would likely be considered "related" to the terminal prognosis
- We lack data on how often hospice patients received blood transfusions or radiation that was covered under the hospice benefit

Note: FFS (fee-for-service).
Source: MedPAC analysis of Medicare hospital inpatient, outpatient, physician, and hospice claims and data from the Medicare Common Environment.

Experiences with models of concurrent care

- Concurrent care: Patients continue to receive certain conventional treatments while enrolled in hospice
- Within Medicare, CMMI has tested several models that give entities the option to offer concurrent disease-directed care and hospice
  - Kidney Care Choices Model
  - ACO REACH Model
  - Medicare Advantage Value-Based Insurance Design (MA–VBID) demonstration
- CMMI's Medicare Care Choices model tested concurrent disease-directed care and palliative care for individuals not enrolled in hospice
- Partnerships between dialysis organizations and hospices

Note: CMMI (Center for Medicare and Medicaid Innovation), ACO REACH (Accountable Care Organization Realizing Equity, Access, and Community Health).

MedPAC interviews

- In 2024 and 2025, Commission staff conducted interviews with:
  - 12 clinicians in several specialties: oncology, hematology, nephrology, and palliative care
  - Clinicians and administrative personnel from 9 hospice providers and 3 dialysis providers, including:
    - Hospice medical directors, hospice physicians, nephrologists, nurses, social workers, and other administrative staff
  - Multiple family caregivers of decedents who used hospice

Source: MedPAC analysis of stakeholder interviews.

MedPAC interviews (cont'd)

- Providers and clinicians interviewed varied by region, urban and rural status, ownership type, and practice setting:
  - Hospices we interviewed were mostly medium or large (by average daily census)
- We asked each interviewee about their perspectives on:
  - The role of certain services in hospice, including dialysis, radiation, blood transfusions, and chemotherapy
  - How they affect patient decisions about hospice enrollment
  - Hospices' experiences with providing services

Source: MedPAC analysis of stakeholder interviews.

Summary of themes from interviews

- Clinicians interviewed generally agreed that dialysis, radiation, and blood transfusion may be palliative for some hospice patients:
  - Less consensus about role of chemotherapy in hospice
  - Some dialysis- and transfusion-dependent patients may be apprehensive about ceasing these treatments to enroll in hospice
  - Need for palliative radiation may affect timing of hospice enrollment for some beneficiaries with cancer
- Hospices that furnish these services reported doing so for multiple reasons, depending on the patient:
  - To provide symptom relief
  - To ease decision to transition to hospice
  - To help patients reach specific goals (e.g., attending a family wedding)

Source: MedPAC analysis of stakeholder interviews.

Summary of themes from interviews (cont’d)

- Interviewees viewed these services as cost-prohibitive for many hospices to furnish:
  - There are other high-cost services besides dialysis, blood transfusions, and radiation that may be palliative for some patients
  - Transportation can add financial and logistical challenges
  - Costs also vary by a hospice’s ability to execute contracts with dialysis facilities and hospitals/clinics and the negotiated rates
- Hospices vary in their policies and approaches to furnishing these services:
  - Protocols about treatment frequency or duration
  - Modified treatment regimen
  - Hospice philosophy of care

Source: MedPAC analysis of stakeholder interviews.

Summary and next steps

Summary

- Limited data to examine frequency of provision of dialysis, radiation, blood transfusions, and chemotherapy under hospice benefit
- Claims data indicate less hospice use and/or shorter stays among beneficiaries with ESRD and beneficiaries with blood cancer
- Interview findings:
  - Concern about ceasing treatments in hospice may affect some enrollment choices
  - These services may have a palliative role for some hospice patients, depending on individual patient's condition
  - The cost of specialized services generally exceed Medicare's daily payment rate and may make it challenging for hospices to furnish these services

Note: ESRD (end-stage renal disease).

Initial findings and considerations for future work

Data	Medicare lacks data on the provision of certain services by hospice providers → Explore the potential for enhanced data reporting
Payment accuracy	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
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 "transitional program"

Discussion

- Questions
- Feedback on materials
- Potential future analytic work

MEDPAC

Advising the Congress on Medicare issues

Medicare Payment Advisory Commission

meetingcomments@medpac.gov

www.medpac.gov

@medicarepayment