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Pierre M. Désy, MPH CAE

August 21, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Calendar Year 2027 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Acute Kidney Injury Dialysis (AKI) Payment, and ESRD Quality Incentive Program [CMS-1846-P]

Dear Administrator Oz:

On behalf of the more than 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment in response to the Calendar Year (CY) 2027 End-Stage Renal Disease (ESRD) proposed rule referenced above. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Overview

AAHPM appreciates that CMS seeks to improve access to palliative dialysis services, as well as CMS' overall prioritization of access to palliative care – as demonstrated by multiple requests for information (RFIs) focused on palliative care that have been included in Medicare rulemaking over the past year.

AAHPM's core mission is to advance hospice and palliative medicine by enhancing learning, cultivating knowledge and innovation, strengthening

workforce, and advocating for public policy to achieve our vision. Our core vision is that all patients, families, and caregivers who need it will have access to high-quality hospice and palliative care. Unfortunately, there are numerous policy, coverage, and payment barriers that prevent our vision from becoming a reality, and with respect to patients with ESRD, in particular, patients too often fail to receive the comprehensive palliative dialysis services they need.

As CMS contemplates how to increase access to palliative dialysis, we believe it is important to consider two distinct populations of patients who require these services:

- ***Hospice Population.*** Patients who have a terminal prognosis of 6 months or less, who require palliative dialysis while enrolled in the hospice benefit. Notably, this population is likely under-represented due to Medicare requirements that beneficiaries waive access to services related to their terminal conditions, as well as due to challenges that hospices face in furnishing palliative dialysis services, as we discuss further below.
- ***Non-Hospice Population.*** Patients who are not eligible or not willing to elect the hospice benefit.

As we detail below, ***we believe that delivery of palliative dialysis will vary across these populations, including when considering which providers and suppliers are involved in their care and how care is delivered.***

We also highlight the role that a physician-led palliative care team should play in supporting patients receiving palliative dialysis. Hospice population patients have *de facto* access to a physician-led team when they enroll in hospice, as a physician-led interdisciplinary team is core to the delivery of hospice care. For patients in the non-hospice population, AAHPM believes that ensuring access to such a team – in addition to their nephrologist and dialysis care provider – will help to improve patients' quality of life, experience of care, and overall well-being, consistent with overall benefits of palliative care that have been widely documented.

Definition of Palliative Dialysis

CMS seeks information on how to define "palliative dialysis" for purposes of Medicare policy. ***AAHPM believes that palliative dialysis is differentiated from maintenance dialysis based on the primary intent of treatment.*** For maintenance dialysis, treatment is intended to maximize longevity and facilitate rehabilitation, including by achieving strict laboratory targets. In contrast, ***palliative dialysis focuses on relieving symptoms, maintaining function, and supporting the patient's quality of life and goals of care.*** Often, the shift from maintenance dialysis to palliative dialysis will result in reduced treatment burden, reduced dietary restrictions, and increased flexibility regarding laboratory values.

Despite this dichotomy in intent, we note that maintenance dialysis and palliative dialysis are both inherently palliative in nature, not curative, as well as inherently life-prolonging. While discontinuation of dialysis would result in uremic syndrome progressing to death, ongoing receipt of palliative dialysis would allow for continued renal replacement, thereby prolonging life consistent with patients' treatment goals. This is true even for patients who have elected hospice who may accept their terminal diagnosis but still desire to prolong survival while receiving hospice care. As a result, a focus on the primary intent is paramount in distinguishing between maintenance and palliative dialysis.

Beneficiary Eligibility and Targeting

AAHPM believes an ESRD patient's managing nephrologist should be responsible for determining when the patient transitions from maintenance dialysis to palliative dialysis, and for overseeing dialysis care before and after such transition. However, in the ideal scenario, a nephrologist would reach the decision to transition to palliative dialysis through shared decision-making with the patient/caregivers and in consultation with the patient's palliative care team, including the patient's hospice care team or community-based palliative care team, as applicable. Factors that the nephrologist should consider include functional status, frailty, disease burden, prognosis, and patient preference.

Notably, we do not believe that eligibility for palliative dialysis should be dependent on prognosis, homebound status, or other existing constructs that limit eligibility for other Medicare benefits. As noted above, beneficiaries who are not eligible for hospice (i.e., have a prognosis of greater than six months) may still desire and benefit from palliative dialysis.

Care Delivery and Settings

As noted above, ***AAHPM believes that access to palliative dialysis will depend on whether the patient has elected hospice or not.***

Hospice Population

For ESRD patients who have elected hospice, under ideal conditions, the hospice should remain responsible for overseeing all aspects of the patient's terminal condition and related care. This includes symptom management, nursing, psychosocial support, spiritual care, bereavement, advance care planning, caregiver support, and coordination of the hospice plan of care. When the plan of care includes palliative dialysis, the hospice would facilitate patient access, including by coordinating with the ESRD facility to furnish the dialysis services. The ESRD facility should remain responsible for dialysis treatment delivery, dialysis-related medications, access management, and dialysis safety – all in a manner consistent with the nephrologists' treatment plan. Additionally, the hospice care team and the ESRD care team should collaborate to develop and regularly update a unified interdisciplinary care plan; the ESRD interdisciplinary team meetings could include a representative from the hospice care team to accomplish this goal.

We note, however, that current hospice payment rates often do not allow for hospices to fully engage in this work. While some hospice programs are able to accommodate delivery of palliative dialysis to patients, in too many cases – particularly for small hospices and non-profit hospices – the costs associated with providing such services are prohibitive. That is because hospices take on full coverage and payment risk for providing services related to hospice beneficiaries' terminal illness, but many hospices serve relatively small patient populations, which does not allow hospices to spread risk. Additionally, the Medicare hospice benefit does not have any payment policies that protect against outlier costs. We also call attention to the fact that hospices would need to rely on ESRD facilities to furnish palliative dialysis. However, hospices often experience difficulties partnering or contracting with these facilities, including finding facilities able to contract for the provision of dialysis at reimbursement rates hospices can afford.

To address these challenges and support hospices in facilitating patient access to palliative dialysis, we believe that new payments to hospices – in addition to what hospices currently receive – would be

necessary. Payments would have to align with the costs of furnishing the dialysis, including costs that hospices incur in coordinating with dialysis facilities, arranging transportation, and managing patients' care. Alternatively, a separate approach – under which CMS pays ESRD facilities directly, rather than requiring hospices to coordinate and pay for services out of the payments they receive from Medicare – could address some of the financial and operational challenges that hospices experience, thereby facilitating access to palliative dialysis services for hospice beneficiaries. However, we note that there will still be new costs that hospices will have to bear, including to arrange for transportation, for which added funding will be needed.

As noted above, we also emphasize that major barriers exist to patients joining this population of hospice patients who would benefit from palliative dialysis in the first place. In particular, statute requires that patients waive access to all other Medicare services related to the terminal condition. As a result, beneficiaries and their families face a difficult choice, and too often, the desire to continue disease-directed care results in late referrals to hospice. For some, the need to make this choice means never electing hospice, depriving many beneficiaries and their families/caregivers of the supportive end-of-life care furnished by hospices to which they are entitled. To address this limitation, AAHPM believes fundamental reforms to the hospice benefit are needed, including that beneficiaries should have access to concurrent care and treatments while receiving hospice care. In the case of dialysis patients, this could entail delivery of either maintenance dialysis or palliative dialysis, whichever is consistent with the patient's goals of care. Indeed, research looking at Medicare hospice patients with access to concurrent care services through the Veterans Administration found that patients receiving concurrent dialysis care had substantially longer hospice lengths of stay than those who did not.[1] 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,[2] 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. Overall, we believe that concurrent care could move the system further towards a future with an expanded seamless benefit for patients with serious illness, in which patients could access both palliative care services and disease-directed services based on their needs and goals, regardless of their prognosis.

Non-Hospice Population

For ESRD patients who are not eligible for or not willing to elect hospice, the ESRD facility responsibilities should remain the same. However, we believe that a physician-led interdisciplinary community-based palliative care team should oversee palliative care plans and coordinate with the nephrologist and ESRD interdisciplinary team to manage the patient's care. The palliative care team would be responsible for many of the same elements as the hospice, including symptom management, nursing support, psychosocial support, spiritual care, advance care planning, and caregiver support. A unified interdisciplinary care plan would continue to be managed jointly across the palliative care team and the ESRD care team and could include home dialysis if feasible and appropriate. And as applicable, home

[1] Wachterman MW, Corneau EE, O'Hare AM, et al. 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. 2022;3(10):e223708. doi:10.1001/jamahealthforum.2022.3708.

[2] Hemrajani A, Lo SS, Vahlkamp A, et al. Concurrent hospice healthcare utilization in the hematology/oncology patient population at veterans affairs. Journal of Clinical Oncology. 2023; 41(16_suppl). doi:10.1200/JCO.2023.41.16_suppl.12125

health may also be involved to provide separate skilled services only when medically necessary and non-duplicative.

As with the hospice population, we note that challenges exist in coverage and payment for community-based palliative care services for this non-hospice population. In particular, we highlight the absence of adequate reimbursement mechanisms for the services performed by the non-physician, non-advanced practice provider (APP) members of the palliative care interdisciplinary team, including social workers, pharmacists, non-APP nurses, and chaplains and other spiritual care providers. AAHPM has raised these concerns with CMS and intends to provide detailed recommendations for addressing these limitations in response to the RFI included in the CY 2027 Medicare Physician Fee Schedule proposed rule.

Additional Considerations

For both the hospice and non-hospice populations, ***AAHPM emphasizes that there should not be any limitations on the number of palliative dialysis sessions that patients can access.*** Recognizing that palliative dialysis services prolong life, we do not believe a short-term, limited duration benefit would accommodate the needs of all patients who elect to receive palliative dialysis.

Payment Policy Considerations

AAHPM appreciates that CMS seeks to support palliative dialysis without creating duplicative payment across the ESRD prospective payment system (PPS), the hospice PPS, and the home health PPS. In response, we reiterate that we do not believe current payment structures enable delivery of comprehensive palliative dialysis – either for patients who have elected hospice or for those who are ineligible or unwilling to do so. For hospice patients, the hospice per diem is insufficient for hospices to regularly furnish palliative dialysis services to enrolled patients who may desire or benefit from such care. And for non-hospice patients, for whom the ESRD PPS would cover the cost of dialysis services, a payment gap remains to support the aspects of care that are critical for designation as palliative dialysis – that is, the symptom management, psychosocial support, spiritual care, advance care planning and more – furnished by an interdisciplinary community-based palliative care team. Furthermore, across both populations, financial incentives could be strengthened to ensure collaboration between the ESRD facility and the hospice or palliative care team, as applicable.

AAHPM therefore urges CMS to explore changes that will ensure that patients who desire and would benefit from palliative dialysis are able to access such care. This could include increased payments to hospice providers to cover the costs of palliative dialysis; direct Medicare payments to dialysis facilities to furnish palliative dialysis to hospice patients; incentives to dialysis facilities, hospices, and palliative care teams to engage in collaborative care planning; payments for community-based palliative care services; and more. ***To the extent that changes in statute are needed, we encourage CMS to work with Congress to achieve such reforms.***

Program Integrity and Safeguards

To ensure appropriate targeting and to prevent overutilization, AAHPM reiterates our position that the patient's nephrologist should be responsible for determining patient eligibility for palliative dialysis

services after consulting with the patient's palliative care team. Patient consent should also be obtained and documented.

Once the decision to transition to palliative dialysis is made, ESRD and palliative care teams should work together to develop the unified interdisciplinary palliative dialysis care plan. This care plan should reflect a comprehensive needs assessment (including psychosocial and spiritual needs) and include clear treatment goals that are consistent with a documented goals-of-care discussion.

Conclusion

Thank you again for the opportunity to provide feedback on ways to improve access to palliative dialysis services. AAHPM would be pleased to work with CMS to address our recommendations above. Please direct questions or requests for additional information to Wendy Chill, Senior Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,



Kimberly Curseen, MD, FAAHPM
President, American Academy of Hospice and Palliative Medicine