August 24, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

RE: Medicare Program; CY 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,

LeadingAge, together with our state partners, represents more than 5,300 nonprofit and mission-driven aging services providers serving older adults and touching millions of lives every day. From our national headquarters in Washington, DC, and in collaboration with state partners whose members are active in 50 states, the District of Columbia, and Puerto Rico, we use advocacy, education, applied research, and community building to make America a better place to grow old. Our membership encompasses the entire continuum of aging services, including skilled nursing, assisted living, memory care, affordable housing, retirement communities, adult day programs, hospice, Programs of All-Inclusive Care for the Elderly (PACE), and home-based care.

On behalf of these members, LeadingAge is pleased to offer the following comments in response to the Request for Information to Advance Palliative Care for Dialysis Patients included in the CY 2027 ESRD proposed rule. Our members would be responsible for operationalizing whatever palliative dialysis policy CMS ultimately adopts, and in many cases the beneficiaries CMS describes in this RFI are already their residents and clients.

That vantage point shapes our comments. Beneficiaries with ESRD are too often forced to choose between the treatment managing their symptoms and the interdisciplinary support hospice provides, and they overwhelmingly resolve that choice by declining or deferring hospice until the final days of life. But the coordination problem CMS has identified extends well beyond hospice: a substantial share of dialysis beneficiaries live in nursing facilities or receive home health services, and any workable policy must account for those settings.

To what extent do current Medicare coverage and payment policies affect the ability of beneficiaries to receive home health and hospice services concurrently for different conditions, and how might these policies impact access to and coordination of dialysis services, including in the home setting?

Patients with end-stage renal disease who are still on dialysis almost never receive hospice care. The payment under the hospice benefit, as we detail below, is insufficient to cover the costs of prolonged dialysis treatment. The benefit policy manual related to the coordination between hospice and ESRD also should be revised to clarify roles and responsibilities, especially if CMS were to pursue a more holistic approach to palliative dialysis. In contrast, the benefit policy manual as it relates to the

concurrent treatment of home health and dialysis patients is much clearer. If CMS moves forward with defining a palliative dialysis service, guidance across the spectrum — hospice, home health, skilled nursing, and nursing homes — would need to be updated to correspond with the new definition and to ensure appropriate coordination of care regardless of setting.

If CMS provides the ability for hospice to offer more access to services like palliative radiation or palliative dialysis, dialysis centers, nephrologists, oncologists, and others will need education about the changes and their impacts on hospice. They would also need to be engaged in conversations about appropriate courses of treatment when the treatment is intended for palliation. For example, there is clinical evidence that fewer fractions of radiation may be appropriate when intended for palliation; hospices will need radiation oncologists to work with them on developing the most appropriate plan of care. In order to do this, the payment and quality incentives need to align across providers. We would also ask that CMS consider corresponding quality measures and incentives to ensure that a referral to hospice, when appropriate, aligns with the goals of these providers.

People might access high-intensity palliative services during different parts of their hospice stay for different reasons. Many will access them as a condition of choosing to elect hospice — for example, a beneficiary might be more willing to come onto hospice if they do not have to "let go of the rope" by immediately stopping dialysis. However, we have also heard from members that at times during the course of a hospice stay, a beneficiary may want one of these therapies. It is not clear what "exhausting other options" would mean in relation to these types of interventions, and such a standard would likely just recreate the access problem that currently exists, but in a different form.

How should CMS define "palliative dialysis" for purposes of Medicare policy?

We recommend CMS define palliative dialysis by clinical intent and goal of treatment, not by modality, frequency, duration, or setting. This intent-based framing matters for three reasons. First, it is consistent with how the clinical literature has defined the concept: palliative dialysis has been described as renal replacement therapy directed to patients in the most critical phases of illness and at end of life, with prescriptions targeted to the patient's condition rather than to standard adequacy metrics. Clinical experts, including Alvin Moss and colleagues, frame the appropriate population as patients with a life expectancy of less than one year, symptoms that dialysis might ameliorate, and values such that they would accept a trial of dialysis. Second, an intent-based definition is auditable through documentation — a goals-of-care discussion, a certification, a plan of care — without requiring CMS to prescribe clinical parameters that will vary appropriately from patient to patient. Third, a modality- or frequency-based definition alone would invite exactly the wrong behavior: providers reverse-engineering a prescription to fit a payment definition rather than to fit the patient.

What clinical characteristics distinguish palliative dialysis from maintenance dialysis?

Palliative dialysis should be focused on symptom relief, function, and quality of life consistent with the goals of the patient. The frequency of treatment, therefore, would likely be reduced from maintenance dialysis, where the goal is long-term survival above all else. Interventions would be more conservative, promoting fewer intensive interventions and prioritizing home and community-based solutions rather than the hospitalizations that many ESRD patients experience over the course of their illness. Patients electing palliative dialysis should be assessed differently when their function declines than a patient whose goal is life-sustaining treatment. Laboratory testing should be reduced to only those tests that inform symptom management.

Care Coordination Across Provider Types

Hospice should retain professional management. CMS should make clear that when a beneficiary has elected hospice, the hospice must retain professional management overall of the beneficiary pursuant to the hospice plan of care under the supervision of the hospice interdisciplinary group. In short, the hospice IDG should own the plan of care, and the ESRD facility must furnish palliative dialysis under that plan of care pursuant to a written agreement.

Coordination across provider types. LeadingAge recommends CMS establish a coordination standard within the ESRD Conditions for Coverage (42 CFR Part 494), paralleling the hospice Conditions of Participation at 42 CFR 418.112 governing care of nursing facility residents receiving hospice services. Just as CMS requires a written agreement and defined communication protocols between hospices and skilled nursing facilities, a comparable provision is needed here. At minimum it should require a written agreement signed before services begin; designated points of contact at each entity; a defined manner and frequency of communication, documented, to ensure the beneficiary's needs are met 24 hours a day; a process for the ESRD facility to notify partners of any change in condition; and a process for reassessing the dialysis prescription as the patient's condition and goals change.

The three-party case requires explicit attention. Where a nursing facility resident elects hospice and receives palliative dialysis, three sets of federal requirements apply at once — the hospice CoPs, the long-term care requirements of participation, and the ESRD Conditions for Coverage. CMS should clarify how the existing 418.112 hospice/nursing facility agreement extends to the ESRD facility, including transportation responsibility, medication reconciliation across three providers, and who is accountable when a resident's condition changes on a dialysis day. Within that framework, the ESRD facility should retain clinical oversight of the dialysis prescription, equipment, and dialysis-specific staff training and certification, while the hospice retains overall interdisciplinary care coordination and symptom management for the terminal condition.

Training must run in both directions. If CMS expands access to palliative dialysis, dialysis centers and nephrologists will need education on how the hospice benefit operates and what changes under a palliative plan of care; hospice, home health, hospital, and nursing facility clinicians will correspondingly need education on palliative dialysis. This cross-provider education is real work that must be funded and cannot be assumed to occur on its own.

Payment Policy Considerations

In order to make payment changes that enable palliative dialysis, CMS should coordinate with Congress, or pursue a demonstration, to ensure both that adequate funding exists and that CMS has the ability to structure an appropriate palliative dialysis bundle.

As it stands, hospices cannot pay for palliative dialysis out of the current per diem, and no restructuring of existing hospice payment will change that. The arithmetic is straightforward. At the FY 2027 routine home care rate of $236.35 per day for days 1–60, thrice-weekly dialysis at the proposed CY 2027 ESRD PPS base rate of $299.55 per treatment would consume roughly 54 percent of the entire hospice payment for the week — before a single nursing visit, medication, or piece of equipment. Beyond day 60, at $186.35 per diem, dialysis alone consumes approximately 69 percent. These figures exclude ancillary costs such as transportation to the dialysis center, which is not covered under the hospice payment even at a reduced treatment frequency.

For this reason, LeadingAge urges CMS to work with Congress to secure the additional funding necessary to make a palliative dialysis payment structure viable. This cannot be solved by redistributing dollars already in the hospice benefit. Absent congressional action to provide those funds, it does not make sense for CMS to pursue an add-on or bump-up to the hospice per diem. An adjustment sized within existing budget authority would be substantially smaller than the cost of the service it is meant to cover; hospices would decline to use it, leaving beneficiaries where they are today while creating the appearance that the access problem has been addressed.

In the interim, CMS should pursue steps available to it that do not require new appropriations: defining palliative dialysis and updating cross-sector guidance accordingly; recognizing palliative dialysis on claims through a modifier or condition code in order to track utilization; excluding beneficiaries receiving palliative dialysis from adequacy-based ESRD QIP measure denominators; and issuing survey guidance confirming that a goal-concordant palliative prescription is not a deficiency.

Thank you for the opportunity to comment. We welcome the opportunity to work with CMS as it develops this policy.

Sincerely,

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