



June 4, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1754-P
P.O. Box 8010
Baltimore, MD 21244-1850

Re: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements (CMS-1754-P)

Dear Administrator Brooks-LaSure:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), I write to offer our comments and recommendations on the Centers for Medicare & Medicaid Services (CMS) hospice proposed rule for fiscal year (FY) 2022. NKCA represents eight nonprofit dialysis providers: Centers for Dialysis Care; Central Florida Kidney Centers, Inc.; Dialysis Center of Lincoln, Inc.; Dialysis Clinic, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; Puget Sound Kidney Centers; and The Rogosin Institute. Collectively, we serve more than 22,500 patients at more than 326 care sites in 32 states. In an effort to keep patients off dialysis, we also serve more than 10,000 patients with chronic kidney disease (CKD), with the goal of avoiding, or at least delaying, the onset of end-stage renal disease (ESRD).

As nonprofit providers, approximately 85 percent of our patients are covered by Medicare, including Medicare Advantage (MA) plans. Hence, the availability (or lack thereof) of Medicare's hospice benefit is of considerable importance. Unfortunately, current Medicare rules pose an obstacle to election of hospice care by ESRD patients. Therefore, we welcome this opportunity to address CMS' request for comment regarding its analysis of hospice utilization and spending patterns.

In Section III of the proposed rule, CMS, using 2019 pre-COVID data, provides its analysis of hospice utilization, noting that there has been "substantial growth" in use of hospice by Medicare beneficiaries. In particular, CMS points to a shift in the "pattern of diagnoses" in hospice patients from predominately cancer diagnoses to neurologic diagnoses, such as dementia, and organ-based failure diagnoses, which now constitute not only the "top-reported" principal diagnoses, but also the conditions with the longest stays. However, with respect to kidney failure, in Table 2 of the proposed rule, CMS reports that of the top 20 ICD-10 reported diagnoses, ESRD is ranked at number 16 out of 20, with only 1.4 percent of reported diagnoses. Moreover, when CMS analyzes data on longer length of stay (a critical factor in hospice, with its assumed six-month

terminal prognosis) CMS notes that unlike other organ-based failure diagnoses, kidney disease/kidney failure is an exception. Indeed, in Table 6 “Average Length of Stay in Days for Hospice Users in 2019,” CKD/ESRD patients have the shortest average length of election, median lifetime length of stay, and average lifetime length of stay. We believe we know why, and, unfortunately, it is not because ESRD patients and their physicians are more parsimonious when considering hospice. Hence, as we describe below, any comparison between ESRD/CKD patients’ diagnoses and others’ diagnoses is probably misplaced.

Simply put, current Medicare policy with respect to hospice election by ESRD patients actively discourages such election not only for those for whom ESRD is the primary diagnosis, but, also for some patients, such as those with diagnoses of both cancer and ESRD, where differing interpretations of CMS policy occur, resulting in further pain and distress for patients and their families. And, when hospice is eventually chosen, election occurs extremely late in the course of the disease—often with mere days remaining. Unfortunately, current Medicare rules governing hospice pose a barrier—unintended, we believe—for patients on dialysis who come to the point in their care where it is no longer congruent with their life goals.

Currently, hospice services are available to people who have a principal diagnosis of ESRD and who are on dialysis only if they completely abandon dialysis—in effect, imposing a “cliff.” It should not be surprising that patients, fully informed of the consequences, are reluctant to take that step. The lack of a smooth transition off maintenance dialysis can lead to significant discomfort and pain, due to shortness of breath from fluid retention, significant and discomforting itching, confusion, and nausea from uremia. Moreover, because it can take days to organize appropriate hospice services for an individual, stopping dialysis suddenly can lead to additional pain and emotional distress at the very time when a person deserves some measure of quality and comfort at the end of life. Rather than providing “palliative care for relief of pain and symptom management” as described in CMS regulations, the denial of all dialysis services—not standard maintenance dialysis—actually imposes pain and thwarts symptom management. In short, for ESRD patients, current hospice policy is turned on its head.

As we have stated in prior comments to CMS, we recommend an alternative policy that eschews maintenance dialysis (as provided under Sec. 1881) in favor of short-term, palliative, concurrent care that employs dialysis services as one of several tools for pain and symptom management. Like other palliative measures, such an approach should be provided for in the plan of care by the hospice interdisciplinary team, working with an ESRD patient’s nephrologist to establish frequency, length of episode, and related services. While an ESRD patient electing hospice due to a primary diagnosis of ESRD would still waive their right to maintenance dialysis, the plan of care could still provide for limited dialysis episodes, modified use of related services such as laboratory tests and pharmaceuticals, as well as a more flexible diet, for the sole purpose of palliation. We believe that such an approach could be provided for under the Secretary’s authority at 418.202(i) that allows:

“any other service that is specified in the patient’s plan of care as reasonable and necessary for the palliation and management of the patient’s terminal illness and related conditions and for which payment may otherwise be made under Medicare.”

We recognize that CMS does not seek comment specifically on any alternatives in this proposed rule; nonetheless, we propose (as we have before) that CMS consider concurrent services for hospice care for patients on dialysis. If CMS seeks to address issues around extended length of stay and possible over-utilization, then it should address the reverse as well. “Palliative dialysis” is a compassionate path for patients with ESRD at their end of life. Rather than facing a cliff, if a patient were permitted to receive a maximum of 10 dialysis episodes, it could provide more comfort than if that patient abruptly goes off dialysis. Those treatment episodes might be shorter and/or less frequent, but still provide palliative symptom treatment consistent with Medicare’s hospice rules. Such an approach likely would not require standard dialysis blood tests and medication administration. Not only can this contribute to a more compassionate end-of-life pathway, but also reduce the patient’s own financial burden, as well as the cost to the Medicare program.

Two of our member ESRD provider companies have tested such an approach for over 50 ESRD patients. While limited in size, both have experience that may be instructive regarding gradual reduction in frequency and length of dialysis episodes, more selective use of labs, reduction in pharmaceuticals (including suspension of ESAs), and, most importantly, patient quality of life at the end of life. Patients report that this type of care provides a smooth transition during an unsteady time for the patient, and their family, as well as the entire care team working to help them with this life transition. One of the companies saw the median length of stay was 20 days. And, although data is preliminary, costs for Medicare beneficiaries were \$28,000 lower on average for those who elected concurrent care versus those that did not elect hospice in the last year of life.

The other group also documented improved end of life experience for the patient, their bereaved caregivers, and clinicians who provided care as part of the concurrent care program. Caregivers underscored the importance of how this program allowed patients the option to continue limited dialysis serving both as a psychological bridge to hospice as well as avoidance of unnecessary pain and discomfort. Indeed, almost half of the 37 patients that were offered the concurrent dialysis option ultimately did not receive a dialysis treatment while on the program. Yet, it was the comfort of knowing that dialysis was an option and that the hospice team would be part of the process moving forward that allowed them to decide not to pursue further maintenance dialysis treatments. For the 37 admitted into the concurrent model there were a total of 52 hemodialysis treatments. The average length of stay in hospice was 10.3 days for all patients. It was 6.1 days on average for those who did not receive dialysis and 15.2 days for those who chose to receive dialysis.

The need for greater access to hospice care among people with kidney disease, particularly those with ESRD who are on dialysis, is quite apparent from CMS’ own data. These individuals are some of the most chronically ill beneficiaries in the Medicare program, and should have the choice of appropriate services for care concordant with their goals. When chronic kidney disease advances to end-stage renal disease, patients face a choice of whether to pursue dialysis, kidney transplantation if a donor is available, or conservative care, ultimately leading to death. Hospice is a choice that should be available to those who wish to immediately pursue the latter, or who

decide to transition later in their course of dialysis—perhaps years later when they are ready to take that step. This can afford them improved quality of life, better outcomes, and less expensive care.

Thank you for your attention to this important issue. We would be pleased to discuss this in greater detail at any time. If you have any questions, please feel free to contact me at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,

A handwritten signature in blue ink that reads "Martin Corry". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

Martin Corry
Executive Director