



Nonprofit Kidney Care Alliance

June 18, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1714-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Fiscal Year 2020 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1714-P)

Dear Administrator Verma:

On behalf of the Nonprofit Kidney Care Alliance (NKCA), we appreciate the opportunity to comment on the request for information regarding hospice care. NKCA represents five nonprofit dialysis providers: Centers for Dialysis Care; Dialysis Clinic, Inc.; Independent Dialysis Foundation, Inc.; Northwest Kidney Centers; and The Rogosin Institute. Collectively, we serve more than 20,000 patients at more than 280 clinics in 30 states. Consistent with our belief that we can do more to keep patients off dialysis, we also serve more than 5,000 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. We would like to address the need for hospice care among people with kidney disease, particularly those with ESRD on dialysis. 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. Hospice is a choice that should be available to those who wish to immediately pursue the latter or transition to later in their course of dialysis. This can afford them improved quality of life, better outcomes and less expensive care. Unfortunately, current rules governing hospice pose a barrier if the patient is on dialysis but finds that it is no longer congruent with their goals.

Currently, hospice services are available to people with ESRD on dialysis only if they completely abandon dialysis or they have a concurrent diagnosis, such as advanced lung cancer, associated with

predicted survival less than 6 months and unrelated to that prognosis. If people with ESRD wish to pursue hospice services without a concurrent diagnosis, they must stop dialysis abruptly—in effect imposing a “cliff.” The lack of a smooth transition off dialysis can lead to significant discomfort, due to shortness of breath from fluid retention or itching, confusion, and nausea from uremia. Because it can take days to organize appropriate hospice services for an individual, stopping dialysis suddenly can lead to additional pain and worrisome symptoms at exactly the time when a person deserves some measure of quality and comfort at the end of life.

We propose that CMS consider alternative models for hospice care for patients on dialysis. “Palliative dialysis” is a compassionate path for patients with ESRD as their end of life diagnosis. Rather than facing a cliff, if a patient were permitted to receive a maximum of 10 dialysis episodes, it could provide more comfort as that patient transitioned off dialysis. Those treatment episodes might be shorter and/or less frequent, but still provide palliative symptom treatment consistent with Medicare’s hospice rules, and with such an approach, might not require blood tests and medication administration. Not only can this contribute to a more compassionate end of life pathway, but also reduce their own financial burden, as well as cost to the Medicare program. A palliative dialysis approach could be considered in the context of an exploratory model, such as a pilot program through the Center of Medicare and Medicaid Innovation’s (CMMI’s) current or future versions of the Comprehensive ESRD Care (CEC) Model, as we look to provide care to people throughout their lives with kidney disease. It could also be an option under CMS’ Medicare Advantage (MA) Value-Based Insurance Design (VBID) model already announced for plan year 2021.

In addition, we ask that CMS provide clear guidance to hospice providers and Medicare Administrative Contractors (MACs) regarding services for patients receiving chronic dialysis who have a non-ESRD end of life diagnosis. Recently, a patient was refused hospice services, despite advanced lung cancer, because ESRD contributed to her prognosis, i.e. six months or less to live. This 90-year-old woman was the matriarch of her family, and voiced the importance of dying ‘with grace.’ Instead, she and her family had to fight for the right to receive dialysis for her ESRD and hospice services for her end-stage cancer diagnosis. Ultimately, she accessed hospice services and dialyzed for 64 days before passing away, with a modest decrease in time on dialysis in her final days. Her family acknowledged that hospice services contributed to a ‘good’ death for their mother, who left the world with grace, as she wished. Absent dialysis treatment, her final days would have been ones of extreme discomfort, and not the “comfort and dignity throughout the dying process” which CMS correctly refers to in the 2014 hospice final rule (FR 78, no. 152, p 48251.) We urge CMS to address this “Catch 22” situation, in which a patient with a non-ESRD terminal diagnosis with a six month prognosis, is denied care, because some other condition might be construed as “related” to a six month prognosis.

While access to hospice services is available to all Medicare beneficiaries, those in Medicare Advantage plans—now over a third of Medicare beneficiaries—face a fragmented system if they elect hospice. A similar case can be made for those in other alternative delivery care systems, such as Accountable Care Organizations (ACOs). In addition, beneficiaries in traditional fee-for-service (FFS) Medicare also face gaps in advance care planning and coordination of care. Under current policy, if a Medicare Advantage plan member elects hospice, they remain in their MA plan for certain services and drugs, unrelated to their terminal diagnosis, but otherwise default to fee-for-service hospice. CMS pays the hospice at FFS rates and the MA plan receives a partial payment for its residual responsibility.

CMS has announced that through CMMI it will test a voluntary model of hospice care in Medicare Advantage starting in plan year 2021 that will “realign incentives to support concurrent care,” in which the MA plan retains responsibility for the member’s total care. As the RFI correctly points out, this will not be without complexities, such as how to incorporate the cost of hospice into county benchmarks that are part of the MA plan bid process. We commend CMS and CMMI for undertaking this initiative. However, if it is going to truly reduce fragmentation, plans should see hospice as part of a larger end-of-life planning process—otherwise the fragmentation in FFS will simply be added to MA.

An example of what can be done is demonstrated in one of our member company’s ESRD Seamless Care Organization (ESCO). They provide hospice services to individuals within ESCO dialysis facilities. Within the ESCO, a palliative care team provides kidney palliative care throughout a patient’s life on dialysis, including hospice. One gentleman, who had been estranged from his daughter, was able to voice his goals and preferences after several conversations with the palliative care team. In doing so, the team could support this gentleman in reconnecting with his daughter in a meaningful way. The two spent many weeks together before he passed away, and touched the entire family.

For these reasons, hospice services and palliative care should be provided to individuals on chronic dialysis. In a system where a person’s life can be a myriad of clinic appointments and restrictions, these services bring meaning and fulfillment to a person around a time of inevitable transition. Finally, beyond Medicare Advantage, and possible pilot initiatives, we urge CMS to work with Congress to address any gaps in its authority that create barriers to hospice from patients whose ESRD prevents them from receiving hospice care as they reach the end of life’s journey.

Thank you for the opportunity to provide feedback on the possible positive impact hospice can have on ESRD patients’ end of life choices. We would be pleased to discuss any of these suggestions in greater detail at any time. If you have any questions, please feel free to contact Martin Corry at 202-580-7707 or info@nonprofitkidneycare.org.

Sincerely,



Martin Corry
Executive Director